LIBERTY UNIVERSITY

A Grief Intervention for Early Perinatal Loss

A Thesis Project Report Submitted to

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in Candidacy for the Degree of

Doctor of Ministry

by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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Early pregnancy loss has a multidimensional effect on patients, touching the body, soul, and spirit. This project addresses patients' lack of spiritual and emotional support following early pregnancy loss, commonly called a miscarriage. The available research on the emotional impact of early pregnancy loss has grown stronger over the last three decades. However, there is a deficit of research exploring the spiritual impact of miscarriage and how faith is used as a coping mechanism for pregnancy grief. In modern culture, the term spirituality can mean many different things. With this awareness, Mercy Healthcare embraces and supports patients wherever they find themselves spiritually. As a faith-based institution, Mercy acknowledges the importance of spirituality and personal faith in the healing process. When supporting early pregnancy loss at Mercy Springfield, the Pastoral Services department has a definitive standard of care. Nevertheless, a lack of vital ongoing support is unavailable for patients who desire additional assistance in their grief. This study creates an intervention to support the grief of early pregnancy loss patients through an eight-week phenomenological review considering individual life and faith stories. This project, led by a professionally trained chaplain, applied both qualifiable and quantifiable research techniques using patient and stakeholder surveys and the project leader's observational data. It investigates whether further understanding one's life stories and faith experiences can promote quality patient care in their grieving process. The project will also provide additional resources to promote awareness and support of the spiritual aspects of miscarriage grief. In addition, this study will serve as a guide to further evaluate quality patient care offered by Pastoral Services at Mercy Springfield.

Keywords: Chaplain, Coping, Healthcare, Miscarriage, Perinatal Loss, Pregnancy Grief, Spiritual Care Provider, Spirituality

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Abbreviations

ACOG	*American College of Obstetricians and Gynecologists*
CMCC	*Catherine McCauley Conference Center*
COVID-19	*Coronavirus Disease of 2019*
CPE	*Clinical Pastoral Education*
D&E	*Dilate & Evacuate*
DMIN	*Doctor of Ministry*
ERD	*Ethical and Religious Directives of the Catholic Church*
ESV	*English Standard Version*
HIPPA	*Health Insurance Portability & Accountability Act*
ID	*Interdisciplinary*
IRB	*Institutional Review Board*
MFM	*Maternal Fetal Medicine*
NICOT	*New International Commentary of the Old Testament*
NRSV	*New Revised Standard Version*
NT	*New Testament*
OT	*Old Testament*
RSM	*Religious Sisters of Mercy*

CHAPTER 1: INTRODUCTION

Introduction

Pregnancy loss is more common than many realize. During the forty weeks of gestation, most losses occur within the first and second trimesters meaning up to twenty-four weeks of pregnancy.[1] Eighty percent of those losses occur within the first trimester.[2] In the phenomenological examination of this experience, some patients observe that early pregnancy loss is medicalized in a biophysiological sense by their healthcare providers, with little consideration given to the emotional and spiritual impression of the perinatal loss.[3] Focusing on the pathology of the occurrence and overlooking the lived experience of grief and coping is a missed opportunity for healthcare systems to support patients toward holistic health. Research proves that the perinatal grief journey is unique to each patient.[4] This journey can be further complicated by one's life story and the incongruence with one's expectations, such as loss of hopes and dreams for parenthood and anticipated family life. Besides developing an emotional and physical bond between the patient and the baby, other factors influencing the grief process

[1] The American College of Obstetricians and Gynecologists, "Early Pregnancy Loss," last modified February 2023, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss#:~:text=The%20frequency%20of%20clinically%20recognized,at%20age%2045%20years%207.

[2] Ibid.

[3] Julia Bueno, *The Brink of Being: Talking about Miscarriage* (United States: Penguin Publishing Group, 2019), 18, ProQuest Ebook Central.

[4] Ibid., 36

include the social, cultural, and sociopolitical influences one has experienced.[5] In addition, repeated loss and infertility issues further confound this understanding.[6]

As evidenced by this project, academic curiosity about the social and psychosocial implications of pregnancy loss has risen. Topics more frequently discussed and essential to this project include complicated grief and trauma, disenfranchisement, and the ambiguity of silent grief that patients and families keep in the secret places of the soul.[7] Patient experiences reveal that medical professionals often overlook addressing psychological and sociological coping skills and spiritual support for pregnancy loss and grief because it is not the principal focus in a clinical setting where the physiological dimension of pregnancy loss is crucial and can be life-threatening.[8]

However, a negligible amount of academic research is available on the spiritual component of grieving early pregnancy loss, revealing how incorporating spirituality can provide coping mechanisms important to a grief journey. Because of this gap in the literature, this project addresses the innovative integration of spirituality in the perinatal grief journey. A modern view of spirituality has evolved with the contemporary influence of culture, religion, and academics. However, in its most basic sense, spirituality is a belief in something bigger than oneself and can be related to religion, religious rituals, and matters of faith.[9] Most recently, the term spirituality

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[5] Bueno, *The Brink of Being*, 35-36.

[6] Ibid.

[7] Maria Renée Kurz, "When Death Precedes Birth: The Embodied Experiences of Women with a History of Miscarriage Or Stillbirth—A Phenomenological Study using Artistic Inquiry," *American Journal of Dance Therapy* 42, no. 2 (12, 2020): 194-95.

[8] Pelin Palas Karaca and Umran Yesiltepe Oskay, "Effect of Supportive Care on Psychosocial Health Status of Women who had a Miscarriage," *Perspect Psychiatric Care* 57, no. 1 (January 2021): 179.

[9] Carrie Doehring and Allison Kestenbaum, "Interpersonal Competencies for Cultivating Spiritual Trust," in *Chaplaincy and Spiritual Care in the Twenty-first Century*, ed. Wendy Cadge and Shelly Rambo, (Chapel Hill, NC: University of North Carolina Press, 2022), 135.

in healthcare relates to mental health, which connects people to each other or a higher or greater existence that gives meaning to life.[10] Spirituality has also grown in popularity in the pursuit of treating the whole person, including dimensions of body, soul, and spirit, a holistic approach to patient care.[11] In addition, the use of spiritual traditions of varying faith groups is becoming more significant to reduce suffering in healthcare and bring about positive physical and mental health outcomes.[12]

In the hospital setting, professionally trained chaplains are the spiritual care providers and the interdisciplinary professionals in spiritual matters. Chaplains are purposefully trained to discern and support others' spirituality when coping with significant life issues. This project examines a chaplain's use of emotional and spiritual support in assisting patients who are processing early perinatal grief and loss and the bereavement procedures of Mercy Springfield's Pastoral Services department. Chapter one begins this project by examining critical foundational elements, including ministry context, the problem, purpose, and thesis statements, essential definitions, basic assumptions, limitations, and delimitations.

Ministry Context

The ministry context originates with Mercy Hospital in Springfield, MO. Formerly called St Johns, this location is the flagship hospital in the central community of the Catholic-based

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[10] Jan M. A. de Vries, "The Psychology of Spirituality and Religion in Health Care," in *Spirituality in Healthcare: Perspectives for Innovative Practice*, eds. Fiona Timmins and Silvia Caldeira (Cham, Switzerland: Springer, 2019), 23-24.

[11] Nicolas Pujol, Guy Jobin, and Sadek Beloucif, "'Spiritual care is not the hospital's business': a Qualitative study on the Perspectives of Patients About the Integration of Spirituality in Healthcare Settings," *Journal of Medical Ethics* 42, (August 2016): 733-37.

[12] Marina Aline de Brito Sena et al., "Defining Spirituality in Healthcare: A Systematic Review and Conceptual Framework," *Frontiers in Psychology* 18, (November 2021): 1-2.

