

The loss of possibility: scientisation of death and the special case of early miscarriage

Julia Frost¹, Harriet Bradley², Ruth Levitas²,
Lindsay Smith³ and Jo Garcia⁴

¹*School of Nursing and Community Studies, University of Plymouth*

²*Department of Sociology, University of Bristol*

³*East Somerset Research Consortium (ESReC)*

⁴*Social Science Research Unit, Institute of Education, University of London*

Abstract This paper explores the special nature of bereavement in the case of first trimester miscarriage. It is theoretically informed by the sociological literature concerning death and bereavement and is empirically grounded in interviews with 79 women. We argue that the ‘scientisation of death’ in modern societies contributes to the uncertainty and isolation which distinguish early miscarriage as a unique form of loss. In the absence of clear cultural scripts to draw upon, many women interviewed gave meaning to their loss as ‘what might have been’ or what we call ‘the loss of possibility’. Some women juxtaposed the failure of their pregnancy with that of modern medicine either to prevent the loss or provide a credible explanation for their miscarriage.

Little research has been conducted in this area, since the pioneering work of Lovell (1983) and Cecil (1984). Our research draws on one of the largest and most systematic bodies of data ever collected on early miscarriage, and provides continued evidence of the traumas of miscarriage. The strategies employed by women to make sense of, and come to terms with, their experience of miscarriage are explored, employing a typology of pre-modern, modern and postmodern responses.

Keywords: miscarriage, bereavement, death, motherhood, pregnancy, scientisation

Introduction

This paper explores the special nature of bereavement in the case of early (first trimester) miscarriage. We argue that this is a unique type of loss because of the many ambiguities surrounding the event. Early miscarriage can be seen as an ‘imperfectly scientised’ form of death in the context of modern societies where science and medicine are expected to provide ‘rational’ accounts of the causes of physiological phenomena. In addition, silence, isolation and uncertainty combine to augment the suffering of miscarrying women.

Research has highlighted the general problems surrounding bereavement in late modern societies: the decline of religion and ritual have led to what Mellor (1993) refers to as the ‘sequestration of death’, leaving bereaved individuals to handle their loss largely within the private sphere, with a diminution of public and community support (Turner 1987). Social

rules about how to respond to death are weakened (for example the abandonment of 'widows' weeds') and individuals lack guidance as to how they should respond and behave. At the same time there has been a 'scientisation of death' (Walter 1994, Mellor and Shilling 1993), so that the meanings and practices of death are largely controlled by various professional or 'expert' groups: doctors, coroners, surgeons and undertakers, for example. A crucial part of this scientisation process is that death is viewed within the framework of modernist rationality, as an 'outcome' with a 'cause' (Bauman 1992). Thus we come to expect an explanation of how and why each death occurs.

More recent literature has focused upon the collective acts of grief *when no explanation is valid*. This macro-thanatological turn is beginning to tackle events, such as the death of the Princess of Wales (Walter 2001) and the 9/11 terrorist attacks in America (Kastenbaum 2004), which illustrate developments in responses to deaths which medicine and technology have been unable to prevent. These new approaches are interesting in showing how social responses to loss and bereavement may change. Such changes do not, however, necessarily relieve the problems surrounding privatised deaths of ordinary individuals, especially where the loss is clouded by secrecy, as in the situation we explore here. Indeed MacKendrick (2005), in discussing Walter's work on the postmodern revival of death warns that replacing scientific thinking with individualistic or religious sentiments may place too much of a burden on the isolated bereaved person. In this paper we consider these various ideas in relation to a form of death which, although common, is still under-researched and imperfectly understood: the loss of a baby in early miscarriage.

The case of early miscarriage exemplifies these processes of sequestration and scientisation. Modernist complexities are heightened by a set of ambiguities around the event; when did the death occur, what exactly has been lost, what exactly has taken place? In addition, ambiguities are heightened for individuals by the continued 'silence' and lack of public awareness about miscarriage, despite its common occurrence (generally estimated as one in five conceptions); and by the fact that there is limited medical knowledge about its causes. The easy availability of home pregnancy testing kits, plus ultrasound technology used in clinics, means that women now tend to identify pregnancies earlier on than in the past and are thus more likely to be aware that uterine bleeding is in fact a miscarriage (where previous generations may have diagnosed a very heavy period).

While this scientific development enables some women to identify a pregnancy as soon as a menstrual period is missed, others still may miscarry before they know that they were pregnant, thus not being fully aware if they have technically miscarried. There is an aura of uncertainty around such experiences. Some women who experience the trauma of early miscarriage struggle largely on their own to make sense of a confusing and inexplicable train of events. Drawing on material from a study involving interviews with 79 women in the months after their miscarriage, we explore the complex ways in which our respondents strove to comprehend and manage their loss.

Death, bereavement and miscarriage

Miscarriage is a paradigmatic example of the sequestration of death, both in the sense that most women (including the women in this study) know little about it until they experience it themselves, and in the sense that its occurrence is surrounded by secrecy and is hidden from public view. Early attempts to break the silence around miscarriage highlighted the lack of public knowledge and information on the topic and the distress and trauma many women underwent; researchers highlighted the need to improve handling of miscarriage

(Lovell 1983, Cecil 1984, Oakley 1984). Indeed, it was only in the 1980s that miscarriage was clearly acknowledged as a source of bereavement.

Since the 1980s researchers in medical psychology have explored the range of effects of miscarriage, early and late, on women and more recently on their partners. Typical responses include grief, anxiety, depression, stress, guilt and self-blame (Leppert and Pahlka 1984, Friedman and Gath 1989, Prettyman *et al.* 1993); a Finnish study established a link with suicide (Gissler *et al.* 1996). Recent follow-up and longitudinal studies suggest that these effects may be lasting, being manifested at four months (Lee *et al.* 1996), six months (Neugebauer *et al.* 1997) and one year (Robinson *et al.* 1994). Loss was found to be the most common response occurring in 92 per cent of the 24 women interviewed by Conway (1995). Similarly, Zaccardi *et al.* (1993), reporting on a sample of 44 women who miscarried in an Accident and Emergency Department, suggested that over three-quarters of the women experienced a sense of loss. Recent research has also focused on fathers' responses, finding that they too suffer bereavement effects (Johnson and Puddefoot 1996, Murphy 1998). It may also be the case that miscarriage becomes an even more menacing issue in an age of shrinking family size and a more controlled approach to family planning: if people have planned precisely when they wish to have each child, miscarriage disrupts this orderly plan.

Sociological investigation of this topic remains scanty, with exceptions being the pioneering research mentioned above and more recent studies by Cecil (1994) and Moulder (1998). This work points to deeper effects of miscarriage, which is seen as constituting a significant life event or trauma and involving a major disturbance of self-identity. Women interviewed by Moulder (1998) and Oakley (1984) were frequently dissatisfied with the way miscarriage was handled by hospital staff, especially consultants. They complained about the lack of information and the insensitivity of some aspects of the medical care, for example the practice of referring to miscarriages as 'abortions' (with all the stigma and moral confusion surrounding that concept) or the practice of accommodating miscarrying women in a maternity ward among mothers with babies or about to give birth.

While some hospitals seem to have improved some aspects of their care since these studies (although many of our respondents reported similar problems), issues associated with the 'medicalisation' of miscarriage, as of other reproductive processes, remain. As Oakley and Graham (1981), Reissmann (1983) and Martin (1987) have pointed out, medicalised child-birth may be viewed by doctors as a medical event with a successful (or otherwise) outcome, which may need greater or less medical intervention according to clinical diagnosis prior to the birth. Similarly, medicalised miscarriage is viewed as a singular event, its 'outcome' measured in terms of subsequent complications such as infection. Miscarrying women, however, tend to view the miscarriage holistically as an event with emotional, psychological, practical and social aspects. The medicalised approach detracts from the complexity of this experience and contributes to a sense that miscarriage is being trivialised and its seriousness for the woman denied. The public correlative to medicalisation is the often-proffered 'consoling' remark 'never mind you can always have another one', which the respondents in our study universally condemned as insensitive. Here the baby, which, as we will argue, is in many cases regarded as a person, is reduced to an 'outcome' which can easily be replicated.

The medicalisation of miscarriage is clearly linked to the broader issue of the scientisation of death. Rather than being seen as a random stroke of 'chance' or 'fate' or as a part of a life trajectory ordained by God, death becomes a rational event with biological and medical 'causes'. As we shall show, these differing views may be held in tandem or juxtaposed.

Bauman (1992) suggests that the sequestration and secularisation of death and grieving, alongside the modern fascination with youth and the construction of the self (Mellor and Shilling 1993), has led to modern men and women struggling to give meaning to both their

lives and death, constructing narratives that 'make sense of it all'. Mellor and Shilling (1993) contend that in an age of science and reason, where youth and health are valued, death is problematic because it challenges the reality which man and science have been so busy creating. As such, there are now complex constructions concerning the *cause* of death: people no longer die as a result of their *mortality* or *old age*. Rather we hear of people dying from 'heart disease' or 'renal failure', labels that are added at the post-mortem, which we believe are less likely to affect *us*, as individuals. Although it is estimated that we witness the deaths of thousands of strangers each year via television, a real death within our own milieu is shocking, particularly if we consider it premature (Bauman 1992, Walter 1994).

The problem, here, is that modernity has promised so much but has ultimately failed to prevent death. Bauman proposes that in the face of this challenge, modern individuals adapt 'life strategies' to make sense of death, which are again mainly based upon scientific wisdom (we adopt lifestyle programmes, go to the gym, eat healthy food, quit smoking). In sum, in an attempt to *defeat* death, the individual life narrative becomes a reflexive project, something to be worked on, modified and managed. There is a paradox here: as we commence the 21st century; there is a growing disillusionment with scientific medicine (seen in the proliferation of complementary therapies); there is, however, an *increasing* dependence upon biomedicine to provide the answers to medical and social problems, particularly for an ageing population (Lupton 1998). Critics have suggested that this has led to the scientisation of normal reproductive functioning, which has been redefined as pathological; medical intervention can be viewed as a form of 'patriarchal surveillance' (Doyal 1995). Others, however, have suggested that such interventions are liberating for women, allowing them to control their own reproductive functioning and family planning. From interviews with women about their experiences of pregnancy and birth, both Franklin (1997) and Evans (1985) concluded that women expressed the desire for greater control over their pregnancies, while *simultaneously* accepting the use of medical technology.

Hospitalised miscarriage is framed within such notions of rational explanation, but unfortunately medical understanding of the causes of individual miscarriages is incomplete, though they may be sometimes linked to the existence of a specific cause, *e.g.* abnormal chromosomes (Regan 2001). Yet most women will never get a coherent explanation of why they miscarried. Thus miscarriage might be seen as an *imperfectly scientised* form of death. It is this, as we shall see, which makes miscarriage such a bewildering experience for many women and their partners. The lack of a cause/outcome framework can challenge their sense of living in a rational world.

Some authors are critical of the lack of a feminist alternative to the dominant discourses regarding pregnancy loss. This may be due to a lack of willingness to engage with the debate concerning abortion. Indeed, if a stance is proposed by feminists that acknowledges the 'baby-ness' (for some women) of what is miscarried, Lovell (1997) suggests that:

by focusing attention on the 'personhood' of the baby lost through miscarriage, stillbirth and early neonatal death, they might be seen as adding ammunition to the anti-abortion lobby (1997: 47).