Mercy Health System headquartered in St. Louis, MO, which was established there in 1871.[13] When fully staffed, Mercy Springfield is a 450-bed hospital with five critical care units for newborns to adults, a level one trauma center/emergency department, a heart hospital, and a level one burn unit. This hospital location supports over 150 clinics of various disciplines connected within Mercy's central region. The diverse clinical disciplines include the obstetrical, gynecological, and midwife practices that provide care for women's health and specifically for patients who are imagining a family, as well as antenatal, postnatal, and follow-up patients. The maternal-fetal medicine clinic works with obstetrical clinics to provide critical care for antepartum patients with high-risk pregnancies.

The Sisters of Mercy, a global community of Catholic women devoted to service and care, started Mercy Healthcare and, inspired by their foundress, Catherine McAuley, came to the United States from Ireland and England in 1871. Sister Catherine began caring for women and children in her House of Mercy in Dublin, Ireland, in 1827. While she did not have children, she adopted orphaned children in her care. Eventually, she inspired other women who joined her in this ministry. They formed the Sisters of Mercy community to care for the sick and dying. Their ministry spread to new communities and countries, taking the Sisters of Mercy to many places to care for the sick in times of great need, such as the Cholera outbreak of the nineteen hundreds.[14] This type of care for others, exemplified by Catherine's calling, inspired the Sisters of Mercy healthcare system that today innovatively serves the sick and needy throughout Arkansas, Kansas, Missouri, and Oklahoma through community clinics, hospitals, and virtual care.

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[13] "Heritage and history," "Mercy Hospital St. Louis Quick Facts," and "Mission, Vision & Values," www.mercy.net/about/mission/, last modified January 2023.

[14] "History & Heritage and The Story of Catherine McAuley," www.mercy.net/about/mission/, last modified January 2023.

Mercy Mission

With this foundation, Mercy Healthcare is motivated to compassionately care for others and live out the mission and vision of Jesus Christ informed by the legacy of Catherine McAuley, the Sisters of Mercy, the Religious Sisters of Mercy (RSM), and the theology of the Catholic Church. This rich legacy is noted in Mercy's mission statement: "As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service."[15] The impactful statement is a constant reminder to all cared for and employed by Mercy Healthcare that this medical facility merges mission and medical care distinctly and biblically.

While the charge of Mercy Healthcare's mission portrays a sacred focus, it also speaks to the blessed hope of Christ and God's redeeming plan of salvation, which is meaningful to this project as a replica of hope to grieving patients. Narrowing the sacred focus of the mission is imperative in connecting the mission to the day-to-day interactions with patients and coworkers. Mercy's fundamental values of excellence, dignity, justice, service, and stewardship are specific to this focus.[16] They expound the mission of Mercy and anchor this perinatal loss project.

Mercy Values

The value of dignity infers worth and human significance, meaning, and purpose. It is often partnered naturally and effectively by Mercy coworkers with the action of respect in patient care. While respect is not a stated value, it is part of Mercy's commitment to caring for all people, no matter their circumstances or spirituality. In perinatal loss, all patients, regardless of

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[15] "Mission and Vision," Mission and Formation, www.mercy.net/about/mission/, last modified January 2023.

[16] Ibid.

age, belief system, culture, or context, are cared for as God's created beings. Providing dignity and respect in this manner promotes the importance of the remaining four values of justice, service, excellence, and stewardship.[17] Justice is a substantial element of the Catholic worldview found throughout the Catholic Ethical and Religious Directives (ERD), specifically emphasized in the Mercy Healthcare organization through the Sisters of Mercy, who underscore serving the "poor, sick, and uneducated in local communities."[18]

Undoubtedly, all five values relate to caring for the patient and the unborn, also created in the image of God and as one who has no voice. Moreover, these values are promoted in an ethical directive clarifying beginning-of-life care and decision-making issues that significantly inform the ministry context of this writing, further detailed in chapter two.[19] Mercy demonstrates their values in many practical ways and specifically in obstetrical medicine. One example would be Mercy Springfield's partnership with local community clinics such as the MSU Clinic and Jordan Valley, which provides care, including prenatal care, for uninsured patients. Making medical care and service available to all community members regardless of income and economic status demonstrates Christ's love and service to all who are in need, including the unborn. Mercy Springfield's support of this project exemplifies the continued pursuit of excellence in patient care and stewarding opportunities to support those in need and use resources wisely, justly, and compassionately. The values of Mercy firmly support the problem and thesis statement for this work, and conversely, the problem and thesis statement support the overall mission of Mercy.

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[17] "Our Spirit, What We Stand For," Mission and Formation, www.MercyBaggottStreet.org, last modified January 2023.

[18] "Mission and Vision," www. mercy.net/about/mission. Last modified January 2023.

[19] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* sixth ed., (Washington, DC: United States Conference of Catholic Bishops, 2018) 16-20.

Mercy Charisms

Mercy Healthcare's charisms further narrow the mission and values to focus on benevolence toward others. Charisms are graces given by God for the good of others.[20] The charisms reveal the day-to-day stewarding of one's gifts and opportunities to serve others, and they are book-ended with the notion of doing right and doing good. Charisms include having a bias for action, an entrepreneurial spirit, offering hospitality and a gracious spirit, and pursuing the right relationships through honesty and integrity.[21] As a means to live out the gospel, charisms are crucial reminders that apply not only to patient care but the missional work of serving as a demonstration of Christ's love and service to humankind.

Each charism also holds significance in the ministry context of caring for patients who have experienced early pregnancy loss. For example, serving patients who have suffered a fetal loss with dignity and respect includes being aware of and providing for their unique needs. Each patient responds uniquely to loss, trauma, and grief.[22] Respecting a patient's story, needs, and personal spirituality is the beginning point of patient care for chaplains. Having a bias for action and an entrepreneurial spirit in anticipating and responding to the needs of others is where this project originated.[23] Mercy is full of coworkers who create ways to improve holistic care in the ever-changing healthcare industry. For example, thinking outside the box for holistically treating patients experiencing fetal loss takes an entrepreneurial mindset and innovative spirit. Likewise,

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[20] "Our Spirit, What We Stand For," Mission and Formation, www.MercyBaggottStreet.org, last modified January 2023.

[21] Ibid.

[22] Dagmar Grefe and Pamela McCarroll, "Introduction to Meaning-Making Competencies," *Chaplaincy and Spiritual Care in the Twenty-First Century*, eds. Wendy Cadge and Shelly Rambo, (Chapel Hill, NC: University of North Carolina Press, 2022), 61-65.

[23] Mercy burial statistics for 2021 reported the burial of 248 babies under twenty week's gestation.

creating robust ongoing grief support by evaluating that process at Mercy Springfield will require thinking outside the box and a determination to initiate.

Along with a bias for action and an entrepreneurial spirit, compassionate care for perinatal loss patients includes being gracious and hospitable and pursuing the right relationships with others honestly and responsibly. These charisms go together and promote the dignity and respect of others. Mercy's foundress, Catherine McAuley, was known for promoting dignity and respect for others through the simplest acts of grace and hospitality she offered, especially in a person's time of need.[24] Meeting to support each other in fetal loss grief while graciously extending hospitality fits Mercy's mission, values, and charisms.[25]

Mercy Ethics

The hospital operates in a modern competitive healthcare market, striving to maintain cutting-edge techniques, treatments, and technology while maintaining stewardship of its mission, values, and charisms. An essential and often tedious equilibrium exists between a faith-based health system and the state and federal governing agencies of healthcare. Mercy's inclusion of a strong business management team and a missional leadership team ensures their stewardship of Mercy's mission, values, charisms, and the ethics of the Catholic Church. Within the mission team, not only are the ethical and religious directives of the ministry instilled but also an emphasis on community health ensures Mercy is advocating for the health needs and social justice of patients and the community. The Pastoral Services department is part of the Mission team and manages the spiritual caregivers of the Mercy system. Professionally trained

[24] Mary C Sullivan, *The Path of Mercy: The Life of Catherine McAuley* (Washington, DC: The Catholic University of America Press 2012), 362.