Several writers, however, contend that this identification with foetal personhood is already with us. For Littlewood (1999), the personhood of the foetus is both culturally and historically specific; whereas Letherby (1993) suggests that such an identification occurs at the level of the individual woman or couple. Indeed, there are interactions at many levels in this construction, as the would-be mother comes into contact with media, technologies, discourses, gifts and images throughout her pregnancy which both construct her as a mother, and her pregnancy as a baby. Early scanning may contribute significantly to this:

the expectant couple is presented with a 'photo' of their baby, which establishes her/him as a family member.

Layne (1997: 304) argues that feminists are well placed to create 'a more liberatory discourse of pregnancy loss' by creating a new language (or indeed languages) to breach the silence. This involves thinking *beyond* the notion of abortion and miscarriage as dichotomous (as proposed by Hey *et al.* 1996). Adopting a postmodern approach, which acknowledges the fluidity of interpretation, Layne (1997) proposes:

If, on the other hand, one accepts an anthropologically informed view of personhood, that is, that personhood is culturally constructed (and that the ways it is constructed differ among cultures and within a given culture over time), one can see that the process of constructing personhood may be undertaken with some embryos and not others (1997: 305).

As we shall see, this fits with the data from our study.

Methods

This research explored 79 women's experience of early miscarriage (Smith *et al.* 2006), which in turn followed on from a large quantitative medical study (Trinder *et al.* 2006). The Miscarriage Treatment (MIST) Study (Trinder *et al.* 2006) was a randomised controlled trial (RCT), which recruited women from the South West of England, and randomised them to one of three types of management: surgical, medical and expectant. Surgical management involves general anaesthetic and an operation to empty the womb, which is legally recorded as an evacuation of retained products of conception (ERPC), more colloquially known as a 'D and C' (dilatation and curettage). Medical management involves the administration of prostaglandin drugs (mefipisterone and misoprostol), both orally and vaginally, to encourage the womb to contract and empty. Expectant management involves providing pain relief (analgesia), and waiting for the womb to empty naturally (this is often referred to as the 'wait and see' method). The primary concern of the RCT was to access the infection rates associated with the three different methods of management (Trinder *et al.* 2006).

The qualitative research built on from the RCT, and used the trial population as its sampling frame – a method that is increasingly becoming established in health services research (Donovan *et al.* 2002, Murphy *et al.* 2003, Wass *et al.* 2003). The qualitative study focused on women's experiences and responses to the three management methods, as well as seeking women's experiences of miscarriage more generally (including their emotional as well as their medical needs). In-depth interviews were carried out with a sub-sample of trial participants who had volunteered to be approached subsequent to the trial. The aims of the qualitative study were to:

- contribute to a more complete understanding of women's experience of early miscarriage;
- investigate factors which help women cope more satisfactorily with the experience of early miscarriage;
- relate the above factors to the different methods of management;
- explore the findings in the light of sociological work on the centrality of maternity to women's self identity;
- provide information which may help the appropriate health professionals and agencies provide more effective support.

Key findings from the project have been summarised in Smith *et al.* (2006).

The RCT recruited 1,200 women between May 1997 and December 2001 (Trinder *et al.* 2006). 111 of these women were sent information about the qualitative research and a consent form. 48 women declined to be interviewed, and 63 were interviewed, including seven with whom the interview schedule was piloted and refined. Following ethical approval, a further 35 women who had not participated in the RCT were contacted via the trial recruiters at the three participating hospitals.

The purpose of interviewing some of the RCT non-participants was to control for any effects that may have arisen as a result of taking part in the MIST study. It was clear that the trial involved more attention being given to miscarrying women than is normally the case, and the research team wanted to be apprised of any 'Hawthorn effect'. Sixteen non-participating women were interviewed, while the remaining 19 declined. The non-participants had consented to be contacted at the time of the miscarriage, and most had undergone the traditional management method offered by the three hospitals, which was surgical intervention, undertaken as a day patient. As we expected, it became clear that some aspects of the trial procedure meant that women in the trial felt they had received better treatment than those who had not participated. For example, they greatly appreciated the follow-up interviews, which were not offered as standard, and felt that they had been kept better informed. Otherwise, there was little difference in the women's stories, though the worst cases reported tended to refer to miscarriages experienced prior to the trial period.

Once the research had been explained, women were given a cooling-off period between being contacted and being interviewed to enable those who wished to opt out to do so. They were told about the research when they were contacted eight weeks after miscarriage to receive the last trial paperwork, and re-approached six to twelve months later. Interviews were then arranged as convenient for the women. With early grief responses to miscarriage now well established, our foci were the longer-term implications of miscarriage and its sociological context: we wanted to see how women's responses had changed (or not) as they were more distanced from the miscarriage and what coping mechanisms had been employed. In some cases, as is shown in Table 1, women had become pregnant again. This allowed us to explore how the miscarriage had affected their responses to the current pregnancy (caution and wariness about celebrating it were widely reported) but also to see how the new 'happy event' altered their feelings about the miscarriage (in some cases compensating for it, in others not as 'each pregnancy is different').

The team, several of whom had suffered problems around reproductive capacity, were well aware of the sensitivities and pain involved and took care not to put pressure on people to participate. The fact that we had ourselves experienced some of the emotions reported by the women we interviewed opened the way for self-reflexive thinking as we worked on the interpretation of our interview material and acted as a reality check. The interviewers were carefully briefed on how to deal with evidence of distress, and with their own responses to often harrowing stories; handouts were given to the women with various contacts for help, support or counselling. In fact, we found that many women were relieved to talk to somebody neutral about their experiences and wanted to give vent to their feelings about the services they had encountered. Many described the events in quite astonishing detail; the shocking nature of the loss seemed to encourage near total recall. Some of the women appeared to offer well-honed and shaped narratives, which had either been repeated before or prepared in advance of the interview, while other accounts appeared more spontaneous and unrehearsed. The continued pain felt by many women was apparent in their stories and in the passion with which bad experiences were detailed.

For some women the miscarriage that was the focus of our enquiry occurred during their only pregnancy, whereas for others this pregnancy loss was part of a continuum of reproductive events (see Table 1).

Table 1 *Participants' reproductive experiences*

<i>Characteristic</i>	<i>n</i>	<i>Total*</i>
Previous early miscarriage (1 or more)		7
1 miscarriage	3	
2 miscarriages	3	
3 miscarriages	0	
4 miscarriages	1	
Previous late miscarriage		3
Less than 24 weeks	2	
More than 24 weeks	1	
Previous terminations		3
Previous successful pregnancy (1 or more)		20
Subsequent early miscarriage (1 or more)		6
Subsequent pregnancy at interview		20

* *Note:* while some women have experienced no other reproductive event, others have experienced one or more (e.g. a further miscarriage *and* a successful pregnancy), therefore the total number of events does not add up to 72.

The 79 women interviewed as part of this qualitative study were representative of the women who had participated in the MIST study, with reference to parity, marital status and occupation. However, our participants were slightly older than those who took part in the MIST study. It is possible that older women may have agreed to be interviewed because they had particular concerns that they wished to address; or their participation may be because, as women age, they become more confident and more used to talking about themselves. Of the 79 women interviewed, 50 were under the age of 35, and 29 were over the age of 35. Only one of the women who participated in the qualitative study was from a minority ethnic background (she described herself as 'Asian'); however, the MIST study did not collect data concerning ethnicity, and as such, it is difficult to estimate how representative a percentage of RCT participants this is. As such, these findings can not be generalised to women from minority ethnic backgrounds.

It was not the intention of this research to gather the narrative accounts of the women's partners. While in at least two of the interviews, the woman's partner was present for the duration of the interview, in several others the male partner made a briefer appearance. While the majority of these men commented on how they had experienced the early miscarriage, the focus of the interview was clearly upon the *woman's* experience of the loss, and as such, many of the men did not discuss their *own* perceptions of the experience in great detail. Therefore, the findings of the research presented here should not be generalised to men more generally.

The semi-structured interviews, carried out in the women's homes, lasted between 45 minutes and two-and-a-half hours, covering demographic details, previous reproductive history and experience, history of the miscarriage, experience of the mode of management and of other related healthcare services, support from family, doctors, midwives etc., feelings before and after miscarriage, effects on partner and other family members, coping strategies, future reproductive hopes and plans. The interviews were taped, transcribed and analysed using iterative readings, cover sheets to record themes and whole team discussions of the narratives. The transcripts were then codified for identified themes using NUDIST software.

Subsequently, feedback groups were held with any respondents who wanted to discuss the key findings. All participants were sent a summary sheet and invited to attend. Two groups were arranged, though only a small number of women chose to turn up. Five focus groups were held in the participating hospitals with professionals concerned with handling miscarriage (midwives, nurses, doctors, voluntary agencies). At these meetings the team presented key findings and asked for comments and responses. These were incorporated into the final report.

A full account of the mediating effect of the three miscarriage management methods can be seen in Smith *et al.* (2006). It is however significant that a number of the respondents described miscarriages outside the trial. The extraordinary detail with which women accounted for the whole experience of every specific miscarriage enabled the authors to feel reasonably confident that they were gaining accurate descriptions of how women felt about the miscarriages, both at the time and subsequently.

Sequestration and scientisation: the experience of miscarriage

Sequestration and silence: the privacy of suffering

Traditionally it's an untalked about thing, isn't it, miscarriage? You just go back to work and tell them you've had 'flu or something (Interview 1).

Despite the efforts of the early researchers, miscarriage is still a 'hidden loss' (Hey *et al.* 1985). The vast majority of the women had minimal prior knowledge about the process of miscarriage and few were aware of how common it was. Indeed, many told us that it was only after their own miscarriage that they learned that their own relatives and friends had miscarried. They come 'crawling out of the woodwork' as one woman put it. Another woman's account illustrates the difficulty women find in vocalising their experiences:

I hadn't realised until I miscarried that my Mum had done years ago . . . I've got a couple of friends that are trying and I know she's miscarried a few times but . . . she likes to keep it to herself and she doesn't want to speak about anything, so, I know a few people who've had miscarriages but not to speak about (Interview 16).

While sharing experiences with others after the event can be reassuring, many women felt that the problem of early miscarriage should be more publicly highlighted; but as individuals they may find this difficult because of feelings of guilt or shame:

It is just such a taboo subject that people don't wanna talk about it. They just don't know how to react. That's why you don't tell them. 'Cos you feel like you're saying that you've suddenly got cancer or something . . . it's the most bizarre thing (Interview 5).

Discussing infertility in the USA, Greil (1991), Miall (1989) and Whiteford and Gonzalez (1995) have used Goffman's (1963) concept of stigma in relation to the social and psychological problems faced by infertile couples. Women (and men to a lesser degree) often experience social isolation, finding it difficult to engage in social relations with couples who have children. Some women see this 'spoiled identity' as pervading their whole existence, while achieving motherhood becomes the central preoccupation. Greil (1991) describes this as a 'secret' or 'private' stigma since it is not socially visible in the same way as many spoiled

identities (such as disability or criminality). While the case of miscarriage is less extreme than that of infertility, it is clear that a similar veil of secrecy cloaks it, which in its turn may be linked to stigma. Many women spoke of how hard it was to tell acquaintances about what had happened. A common response among those who subsequently became pregnant was to conceal their pregnancy from friends as long as was possible:

You try to sort of not tell people because you don't want to tell them again if it does go wrong (Interview 1).