[25] "Our Spirit, What We Stand For," Mission and Formation, www.MercyBaggottStreet.org, last modified January 2023.

Chaplains of many faith and cultural backgrounds meet patients and staff in times of joy and pain to provide appropriate spiritual support.[26] At Mercy Springfield, the Pastoral Services team provides spiritual and emotional support to patients and staff twenty-four hours a day, in person, via video, and through a telephonic presence.

Mercy Demographics

A final consideration is the population diversity of patients in Mercy's central region. In a cooperative and in-depth study by two Springfield universities in 2016, the long tradition of local congregations and their dimensions and the community-wide impact was explored.[27] Springfield, MO, and its surrounding metropolitan area encompassing Greene and Christian counties are considered conservative but not primarily Catholic.[28] The Baptist Bible Fellowship and the Assemblies of God denomination have located their international headquarters in Springfield. The 2016 study referred to this area as the "buckle of the Bible belt," where there is a church on every corner.[29]

Among key findings, the study concluded that the Springfield metropolitan area "has a higher density of religious congregations than comparably sized counties nationwide, and congregations are slightly larger on average than nationwide.[30] A substantial majority of

[26] Chaplains must be ordained with their sponsoring faith organization, hold at least a Master of Divinity or an equivalent in theological field of study, and are encouraged to obtain at least four units of Clinical Pastoral Education through a residency or internship program.

[27] Catherine Hoegeman et al., "Springfield Area Congregations Study: Profile and Community Engagement," Drury University of Nonprofit Leadership and Missouri State University, (2016): 1.

[28] Ibid., 7.

[29] Ibid., 1.

[30] Ibid., 49.

congregations reflect an Evangelical Christian tradition and have a majority white membership."[31] Only 3.5 percent of the churches surveyed were of the Catholic faith tradition.[32]

Springfield Catholic churches, missions, and ministries, governed by the Roman Catholic Diocese of Springfield-Cape Girardeau, is one of four dioceses in Missouri. The diocesan Bishop represents the head of all Catholic ministries, including the mission and ministry of Mercy.[33] The Catholic church joins a strong Protestant representation in supporting conservative values in Springfield. The shared conservative community-ministry perspective enables Mercy to strategically serve its clientele in a manner that promotes a general knowledge of the faith-based and spiritual components of healing, including supporting loss and grief from a faith perspective. The common ground of conservative principles amongst the religious diversity in the community is a benefit to supporting the understanding of the problem and purpose of this work.

Problem Presented

In obstetrical medicine, an early perinatal loss is commonly known as a miscarriage or missed spontaneous abortion.[34] Research is unclear on an agreeable percentage of pregnancies that end in miscarriage, primarily because some miscarriages occur at home before a doctor has verified the pregnancy.[35] Professional organizations vary in their statistical analysis of such. The

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[31] Hoegeman et al., "Springfield Area Congregations," 49.

[32] Ibid., 12.

[33] Employed professionals of Mercy healthcare oversee the business of running a healthcare system. The Bishop and his staff direct the mission of Mercy. In addition, mercy employs mission leaders to ensure the mission of Mercy blends into the business of Mercy.

[34] Karen J. Carlson, Stephanie A. Eisenstat, and Terra Diane Ziporyn, *The New Harvard Guide to Women's Health*, s.v. "miscarriage," Harvard University Press, 2004. Accessed August 30, 2022, https://go.openathens.net/redirector/liberty.edu?url=https%3A%2F%2Fsearch.credoreference.com%2Fcontent%2Fentry%2Fhupwh%2Fmiscarriage%2F0%3FinstitutionId%3D5072.

[35] This statistic would not measure the repeated miscarriages that patients experience in infertility and in vitro fertilization, further complicating pregnancy loss and grief.

American College of Obstetrics and Gynecology says "10 out of 100 known pregnancies" end in early pregnancy loss.[36] The March of Dimes, the World Health Organization, and the Library of Medicine suggest that as much as 20 to 26 percent of reported pregnancies end in miscarriage.[37] It is unclear whether the sociopolitical environment influences these numbers or other unknown reasons not previously mentioned.

Along with empowering early perinatal loss patients with the right to determine the disposition of remains, Missouri statute 194.387.2 directs counseling support for patients experiencing a miscarriage.[38] While this statute is purposefully broad, it demonstrates the government's acknowledgment and encouragement of the need for supportive intervention for patients following perinatal loss. In line with this Missouri statute and the theology and ethics of the Catholic Church, Mercy Healthcare holds the sanctity of life in the highest esteem. It assumes sacred care and appropriate disposition of all fetal demises. Therefore, extensive effort in meeting the needs and desires of patients concerning the burial of fetal remains that are less than twenty weeks gestation is compulsory. This effort is directly related to Mercy's respect for the sanctity of life, from the point of conception to the end, no matter how many weeks, months,

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[36] "Early Pregnancy Loss" American College of Obstetrics and Gynecology, last modified February 2023, https://www.acog.org/womens-health/faqs/early-pregnancy-loss.

[37] "Miscarriage" March of Dimes, last modified in 2017, https://www.marchofdimes.org/complications/miscarriage.aspx; and "Miscarriage," StatPearls Publishing National Library of Medicine, last modified May 8, 2022, https://www-ncbi-nlm-nih-gov.ezproxy.liberty.edu/books/NBK532992/. "Miscarriage," World Health Organization, https://www.who.int/news-room/spotlight/why-we-need-to-talk-about-losing-a-baby.

[38] Public Health and Welfare, Death-Disposition of Dead Bodies: Miscarriage-Mother's Right to Determine Final Disposition of remains—counseling made available, when. (August 8, 2004), Missouri State Revised Statute, 194.384,87 Title XII - Chapter 194. "The facility shall make counseling concerning the death of the fetus available to the mother. The facility may provide the counseling or refer the mother to another provider of appropriate counseling services."

or years. Further, it sustains the ethic of dignity and respect for the fetus and the parents as a family unit and as it helps initiate the grieving process.[39]

While care for the patient's physical being after a fetal loss is the medical team's responsibility, emotional and spiritual support must be overseen by those specifically trained in this field. Cadge and Rambo, in their work *Chaplaincy and Spiritual Care in the twenty-first Century*, write about providers of spiritual and emotional support, "Chaplains appeal to a quality of being, rather than simply of doing, that suggests that they tap into currents of life that may surface only in times of need and distress. They develop skills of deep listening, of advocacy, of bridging community, and of navigating conflict that set them apart from other care providers."[40] That is not to say that the medical team should not or cannot provide spiritual and emotional support to patients and family members in their care. However, professionally trained spiritual care providers such as chaplains are part of the interdisciplinary team with extensive and ongoing training in spiritual and emotional support, which includes journeying with others who experience loss, grief, and trauma. At Mercy, it is a standard of care for patients who experience fetal loss to be supported by a chaplain. The chaplain assesses the patient's needs and intervenes, offering appropriate support in the moment of loss. Considering the previously stated mission, values, and charisms of Mercy Healthcare, their ethical directives, and the Missouri statute, chaplains are embedded within Mercy Healthcare to offer professional-level, meaningful spiritual and emotional support to patients experiencing pregnancy loss.

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[39] ERD 44: "A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission." ERD 46: Catholic Health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion." "Part Four: Issues in Care for the Beginning of Life," United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* sixth ed., (Washington, DC: United States Conference of Catholic Bishops, 2018), 16-19.

[40] Wendy Cadge and Shelly Rambo, "An Introduction," *Chaplaincy and Spiritual Care in the Twenty-First Century*, eds. Wendy Cadge and Shelly Rambo (Chapel Hill, NC: University of North Carolina Press, 2022), 3.

At Mercy Springfield, purposeful emotional and spiritual support for fetal loss patients begins with an initial spiritual assessment encounter by trained chaplains, charted in the patient's electronic health record for the interdisciplinary team to view. Next, the patient is offered a packet of grief support materials to take home. Within the first few weeks following the chaplain visit, follow-up communication is initiated through a bereavement card and phone call, followed later by a burial card and the first-anniversary card. While the initial packet contains a plethora of grief support information for personal consideration, it lacks a modern appeal to patients of a generation who highly value technology and social media. It also offers minimal connection to others who have experienced a similar loss. Further, the grief support packet lacks a robust spiritual component that could be consequential in the grief journey. For this project, the problem addressed at Mercy Springfield is inadequate ongoing emotional and spiritual grief support for miscarriage patients.

Purpose Statement

Based on the stated problem, this DMIN thesis project explores the impact of a unique ongoing grief support opportunity that will be offered to fetal loss patients. This project will gather data from patient surveys after participating in the grief support project. The grief support experience presents a setting that provides one-on-one, online, and group support opportunities with others who have experienced a similar loss. In addition, significant stakeholders will be surveyed following the project for their observations on the feasibility and impact of the project.

This project's theological and phenomenological basis is purposed in a Christian perspective of how God sees and knows His creation. The writer of Psalm 139 effectively elucidates the all-knowing God. In verse 2, he writes of God, "You know when I sit down and when I rise up; you discern my thoughts from afar" (English Standard Version). Verse 4 further

clarifies, “even before a word is on my tongue, behold O Lord, you know it altogether,” and verses 13-14a, “For you formed my inward parts; you knitted me together in my mother’s womb. I praise you, for I am fearfully and wonderfully made” (ESV). This writing clarifies one part of the purpose of this project which is to embrace the phenomenological experience of miscarriage and join it with the theological component of God’s omniscience and deeply loving character. This combination points directly to God’s concern for the patient’s feelings and experiences of the silent grief of miscarriage. The multifaceted emotional and spiritual components that complicate the grieving process can be understood through the lens of a faith experience. The processing of grief emphasizing faith promotes building coping skills and a healthier grieving process.

There are substantial benefits of connecting with others in suffering, whether one-on-one, online, or in a group setting. While childbirth is a universal experience across cultures and circumstances, and the needs of patients are similar, this experience is also distinctive and sacred.[41] Further, adding to the pregnancy experience, the loss of a child before full term magnifies the uniqueness and sacredness of the experience. The solidarity among patients experiencing a loss can be a treasure for processing grief and recovery. Patients can indeed develop a close bond with their medical providers during a fetal loss, which can be very helpful.[42] However, this is insufficient to substantially support the grief journey once the patient returns home.

[41] Mark Evans and David Mitchell, “Exploring Midwives’ Understanding of Spiritual Care and the Role of the Healthcare Chaplain within a Maternity Unit,” *Health and Social Care Chaplaincy* 2, no. 1 (2014): 81-82.

[42] Ibid., 82.

Basic Assumptions

This DMIN thesis project proposal recognizes basic assumptions related to the disposition of participants. This study will serve participants who have experienced fetal loss under twenty-five weeks and who desire the opportunity to grow in processing their grief. This project also assumes participants will be willing to partake in the experience and commit to the process as representatives of the general population who are open to exploring faith and spirituality related to grieving and their personal stories. Each participant offers differing pregnancy experiences, and each of these differences represents the vast array of patients who experience varying forms of pregnancy loss and grief. Further, despite their differences, this project assumes participants will allow themselves to grow and, if given the opportunity, embrace others in their journey.

The final assumption relates to one's unique understanding of their spirituality. While each patient has a different life story and pregnancy loss experience, each participant is also at a different place in their spiritual journey. Some will have a formal faith tradition, while others may not. The patient's willingness to be curious about their spiritual traditions related to grief is assumed. Within this professional assumption, the leader will meet the patients and journey with them in the sacred places of loss and grief. Finally, because of this project, the Pastoral Services department at Mercy will continue to extend this opportunity to other patients experiencing fetal loss. The opportunity could also be extended to other family members to encourage emotional and spiritual health and connection within the family unit.

Definitions

This study concerns the experience of miscarriage and the bereavement services offered by the Pastoral Services department at Mercy Springfield. Therefore, it is essential to clarify

terms associated with pregnancy, pregnancy loss, and its treatment to better comprehend the work's meaning.

Antenatal or Antepartum. Antenatal or Antepartum are generally used in pregnancy and are synonymous with describing the period before childbirth. Obstetricians, midwives, and other medical professionals provide antenatal care prior to the delivery of a baby. If a patient experiences a high-risk pregnancy, the patient would be labeled antepartum in the hospital and receive specialized obstetrical care from a maternal and fetal medicine (MFM) provider.

Ectopic Pregnancy. Ectopic pregnancy, sometimes referred to as a tubal pregnancy, occurs when the fertilized egg implants and grows somewhere besides the lining of the uterus. Most commonly, this takes place in the fallopian tube. As the embryo grows, it can cause the tube to rupture, leading to internal bleeding, which can cause an emergent and life-threatening condition prompting immediate surgery.[43] Medical experts treat ectopic pregnancies either pharmacologically or surgically. However, an ectopic pregnancy can be ethically challenging to treat if the baby still has a heartbeat and the mother's life is threatened.

Embryo. In reproduction, an embryo forms after the egg and sperm meet to form a zygote. Then, the zygote rapidly begins dividing to form the embryo. The embryonic stage of pregnancy lasts through eight weeks of gestation, where all the major organs develop.[44]

Embryonic Demise. An embryonic demise is the death of a baby inside the womb during the embryonic stage of development through eight weeks of gestation.

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[43] "Ectopic Pregnancy," Definitions, ACOG.org, last modified in 2022, https://www.acog.org/womens-health/faqs/ectopic-pregnancy.

[44] Jonathan Law and Elizabeth Martin, eds., *Concise Medical Dictionary*, s.v. "embryo," 10th ed. (Oxford University Press, 2020) accessed August 30, 2022, https://www-oxfordreference-com.ezproxy.liberty.edu/view/10.1093/acref/9780198836612.001.0001/acref-9780198836612-e-3092?rskey=QLkQ8U&result=1.

Fetal Viability. This medical term describes the gestational age of a fetus where medically, fetal development promotes the most significant opportunity, with medical support, for survival outside of the womb. While there is no firm consensus on the exact week of gestation, it ranges from twenty-two to twenty-five weeks.[45] Another term analogous to fetal viability is periviable birth. According to the American College of Obstetricians and Gynecologists (ACOG), periviable birth is "delivery occurring from 20 0/7 weeks to 25 6/7 weeks of gestation. When delivery is anticipated near the limit of viability, families and health care teams are faced with complex and ethically challenging decisions."[46]

Gestational Age. The measurement of an unborn baby's age is in weeks based on the mother's menstrual cycle or by ultrasound measures. While the division of gestational age is into two parts, embryonic and fetal, the measure of time is vital to gauge the growth and development of the baby in the womb. An average pregnancy is from thirty-eight to forty-two weeks.[47] Babies born before a full-term gestational age of forty weeks could be considered premature and at risk of needing medical support to complete their fetal development and sustain life outside the womb.