Thus we see an extreme form of the modernist sequestration of death, with miscarriage seen as a deeply private event and a matter of private grieving. There are no public signs or rituals to provide positive social sanction.

Imperfect scientisation and ambiguities around the event

The silence around miscarriage may contribute to the most distinctive characteristic of this form of death, the confusion about the actual process of miscarriage (Hey *et al.* 1996, Layne 2003). Partly because they know little about it beforehand women are often in the dark about what is happening to them. Most are alerted to the advent of the miscarriage by bleeding, but many are told that spotting is commonplace during pregnancy. It occasionally may take several weeks, several visits to different doctors, midwives or clinics before the miscarriage is established. This is now becoming rarer, as nearly all women who report such symptoms to a doctor or other health professional are referred to an Early Pregnancy Assessment Unit (EPAU)¹ to have an ultrasound scan within 24–48 hours. Exceptions are women who miscarry 'internally' (a missed miscarriage) who have no bleeding or pain. Such missed miscarriages are diagnosed at routine dating scans at around 10–12 weeks of pregnancy, and women are informed at the time of the scan. One woman found herself in the middle of miscarrying before she had even established that she was pregnant. Some may have been bleeding for several weeks before medical intervention occurs. Those in the trial who underwent medical management (which involves vaginal and oral ingestion of prostaglandin) or expectant management were often unclear as to whether they had passed the complete foetus or not.

This is, then, a loss of a (potential) life in which it is not clear when the moment of death has actually occurred. There may be doubt as to whether the foetus was ever in any very clear sense 'alive', while in other cases medical staff may give an estimate of when the foetal heartbeat ceased. One or two women, who had been given such information, expressed a kind of repugnance at the thought of carrying around a 'dead thing' inside them for any longer and consequently were anxious to have surgery as quickly as possible. Conversely a couple of women resisted surgical intervention precisely because of a lingering hope that 'the child' might still be alive. For them the evacuation represented an unnatural termination of a life. Thus it was frequently impossible to give a date to the death of the foetus, although most women had some sense of when the miscarriage was finally complete.

There are clear guidelines for the strictly medical management of miscarriage, but little guidance on how to handle the psychological or social aspects or even discursive frameworks for understanding the event. So, women are left to struggle towards their own forms of meaning. Here, miscarriage appears unlike many other forms of death, because it is surrounded by multiple forms of uncertainty (Frost 2006): how, when, where, why – or as the women so often expressed it 'Why me?' We could describe it then, in the context of scientific, rationalist explanations of death as 'imperfectly scientised'. Consequently, the sense of loss is exacerbated by the taboo and silence that surround the loss, the ambiguous status of the loss, feelings of self-blame, and the lack of commemoration, all of which make

the meaning of the loss difficult to grasp. Indeed, the fragile sense of the event *as a death* is encapsulated in the term ‘pregnancy loss’ itself, which may lead some women to question not only ‘what died’, but also the ‘meaning of life’ more generally:

I mean it just sort of makes you wonder what it’s all about, you know: why? . . . but then that’s life in general, isn’t it? Really, it’s like when young people die, you think: why? (Interview 19).

All this confusion is increased by the difficulty in identifying the death as the death of a person (Layne 2000). The status of the foetus is ambiguous, and in many cases the reality of its existence is hard to grasp. Women struggle to comprehend what has actually been lost, and what has taken place:

I don’t think of it as a baby . . . I don’t know what I think it was really, I don’t think of it as, you know, in terms of the things that you produce after nine months . . . I don’t probably allow myself to think about it that much (Interview 15).

Like Moulder (1998), we found considerable differences in the ways our interviewees made sense of their loss. We can identify at least three typical ‘framings’ as narratives within which women ‘placed the experience they had undergone:

a) An incomplete or failed attempt to conceive:

Some women firmly denied that they saw what they had lost as a child:

I thought: well, it’s only a fingernail, you know, it’s not a baby (Interview 46).

I don’t think that I miscarried a child . . . it was a small seed as such, so I never thought of it as being a baby really . . . I never thought of it as being a formed baby that I was miscarrying (Interview 24).

Such women often compared their experience favourably with women who had suffered a late miscarriage or perinatal loss. A later loss is perceived as more traumatic as the baby is now more developed, moving about in the womb, and the mother has a more fully evolving relationship with it.

b) A baby that was lost:

Other women stated that the use of medical terminology such as ‘uterine contents’; ‘a non-viable foetus’; or ‘products of conception’ (Wallace 1999) added to their distress, when they were adamant that *their* loss had been a baby or child:

Although it was only a 10-week foetus, embryo in medical eyes, to me when it happened, it felt as though I’d lost a baby (Interview 3).

It became very real then, I wasn’t just losing blood, I was losing my baby (Interview 20).

I feel as though I’ve lost a child, I do . . . I mean, that’s the thing, I mean people sort of say, you know, as they said in the hospital, it probably never even formed, but there was something there . . . I don’t feel as though I’ve lost a few cells that might have become a child, I feel as though I’ve lost a baby (Interview 18).

c) Part of their family that was lost:

Some women further personified their loss, by incorporating it into the family narrative, or identifying with the suspected gender of the baby; and as Moulder (1998) has suggested, this indicates the strong level of attachment that some women feel towards their pregnancy, regardless of the gestational stage of development:

I think that I feel that they are my children, I mean, we were talking about it today actually, and my little girl was saying how many children there are in the family, and she said 'we've got to count baby X and Y' 'cos she didn't know about the third one, 'cos I was okay, we didn't want to tell her (Interview 1).