Mercy Central Communities. Within Mercy Health systems, the central region comprises hospitals and clinics in eighteen different areas. Springfield, MO, is the headquarters for the

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[45] In the current culture of abortion vs. anti-abortion, fetal viability conversations contain emotions and varying opinions. However, for this writing, the term fetal viability relates to a premature baby being able to survive outside of the womb with or without medical support and how the loss of a baby before fetal viability will impact the emotional and spiritual life of the one who is pregnant.

[46] "Periviable Birth," ACOG Clinical Updates October 2017, ACOG, last modified October 2017, https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2017/10/periviable-birth.

[47] Winningham, April L. *Encyclopedia of Epidemiology,* s.v. "Gestational Age." (Sage Publications, 2008), accessed August 31, 2022, https://go.openathens.net/redirector/liberty.edu?url=https%3A%2F%2Fsearch.credoreference.com%2Fcontent%2Fentry%2Fsageepid%2Fgestational_age%2F0%3FinstitutionId%3D5072.

central region and houses its leadership. The central community is one of three communities that comprise the Mercy Health System.

Miscarriage. A miscarriage is medically known as a spontaneous abortion and occurs when a pregnancy ends during the first twenty to twenty-four weeks of gestation. When the pregnancy ends, the body spontaneously expels the ended pregnancy. However, if this does not occur, pharmacological or surgical intervention can assist in the spontaneous abortion for the patient's health. A threatened miscarriage is signified by bleeding and may end in the continuation of the pregnancy or pregnancy loss. The cause of miscarriage is often difficult to diagnose and can occur even before a pregnancy has been confirmed.[48]

Molar Pregnancy. A molar pregnancy occurs when there is an abnormality in the placenta. When the fertilized egg does not develop correctly but grows abnormally in the uterus, it appears as a rather large and random collection of cell bunches resembling a grape cluster. According to the American Pregnancy Association, one in every one-thousand pregnancies is a molar pregnancy.[49] If the patient's body does not naturally expel the molar pregnancy, it is treated through pharmacology or surgery.

Perinatal. The term perinatal designates the time of pregnancy before and through delivery and generally one month after delivery. According to Taber's Cyclopedic Medical Dictionary, it is the period from the twentieth to the twenty-eighth week of pregnancy.[50]

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[48] Karen J. Carlson, Stephanie A. Eisenstat, and Terra Diane Ziporyn, *The New Harvard Guide to Women's Health*, s.v. "miscarriage," Harvard University Press, 2004. Accessed August 30, 2022, https://go.openathens.net/redirector/liberty.edu?url=https%3A%2F%2Fsearch.credoreference.com%2Fcontent%2Fentry%2Fhupwh%2Fmiscarriage%2F0%3FinstitutionId%3D5072.

[49] "Molar Pregnancy," American Pregnancy Association, https://americanpregnancy.org/healthy-pregnancy/birth-defects/molar-pregnancy/.

[50] *Taber's Cyclopedic Medical Dictionary*, "perinatal." edited by Donald Venes, 24th ed. (Philadelphia, PA: F.A. Davis Company, 2017), 1793.

Religious Sisters of Mercy. Women who hold the designation of RSM have joined the Sisters of Mercy community founded by Catherine McAuley. To be considered for a Sister of Mercy, Catholic women must be single, ages twenty to forty-five, and commit to prayer, compassion, and action. A minimum of seven years of training are required to prepare for the final vows. These years of training include learning about prayer and Catholic theology, living and ministering alongside other sisters, deep reflection, growth, grace, and joy. After training and incorporation, the candidates take their final profession of vows of "poverty, chastity, obedience, and service of poor, sick and ignorant" to become a Sister of Mercy.[51]

Limitations

There are limitations in this DMIN action research project proposal which provide distinct opportunities to adapt this work to meet the needs of the participants. First, recruiting participants for this work will be limited to patient referrals made as the standard of care for the interdisciplinary team at Mercy. Since Mercy's healthcare reach in southwest Missouri is large, one-on-ones and in-person meetings will be limited to the central region of Mercy. This limitation may exclude some patients who would not want to travel an extended distance to participate. Additionally, in-person meetings may be impossible if an unforeseen change in the pandemic occurs.

While an effort to retain group members for the length of the grief support project is essential, the inevitability of life events makes it impossible to guarantee. Additionally, every effort will be made to encourage and accept each participant's level of comfort interacting with this project. However, there is no certainty that each participant will interact by being open and

[51] "Become a Sister," Sisters of Mercy Hermanas de la Misericordia, Embodying the Mercy of God For a Better World. https://sistersofmercy.org/ways-to-get-involved/become-a-sister/. Last updated in 2021.

vulnerable. Due to the impact of pregnancy loss and grief and the vulnerable nature of this experience, patients may not yet feel comfortable joining with others to share. There is no way to predict these limitations, and the project design offers options. Finally, each person's unique story includes varying trauma, loss, and grief. While this factor is unforeseen, the individuality of the participants and their stories strengthens the dynamics and effectiveness of processing in a community setting and will be regarded with the utmost respect if meeting in group settings.

Delimitations

The delimitations of this proposed DMIN project begin with securing participants. Foremost, because of the enormous geographical range of Mercy central communities, the scope for this work will be limited to pregnancy loss patients under twenty-five weeks gestation,[52] whom a chaplain initially sees. Also included will be any patients referred to Pastoral Services by clinical staff for spiritual and emotional support following a miscarriage at home.[53] The target age group for this research is patients of childbearing age over eighteen years of age.

Secondly, the group's size and intervention length will be no more than seven participants to promote an environment for interaction and connection. The intervention will be at least eight weeks with each participant and designed from a Christian perspective, respecting all belief systems. Each participant will be requested to meet with the project leader in person or online at least once a week. The online encounter will take place on a hospital-approved platform.

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[52] This specific gestational age is selected because it is the medically designated age of fetal viability, which infers that even if the baby is born living, developmentally, and with medical support, it could not survive. See definitions: For fetal viability and periviable.

[53] Connecting with a chaplain during the patient's loss is instrumental in preparing the patient for the potential for ongoing spiritual and emotional support. Without this connection, follow-up support is not anticipated by the patient and is often not appreciated.

This proposed work will be limited to pregnancy loss patients, not family members. While research, as seen in chapter two's literature review, indicates the need to support the family unit experiencing pregnancy loss alongside the patient, the scope of this proposed research will limit participation to patients. Because this is a quality improvement project, gathered data will be limited to broad descriptive data and Likert scale diagnostic tools. No individual data will be identifiable, and no private information will be accessed outside the standard of care for fetal loss patients.

Thesis Statement

Promoting strategic emotional and spiritual health following a perinatal loss can have a long-term impact. For this reason, support will include eight weeks of grief work where participants interact with the project leader and others through storytelling and fostering positive coping skills. Filtered through a faith-based approach to intervention, participants will interact in this project while exploring spirituality and considering life's meaning and purpose. This experience will be encouraged through the lens of God's redeeming love for humanity and His presence in daily life.

Specifically, participant selection in this eight-week grief support intervention will occur by meeting the target group criteria after being referred by the interdisciplinary team. During the eight weeks, faith-based, intentionally designed interactions, relationship-building, and creative projects to memorialize and celebrate the sanctity of life will foster emotional and spiritual support. At the end of the eight-week intervention, participants will respond to a patient survey, enabling them to report their level of satisfaction with their experience. Additionally, the data gathered from the participants, the stakeholders, and the project leader will support the value of grief work in improving the quality of Pastoral Services at Mercy Hospital. Data will further

show the importance of faith-based spirituality in the grief process and the value of relationships and storytelling in promoting emotional and spiritual health. If Mercy offers extended grief support to miscarriage patients, then patients will be assisted in processing their initial grief, therefore promoting emotional and spiritual health and quality patient care.