The interviews took place six months to one year after the miscarriage. Another common response was to visualise the baby as if it had not been lost; and in doing so, women often compared themselves with women who were currently pregnant or had recently given birth:

I think that she would have been five months old, you know, I look at other people, and I think: that would have been me (Interview 48).

Miscarriage as the loss of possibilities

It's the possibilities really, it wasn't really the loss of a child (Interview 29).

These different narrative framings in which women strive to come to terms with the loss are indicative of the complex and sophisticated way in which women think about what the miscarriage means. At the same time, women confront the loss holistically, in terms of their own lives and identities. Nicholson's research (1998) has highlighted how when women become pregnant there is more than just a physical transition: an old 'self' is left behind as a new one develops. Our respondents struggle to express miscarriage as a loss of a former or *potential* self:

I felt sad about it because that was my last, in my mind, last stab at having a child . . . and you know, just sort of issues around that, you know, the end of a phase of my life . . . that kind of issue, rather than with physically what happened, that's all . . . I think that the one thing that I will always think about, and feel a bit sad about, is that I'm not going to have any more children (Interview 9).

It's a loss of experience I suppose, the loss of a child, or the loss of something, I wouldn't say so much the loss of a child, because the child, um, was never there, um, loss of possibility (Interview 11).

Jones (2001) suggests that following a miscarriage many women experience a loss of hope, a loss of agency, a loss of bodily integrity and the loss of identity. While for many this is a transient stage in their grief, for others it represents a long-lasting state. Jones states that this is because our identities are interlinked with what we *do*; women's experience of miscarriage and subsequent feelings of inadequacy are compounded by a society that emphasises the positive virtues of motherhood, whilst perpetuating the negative value of failure (Jones 2001). Many of the women had longed to be pregnant, and the miscarriage signified the loss of dreams, aspirations, expectations and possibilities:

As soon as you're pregnant, you have these hopes, it's dashed hopes . . . in nine months your life is going to change . . . you've lost your projection forward, you know, nine months (Interview 64).

I think as well, you can say: 'well, there was never anything to actually lose', but there was 12 weeks of expectations to lose (Interview 38).

Speakman (1996) also stresses that this sense of loss may coexist on many levels:

What we have lost is far more than just a baby, for that baby represents so many other facets of our lives, hopes and fears, and will be different for each of us. We have lost a much-wanted daughter or son, who might also have been a sister or brother and grandchild; we have lost proof of our ability to conceive, which may be especially hard to accept if we have experienced fertility problems; we have lost a belief in the reliability of our bodies; we have lost the outward evidence of the bonds between us and our partners (1996: 165–6).

Such losses can be overwhelming and confusing as they encompass: a loss of the identity 'mother' (Lovell 1983, Oakley *et al.*, 1990, Letherby, 1993); a part of one's self (Leroy 1988); a loss of (and possibly confirmation of) one's femininity (Hey *et al.* 1996); of one's bodily integrity (Jones 2001) and of innocence (Hey *et al.*, 1996). In part, these various senses of loss are due to the embodied nature of miscarriage; where women either physically expel their pregnancy, or wake up after surgical removal. Leroy (1988) contends that many women describe both a sense of physical and emotional 'emptiness' following an early pregnancy loss and, for the woman who miscarries naturally, Jones (2001) outlines how these various identities and certainties ebb away, as the woman literally feels what is inside her 'leaking' to the outside of her body.

In a society which still tends to identify *successful* and *completed* femininity with maternity, this may lead, in the case of women who do not already have children, to a devastating sense of unfulfilled potential, of something that makes them lacking as a human being:

I think, at the time, it felt like a big thing, I felt like a failure; and sometimes, if I look back on it, now, I could still sort of say: I haven't done that, I haven't achieved that (Interview 44).

Sometimes I feel so sad about it . . . [husband's] missing out on things . . . I think that it's the intimate kind of, the idea of being ultimately responsible for somebody, who really needs you . . . [that's] the part I feel we've missed out on, I think that if we adopt, we'll still miss out on that, because . . . you basically can't adopt children that are babies . . . you know, I want to know what that's like, you know, and I want to know what it feels like to give birth, I just want to be on my death bed and say: I did those things! (Interview 6).

Other research has shown that women who are infertile perceive this as a major blow to both their sense of femininity and adulthood (Greil 1991, Franklin 1997). Such problems are probably heightened by the tendency in Western societies to delay child-bearing, so the pressure for each pregnancy to be a successful one is more acute.

Why me? Incomplete femininity and imperfect scientisation

As discussed earlier, in cultures where death has been 'scientised', any death which does not seem to have any reason behind it is particularly difficult to make sense of (Bauman 1992).

A common reaction to this uncertainty is indeed to look for causes. Here women, drawing more on lay thinking about pregnancy than on the current received medical line, may well blame themselves for the event: for engaging in unsuitable strenuous activities, such as gardening or cycling, or continuing to work and not taking enough rest, for smoking and drinking:

Because I'd been doing a lot of cycling you see . . . And I wondered if that could have caused it, as there was a lot of straining as I went up the hills sometimes, but the doctor reassured me that I couldn't have caused it, but I know my mother was under the impression that she'd caused her miscarriage and she was quite dubious when I said, when I'd been told that wasn't true (Interview 2).

Even when women are assured by their doctors, partners and friends that they are not to blame, there remains the struggle to understand why, if one is blameless, such ill consequences should follow:

I didn't have any idea how common miscarriage was, and if, if people did miscarry, I thought it was because they smoke, or drank every day, and did all of the things that you're not supposed to do . . . And I'd been doing everything right, and I didn't even realise that it was something that happened to people that did things right (Interview 3).