CHAPTER 2: CONCEPTUAL FRAMEWORK

One of the most common experiences and complications of pregnancy is miscarriage.[1] Beyond the statistics, the American College of Obstetricians and Gynecologists references miscarriages using terminologies such as spontaneous abortion, a missed spontaneous abortion, or early pregnancy loss.[2] In addition to these expressions, terms such as molar pregnancy, embryonic demise, tubal pregnancy, and early perinatal loss are standard when referring to medical diagnosis and interventions for the gestation of a pregnancy that ends before fetal viability.[3] Specifically, tubal pregnancy can result in life-threatening health risks for the patient if medical intervention is not sought. Therefore, for this project, all pregnancy experiences that end in loss before fetal viability, believed in the range of twenty to twenty-five weeks gestation, will be regarded as a miscarriage.[4]

The effects of miscarriage are multidimensional, impacting the body, soul, and spirit. The emotional and spiritual components of grief and loss associated with this condition are uniquely complicated. From a theoretical perspective, loss and grief can have multifaced effects on

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[1] Elisabeth Larsen et al., "New Insights into Mechanisms Behind Miscarriage," *BMC Medicine* 11, no. 154 (2013), 1-3.

[2] "Definition for Miscarriage," The American College of Obstetricians and Gynecologists, last modified January 2022, https://www.acog.org/womens-health/faqs/early-pregnancy-loss.

[3] "Early Pregnancy Loss," The American College of Obstetricians and Gynecologists, last modified 2022, https://www.acog.org/womens-health/faqs/early-pregnancy-loss.

[4] Many medical factors affect fetal viability in the gestational range, which is outside this project's scope. "Previable Birth," The American College of Obstetricians and Gynecologists, last modified 2022, https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2017/10/periviable-birth.

individuals.[5] Consequently, experiencing a perinatal loss can be difficult to process and communicate to others, not merely in the physical sense but emotionally and spiritually as well. Miscarriage grief evokes feelings connected to the loss of life, including loss of hopes and dreams, loss of control, loss of anticipated parenthood and family planning, and loss of oneself.[6] Intense emotions such as shock, guilt, anger, blame, shame, failure, depression, and confusion can also be present.[7] A perinatal loss is an understood experience of saying goodbye before saying hello or simultaneously saying hello and goodbye. Ryan D. Keuhlthau uniquely expounds on this loss in the title of his writing on miscarriage, "Giving Birth to Death."[8] The name of his writing represents a powerful perspective on the potentially agonizing grief of miscarriage as a unique multidimensional loss. He further expounds on the grief of perinatal loss as concurrently living with birth and death.[9] With this in mind, it is less difficult to comprehend the lack of awareness and the silent grief of miscarriage. In chapter two of this project, the conceptual framework of miscarriage grief is surveyed by presenting a review of the literature and consideration of theological and theoretical implications.

Review of Literature

A review of the literature on the topic of miscarriage and the grief associated with this phenomenon will give further attention to key elements of this project. Understanding

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[5] Amy Hillis, "I Can't Tell You How to Grieve," *Sunshine After the Storm: A Survival Guide for the Grieving Mother*, ed Alexa Bigwarfe, (Coppell, TX: Kat Biggie Press 2013), 27.

[6] Natalie Figueredo-Borda et al., "Experiences of Miscarriage: The Voice of Parents and Health Professionals," *OMEGA, Journal of Death and Dying*, (2022): 2-4.

[7] Angela Hiefner, and Astrud Villareal, "A Multidisciplinary Approach to Caring for Parents After Miscarriage: The Integrated Behavioral Health Model of Care," *Frontiers in Public Health* 9, (November 2021):1-3.

[8] Ryan D. Kuehlthau, "Giving Birth to Death," *Journal of Psychology and Christianity* 36, no. 4 (Winter, 2017): 316.

[9] Ibid.

miscarriage as a unique phenomenon and the importance of awareness about the silent grief of miscarriage and the psychosocial factors that can be found in miscarriage grief are momentous to this project. Nonetheless, the available research on miscarriage grief support is somewhat shallow. It is limited primarily to addressing medical and mental health professionals. For example, academic literature studies and suggests ways doctors and nurses offer care targeted to the emotional needs of their patients with the medical care they provide. It also studies and guides systems that therapists and counselors use to support the unique grief of perinatal loss to further encourage their patients toward mental health. Additionally, a portion of the literature is a phenomenological account of miscarriage grief, appropriately revealing patients' experiences with self, doctors, nurses, therapists, family, and society at large.

Nonetheless, a gap in the literature exists concerning the need for spiritual grief support offered to patients experiencing fetal loss. This gap in research is a primary impetus for this DMIN project because spirituality is an essential dimension of humanity. There is also little mention of the value and role of professionally trained chaplains, spiritual care advisors, clergy, or faith communities in supporting patients experiencing early perinatal loss. While there is much writing and research on chaplain roles in patient care, there is little from an interdisciplinary perspective with specific training on caring for fetal loss patients. Understanding the necessity for spiritual and emotional support from perinatal loss begins with understanding both miscarriage and grief.

This chapter lays a framework that examines the unique grief associated with miscarriage loss. The project will pursue a specific interest in the awareness and spiritual impact of miscarriage grief and psychosocial factors affecting perinatal loss patients. Further examination

of how hospital chaplains can provide space to foster coping mechanisms and promote a healthier patient grief experience is included.

Overview of Miscarriage

Miscarriage is considered a natural event of the reproductive experience.[10] While much basic information has already been covered about miscarriage and its frequency, the literature reveals the importance of considering the historical term 'miscarriage' and its connection to the term 'abortion.' Common medical terminology for perinatal loss in the first or second trimester is 'spontaneous abortion' or 'missed abortion,' which takes place before the age of viability.[11] Today culture knows the term 'abortion' as a modern political hot button, and in academic literature, it infers induced pregnancy loss or induced termination of pregnancy.[12] The ways in which women have historically understood miscarriage and abortion are definitely eclipsed by the political culture of their day and the many debates on abortion, female reproductive autonomy, the right to control fertility, and the stand of the religious faithful.[13]

However, as early as the sixteenth century, historians have revealed the presence of the term abortion rooted in the Latin word *aboriri*, meaning to miscarry, disappear, or be lost.[14] It has been used interchangeably for elective termination of pregnancy as well as a pregnancy loss occurring naturally.[15] During the early and mid-twentieth century, in medicine, the word abortion

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[10] Rosemary Elliot, "The Meanings of Miscarriage in Twentieth-Century Britain," *Navigating Miscarriage: Social, Medical and Conceptual Perspectives*, eds. Susie Kilshaw and Katie Borg, 45, (Berghahn Books, 2020), 80.

[11] Ibid., 64.

[12] Ibid.

[13] Ibid, 60-62.

[14] Pedro Melo and Ingrid Granne, "Does Twenty-first-Century Technology Change the Experience of Early Pregnancy and Miscarriage?" *Navigating Miscarriage: Social, Medical and Conceptual Perspectives*, eds. Susie Kilshaw and Katie Borg, 45, (Berghahn Books, 2020), 35.