Like the infertile couples interviewed by Greil (1991) women tended to question 'why me'; 'Why me, why can't I do it?' (Interview 22); 'Why me, when you see other people sailing through it' (Interview 34). This stage of confusion and questioning is one which may last some time as women struggle with feelings of personal failure and inadequacy and a potential impairment to their sense of successful femininity. In a world framed by scientific linkage between cause and outcome, an apparently causeless and tragic event leaves people feeling at sea, directionless:

It's reaffirming that we are not in control of life as we like to think we are sometimes, that you know . . . yeah, I think that that's it really, that we don't know what will happen, I mean we don't know, in a sense, what will happen, we don't . . . so nothing is fixed, is that fixed or permanent (Interview 12).

Women, however, are resourceful and resilient and our interviewees described a variety of ways in which they constructed a sense of meaning for what had happened to them. For many, a way of finally dealing with the apparent randomness of the occurrence may be to endorse a scientific explanation, *even when there is no firm evidence to support it*:

I just think that there was obviously something wrong with each of the babies (Interview 18).

Constructing a *medical* explanation enabled them to consider the pregnancy as in some way flawed. Consequently, some women were able to suggest that, with hindsight at least, they saw the miscarriage as having been something of a 'blessing in disguise' as they would not have wished to bear a disabled child:

I can say in one way, now that I'm away from the hospital, that I'm glad it actually happened, 'cos it would have saved a lot of heartache later on, and if it turned out that it had Downs Syndrome, then I would have had to have got rid of it anyway, 'cos there's no way I could have coped with a child with Downs Syndrome at all (Interview 17).

You've got to look at it, whether you'd rather miscarry, or would you rather bring a child into this world who could not walk, or not talk, or not hear, have severe disabilities, and not have much of a quality of life (Interview 49).

The research findings of Tunaley (1993) suggest that women who accept a medical explanation for their miscarriage have lower levels of anxiety, because they are less likely to blame themselves for the loss (Conway 1995). In our research, women who clung to medical explanation as to why the miscarriage had occurred were more likely to suggest that something positive had arisen or could arise from the experience. They were able to construct narratives which found positive signs in a negative experience: for example, some who feared that they were infertile could read the miscarriage as an indication that they could conceive:

When I think about it, I still think it was sad, you know, because I did want the baby, um . . . the one positive thing that I keep thinking about is that at least it showed that I can get pregnant, and that sort of has been a weight lifted off me, 'cos until that point I was thinking: you know, perhaps I couldn't (Interview 16).

I think of it like a practice run, it was my body getting ready for the real thing (Interview 60).

By these strategies some women were able to reaffirm for themselves the sense of an ordered and rational universe. But alternatively many women ended by explaining the event to themselves in ways which basically challenged scientific rationalism. This might involve what one might call pre-modern meanings, in terms of fate (often conceived as 'nature') or religion:

I can only think that it wasn't meant to be, for some reason or another . . . it wasn't the right time (Interview 27).

Quite a number of the women were strongly religious and spoke of the comfort provided by their faith. For such women, religious meaning may override scientific explanation. The miscarriage became seen as God's will:

Most of my family are Roman Catholics, so it's like: what happened, happened for the best reasons, it's God's will (Interview 17).

We're both Christians and you feel . . . what God gives, God takes away . . . I don't think that we are that in control of things . . . I think modern expectations of: I'm gonna have a child now, and on this date . . . I just don't think that's right (Interview 1).

One woman believed that the spirit of the lost child was now embodied in her new pregnancy, having made one failed attempt to enter the world and now starting out to be born once more.

Religious belief could also provide a positive meaning to the experience in that the miscarriage might be seen as learning more about oneself, along with ability to empathise more with other peoples' suffering. This can be linked to a stoic vision of life as inevitably hard; learning to handle suffering can be construed as a necessary strength:

In a way, I think that they [the miscarriages] have given me a bit of strength . . . but I think that it's more of a strength so that I can be maybe more of a comfort, in the future,

for other people that go through maybe a loss of any kind maybe not necessarily a miscarriage, but somebody who's feeling low . . . or even people that felt as though they've failed in a way, 'cos you do feel that (Interview 20).

Other women developed a more general scepticism and critique of the rational scientific view of life, which resonates with postmodern sociological perspectives:

I was cross because I thought they were trying to scare me into going in and having medical intervention, but you know that's the way the medical industry works. They don't allow you to trust in your own body . . . it's not the culture we have these days (Interview 64).

Such thought processes may bring women into confrontation with their taken-for-granted view of the world:

You can't always have what you want, when you want it, I think, and that there is an end to that side of life, in terms of reproduction (Interview 21).

I had a, not a logical urge, but I just wanted to give them my foetus, and I wanted to tell them to take it away and have a look at it under the microscope . . . I want you to tell me what you see, each time, why don't they take it away? Why don't they just ask me for it? Why don't they just take something and look at it? . . . I just had that very strong feeling, and that may be because we expect so many answers from our scientists now, I don't know (Interview 43: in feedback group).

In working at this more abstract level, women sometimes constructed a polarisation around explanations that drew upon the roles of both 'nature' and 'science'. For those choosing 'natural' explanations, the miscarriage was perceived as though the woman's body had not been ready to carry a baby to full term. Women often referred to the wisdom of 'mother nature', such that the miscarriage was simply 'not to be'. A few women were able to vocalise the tension they felt existed by resisting the medicalisation of pregnancy loss. Whilst wanting to have a miscarriage 'naturally' (at home, without surgical evacuation) gave the women a sense of empowerment, the need for answers often led them to consider medical treatment, either for explanations as to why the miscarriage occurred, or in the hope of preventing another miscarriage:

There are two bits of me, the one that says it's nature, and it happens for a reason, and it's natural . . . that bit fights against investigations, and finding out what's going wrong . . . medicine is doing too much, and shoving hormones in to make a pregnancy last . . . so that's that bit of me . . . and then there's the other bit of me that, um, just feels it all raw, raw-ly, and just: it's not fair and it's crap, why me again, you know . . . I really do believe that there are some days when they are held in a balance, and yes, it's nature taking its course, but . . . it's a painful course (Interview 45).

Conclusion: modernity and the scientisation of death

In this paper, we have drawn on the work of Walter to distinguish several frameworks in which the miscarriage experience can be viewed, using the accounts of women who were

interviewed. These frameworks are not mutually exclusive. Individual women might draw on more than one of these in contemplating their experiences, vacillate between them, as in the case of the woman last quoted, or cling firmly to one of them as a way to find consolation. The crucial thing here is that these frameworks help women to come to terms with a deeply disturbing and, in many cases, ultimately inexplicable event. They are alternative answers to that key question 'why me?'

We use the term 'pre-modern' not in a pejorative or belittling sense but simply in a chronological sense. 'Modernity' has become a prevalent sociological term in the discussion of culture and value schemes in secular capitalist industrial societies, the type of societies that were discussed in the classic sociological works of Marx, Durkheim and Weber (Giddens 1991, MacKendrick 2005, Walter 1994). Pre-modern then refers to the societies that predated industrial capitalism. In this context the pre-modern framework harks back to the days before the development of modern medical science, when events were construed in terms of nature, destiny and religion (Walter 1994). This framework allows parents to draw on the comforts of religious rites and helps women to develop a fatalistic acceptance of the miscarriage as being the result of some external source.

The modern framework of explanation is that provided by existing medical knowledge which draws upon scientific experience and a view that all natural events have a rational causal explanation. This, of course, is the prevailing explanatory framework in contemporary society (Foucault 2002, Habermas 1986). Unfortunately, this can push the explanation for the event on to women themselves, and may provoke feelings of guilt, or anxiety. Also, since miscarriage is an imperfectly scientised event, some women desperately seek an explanation when simply none is available. This may retard the process of coming to terms with the loss.

A third perspective we have termed postmodern may lead women to develop a view which challenges imperfectly scientised knowledge and to accept the randomness and arbitrariness of life. The notion of postmodernity includes within it ideas of challenge to mainstream scientific orthodoxy (to be replaced by plural voices and accounts) along with a privilege given to popular ideas and values, rather than those of an elite (which includes the scientific elite). In a way this involves a return to some aspects of the pre-modern approach and this is also exemplified in the accounts offered by Walter (2001) and Kastenbaum (2004) of new collective forms of grieving. These can be interpreted as acts of popular resistance to orthodox institutional frameworks for handling loss. However, as yet miscarriage remains a strictly private form of loss contained within the family, so public rites and expressions of grieving are not yet available for miscarriage in our culture, although some couples do develop their own personal rituals (funerals, memorials, shrines).

This paper has highlighted the complexities and ambiguities surrounding miscarriage, which make it a particularly difficult form of death to handle. Continued stigma and silence trap women and their partners, preventing them from expressing their needs or from coming to terms with conflicting feelings. There is currently no public way in which the loss of a miscarried baby can be marked, no consoling rituals or commonly accepted ways of coming to terms with the bereavement (Layne 2003). In such circumstances the grieving process is hard to complete. As a result, for some women the miscarriage may remain an unexpressed pain which may haunt them for many years:

Women who have lost a baby, you can still see the pain in their face and like I said: these women say that you never get over it (Interview 4).

We suggest that there remains a need for more help to be given to women and their partners, who are coming to terms with their loss, and elsewhere (Smith *et al.* 2006) we have pointed

to some ways in which care can be improved, such as the better provision of counselling. It also appears, drawing from the postmodern framework, that more support could be provided to women who pose such courageous challenges to received wisdom. The development of rituals, both individual and collective, may be a positive way in which the post-modern understandings of loss can be employed to help women to move on from their grief.

The paper has also highlighted the continuing problems associated with the scientisation and privatisation of death. There still remains a need for a more sustained attempt to break the silence around miscarriage and to make women and their partners aware of the prevalence of early miscarriage, especially in the light of the new technologies of pregnancy testing and ultrasound scans. If this information is more widely known, women may be helped to come to terms with their loss and be freed from feelings of guilt, shame and personal failure. The importance of being permitted to talk freely about the experience was highlighted by some of the more self-reflexive women interviewees: one described how she, her boss and her three workmates, one of whom was pregnant, decided to push what had happened into the open:

We just took the attitude: let's talk about it, let's not make it into an impossible situation. It doesn't matter if I get upset, because it, the more we talk about it the more of a normal subject it all becomes. Rather than being a huge sort of secret (Interview 6).

Rather than 'hushing up' the event, we suggest that medical and counselling staff be encouraged to talk the events through with miscarrying women and in turn to advise the women to share their experiences more widely. Thus, miscarriage might become seen as a normal facet of reproductive attempts. Media coverage would help, as well as handouts on offer at EPAUs and maternity hospitals. One reason for the stigma and silence is the perceived link between miscarriage and abortion (although the Royal College of Obstetricians and Gynaecologists (2000) has recommended replacing 'spontaneous abortion' with 'miscarriage', and 'missed abortion' with 'missed miscarriage'). There is also stigma because of the perception that the mother's activities might have caused the miscarriage, and publicity should make it clear that that this is not usually the case. A public dialogue around miscarriage may be a way for people to confront the management and definition of death by experts, and begin to reframe its meanings for themselves in the face of sequestration and scientisation.

*Address for correspondence: Harriet Bradley, Department of Sociology, University of Bristol, 12 Woodland Road, Bristol BS8 1UQ.
e-mail: harriet.bradley@bristol.ac.uk*

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Note

- 1 Early Pregnancy Assessment Unit: A specialist unit within a hospital providing support and care for women and their partners who experience problems in pregnancy.

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