[15] Ibid.

was still used to describe both induced or spontaneous pregnancy loss.[16] A British perspective of the historical evolution of the terms abortion and miscarriage reveal that calling a spontaneous pregnancy loss an abortion offended women, leading to legal battles. In addition, technological advances in ultrasounds and other professional and social developments also influenced the terminology change among the general population to miscarriage for spontaneous pregnancy loss and abortion for the induced termination of pregnancy.[17] Andrew Moscrop's study on the terminology of abortion in Britain aligns with other countries' progression in medical vocabulary for miscarriage; descriptive words have also been added to the term abortion to clarify the difference.[18]

Articulating the etiology of a miscarriage is complicated by the mystery of conception, embryology, genetics, and reproductive biology.[19] While medical professionals are looking for biological answers to why miscarriage frequently happens, there is not always a well-defined solution, and post-miscarriage testing to determine a cause can be costly for the patient.[20] Previous miscarriages are clinical risk indicators for future miscarriages, and the risk factor grows exponentially the more miscarriages a patient has experienced.[21] The American School of Obstetrics and Gynecology says that about 50 percent of all cases of early perinatal loss occur

[16] Elliot, "The Meanings of Miscarriage in Twentieth-Century Britain," 65.

[17] Andrew Moscrop, "'Miscarriage or Abortion?' Understanding the Medical Language of Pregnancy Loss in Britain; A Historical Perspective," Medical Humanities 39 (2013): 98-104.

[18] Ibid.

[19] Ibid.

[20] Mercy Hospital provider's standard of care and best practice is to abstain from post-miscarriage testing until a patient has suffered three miscarriages unless extenuating circumstances exist or a patient specifically requests genetic testing, which is commonly paid out of pocket by the patient.

[21] Adam Devall et al., "Progesterone for the Prevention of Threatened Miscarriage," *Obstetrics, Gynaecology & Reproductive Medicine*, 32, no. 3 (March 2022): 44.

because of fetal chromosome malformations.[22] Rabiega-Gmyrek et al., in a study in Poland, found that seventy-two percent of the miscarriages scrutinized involved chromosomal abnormalities.[23] Beyond chromosomal dysfunction, other possible causes of miscarriage include maternal infection, maternal age, exposure to drugs, hormone deficiencies, and inherited diseases of the embryo.[24] This list is merely the beginning of the many suggested causes of miscarriage in the literature. Nonetheless, when a pregnancy outcome of miscarriage occurs, most of the modern literature agrees with the findings of McCarthy et al., that it can be physically and psychosocially overwhelming in surprising ways to the patient while also changing the course of the reproductive plans of families.[25]

A threatened miscarriage or threatened abortion is diagnosed when a patient has a confirmed positive pregnancy test and can often experience cramping and pain as well as bleeding in the first and early second trimester. Providers could also perform an ultrasound, monitor fetal heart tones, and enact bloodwork to detect miscarriage.[26] Medical intervention in a threatened miscarriage scenario can be an observational and expectant approach, meaning watch-and-wait with little intervention, to administering hormone therapy or prescribing bedrest and monitoring.[27] Once a miscarriage is imminent, determined through an ultrasound exam and

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[22] "Early Pregnancy Loss" in ACOG Practice Bulletin No. 200, American College of Obstetricians and Gynecologists. *Obstetrics and Gynecology* 132, (2018): 197.

[23] Dorota Rabiega-Gmyrek et al., "Chromosomal Aberrations - The Cause of Spontaneous Abortions," *Ginekologia Polska (Genetics Poland)* 86, no. 5 (January 2015): 357.

[24] Ibid.

[25] C. M. McCarthy et al., "The General Populations' Understanding of First Trimester Miscarriage: A Cross Sectional Survey," *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 245, (November 2020): 200-205.

[26] J. Trinder et al., "Management of Miscarriage: Expectant, Medical or Surgical? Results of Randomised Controlled Trial (Miscarriage Treatment (MIST) Trial)," *BMJ: British Medical Journal* 332, no. 7552 (May 17, 2006): 1-2.

[27] Ibid.

pathological workup, consideration is given to a treatment regime. Decision-making for the appropriate treatment can range from expectant management to medical or surgical management. Allowing the patient to be a major part of this conversation is essential.[28] Expectant management allows time for the body's natural expulsion of the miscarriage. In contrast, medical management means pharmacological intervention using specific medicines to promote and manage the body's expulsion of the retained products of conception.[29] Medical management in the form of surgical curettage[30] is chosen when the miscarriage is incomplete.[31] This brief procedure is designed to take place under light sedation or anesthesia to scrape the uterus and remove the retained products of conception.[32] It can be initially selected or chosen if the pharmacological management is ineffective. A miscarriage in the second trimester usually requires another form of treatment involving medical induction of labor or a dilate and evacuate surgery.[33] According to the literature review, treatment selections are made for varying reasons. As Olesen et al. confirm in their study of miscarriage treatments, it is more than just the physiological risks to the patient but the psychosocial effects of miscarriage that can influence treatment decisions.[34]

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[28] Trinder et al., "Management of Miscarriage."

[29] Ibid.

[30] Surgical treatment is known as dilation and curettage, called D&C.

[31] J. Trinder et al., "Management of Miscarriage," 1-2.

[32] Ibid.

[33] A dilate and evacuate (D&E) is the same procedure used in an elected abortion. Because of the ethical issues related to this procedure, Mercy Hospital will not perform a D&E. If no fetal heart tones are found in a second-trimester ultrasound, the patient would be induced to deliver their stillborn baby or moved to another hospital at their request to have a D&E.

[34] Mette Linnet Olesen et al., "Deciding Treatment for Miscarriage- Experiences of Women and Healthcare Professionals," *Scandinavian Journal of Caring Sciences* 29, no. 2 (2015): 393.

Overview of Miscarriage Grief

Patients receiving a diagnosis of miscarriage often experience various feelings, including shock, disbelief, and feeling blindsided by the reality of this clinical diagnosis.[35] Shifting from feeling the exuberance and anticipation of pregnancy and the hope-filled dreams in the sound of the baby's heartbeat to the abrupt shock and emptiness in the absence of fetal heart tones initiates the patient's journey into miscarriage grief.[36] Discussing grief in universal terms would include the thoughts and feelings one has inside after something or someone is lost, and it often is difficult to communicate with others.[37] Ratcliffe adds to this conversation in his writing on *Grief Worlds*, clarifying that grief is a two-sided being "about something specific and yet at the same time, encompassing everything," which is very applicable to grief relating to early pregnancy loss.[38] Responses to grief include many different characteristics that fall into a person's behavioral, physiological, cognitive, and affective dimensions.[39] Miscarriage grief can be measured in physiological and psychological responses to the loss, commonly including distress.[40] The body must biologically adjust to the termination of the pregnancy, and the heart and soul have to say goodbye to the hopes and dreams of raising this child.[41]

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[35] Morgan Martin, *Healing Empty Hands: Finding Hope and Peace Through Miscarriage* (Cannon + Rose Publishing, 2023), 10.

[36] Ibid.

[37] Matthew Ratcliffe, *Grief Worlds: A Study of Emotional Experience* (Cambridge, MA: MIT Press, 2023), 1-3.

[38] Ibid., 18.

[39] Norman Brier, "Grief Following Miscarriage: A Comprehensive Review of Literature," *Journal of Women's Health* 17, no. 3, 2008. 451-53.

[40] Ibid.

[41] Donna Rothert, *At a Loss: Finding Your Way After Miscarriage, Stillbirth, or Infant Death* (Oakland, CA: Open Air Books, 2019) 16-18.

While grieving a loss can be initiated in more ways than through death, the grieving process represents feelings associated with one's attachment to the person or thing that is lost. Darcy Harris, the editor of a collection of writings on death, dying, and bereavement, clarifies the work of many by saying, "Grief is the instinctually programmed response to the loss of significant, core aspects of our assumptive world."[42] More of the theoretical discussion on grief will occur later in chapter two; however, with miscarriage grief, the loss incorporates the assumptive world created by the anticipated baby.[43] Miscarriage loss hijacks hopes and dreams, family plans, parenting the child, celebrating life milestones, and so much more.

Some patients begin to experience symptoms of miscarriage before they have medical confirmation of the loss. This can initiate anticipatory grief or fear of a loss to come.[44] If grief is a response to loss, then anticipatory grief is the inner experience of processing and projecting the questions and scenarios that form about the unknown future in light of the impending loss.[45] In a phenomenological methodology, a video was produced for the Public Broadcasting Service titled "If Everyone Knew," to raise awareness of the experiences of early pregnancy loss. It featured the true stories of the unique and intimate happenings of miscarriage grief.[46] One patient stated about her experience with the early symptoms,

> I was at work one morning, and I went to the bathroom… and I didn't quite know what [was going on, and after this brief and graphic experience was over,] I had to go back out to my desk and sit there and think, "What do I do now? Do I do my work? Do I not? So, I

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[42] Darcy L. Harris, "Non-Death Loss and Grief: Laying the Foundation," in *Non-Death Loss and Grief: Context and Clinical Implications*, ed. Darcy L. Harris (New York, NY: Routledge, 2020), 14.

[43] Matthew Ratcliffe, *Grief Worlds*, 79-80.

[44] Allen Wolfelt, *Expected Loss: Coping with Anticipatory Grief* (Chicago, IL: Companion Press, 2021), 4.

[45] Ibid.

[46] "If Everyone Knew," directed by Imogen Harrison (Public Broadcasting Service, 2022), https://video.alexanderstreet.com/watch/if-everyone-knew.

> just started doing my job, I literally just started doing my job, and every time someone spoke to me, it was like I was vacant.[47]

Another woman stated she avoided the obvious intimate signs and symptoms that something unexpected and emergent was happening with her pregnancy because seeing it would make her realize she was no longer pregnant. "It was too much. And it was. It meant I had to admit that something was happening and something wasn't right [with the pregnancy]."[48]

Bearing the news of miscarriage and processing the events connected with the diagnosis can be traumatic and complicate the grieving process. This is due in part to the social perceptions of miscarriage grief. In his writing on healing grief after miscarriage, Alan Wolfelt summarizes simply what others in the literature say about miscarriage grief. "Miscarriage is a significant loss. It is normal and natural to hurt deeply after miscarriage."[49] He further emphasizes that miscarriage grief exists, and it is befitting to grieve this loss because "love plus loss equals grief."[50] A common misconception that complicates miscarriage grief is that the earlier the miscarriage occurs in the pregnancy experience, the less the loss means. This mindset minimizes the anticipated experience of pregnancy and the loss of hopes and dreams of patients that go through this experience.[51] In healthcare and culture, it is not uncommon to view miscarriage loss as less critical or traumatic than other familial losses, minimizing the grief of early perinatal loss.[52] One patient from "If Everyone Knew," adds to the discussion by clarifying about miscarriage and grief, "I think the taboo and stigma isn't with how often it happens and who it

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[47] "If Everyone Knew."

[48] Ibid.

[49] Allan Wolfelt, *Healing Your Grieving Heart After Miscarriage: 100 Practical Ideas for Parents and Families* (Fort Collins, CO: Companion Press, 2015), 1-2.

[50] Ibid.

[51] Rosemary Elliot, "The Meanings of Miscarriage," 78.

[52] Lang, et al., "Perinatal Loss," 184.

happens to, I think it's how it's talked about [or not talked about]."[53] The overview of miscarriage and the grief associated with this experience in the literature confirms that while every patient has a different story and a different way they know the grief of early perinatal loss, there can be named some common components. The primary component to further this discussion in the literature is miscarriage awareness.

Awareness

At the epicenter of the literature review of perinatal loss is a general lack of awareness of the impact of miscarriage on patients and their support systems. In their study on the general population's understanding of miscarriage, McCarthy et al. found that less than 30 percent of survey participants were aware of the occurrence of miscarriage.[54] They further verified that while miscarriage affects as much as 25 percent of pregnancies,[55] there still exists a lack of knowledge, education, and support.[56] Breaking the silence of pregnancy loss is not a new phenomenon and has long been full of complicating factors. However, in her writing on nineteenth-century pregnancy loss and specifically miscarriage, medical historian Shannon Wythecombe found women writing openly about their miscarriages, reflecting an array of feelings. [57] According to Wythecombe, some women were sad about the loss, some felt failure and disappointment, and some were even relieved to no longer be pregnant.[58] The existence of historical social, religious, and cultural norms related to having a big family and the well-

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[53] "If Everyone Knew."

[54] McCarthy et al., "The General Populations' Understanding," 204.

[55] Ibid.

[56] Ibid.

[57] Shannon Withycombe, *Lost: Miscarriage in Nineteenth-Century America* (New Brunswick, NJ: Rutgers University Press, 2018), 14-16. ProQuest Ebook Central.

[58] Ibid.

established primary role of women as family producers shaped the range of emotions discovered by Wythecombe.[59] While the source of these historical feelings may vary from today, the resultant emotional responses to perinatal loss mirror modern-day reactions to miscarriage.

Notably, over time miscarriage is recognized under the primary pretense of being a pregnancy problem in need of medical management without any thought toward the impact of loss and grief.[60] Feministic ethics of a mother's right to autonomy and the stigma of pro-choice advocates influence the consideration of labeling early pregnancy complications as a loss.[61] This mindset further complicates the feelings a patient might experience following a miscarriage by causing doubt and confusion. It also challenges the conservative ethical values of pro-life supporters who understand that a baby's life begins at conception. To be sure, this project will not focus on the historical political argument of the beginning of life issues or argue for or against feministic views. Instead, it has a patient-centered focus advocating for the care of all patients who experience various levels of grief from miscarriage loss, no matter their political or socioeconomic stance. Raising awareness of miscarriage grief will allow the opportunity for appropriate support for each patient and meaningful support concerning long-term mental and emotional health.

Healthcare Professionals

According to the literature, there is a notable disparity in the level of miscarriage grief awareness possessed by those providing medical care to obstetrical patients. Healthcare

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[59] Withycombe, *Lost: Miscarriage in Nineteenth-Century America*, 21.

[60] Maria Renée Kurz, "When Death Precedes Birth: The Embodied Experiences of Women with a History of Miscarriage or Stillbirth—A Phenomenological Study using Artistic Inquiry," *American Journal of Dance Therapy* 42, no. 2 (Dec. 2020): 195.

[61] Bruce Blackshaw and Daniel Rodger, "If Fetuses are Persons, Abortion is a Public Health Crisis," *Bioethics* 35, no 5 (June 2021), 465-472.

providers worldwide observe that their patient care often focuses on the physiological aspects of miscarriage, leaving emotional and spiritual support in the dark.[62] Varied reasons, such as job demands, time constraints, shortage of resources, lack of specified training in addressing loss, underdeveloped bedside manner, the provider's analytical tendencies, and compassion fatigue, are reasons for the seeming lack of awareness.[63] Karaca and Oskay, in their exploration of the psychosocial health status of women having a miscarriage in their country of origin, observe, "In Turkey, [as in other places] healthcare professionals in obstetric clinics tend to focus solely on the physical care of women who have had a miscarriage, supportive care for women who have a miscarriage is consequently insufficient."[64] They further state of miscarriage patients, "their emotional status is generally neglected, and a little to no attention is shown to the process of grief that they [patients] experience after a miscarriage."[65] The study also discovered that, by in large, after discharge, only gynecological follow-up was incurred, with no further purposeful follow-up for the patient's psychological or spiritual well-being.[66]

This is not to say that obstetrical healthcare professionals are unaware of or do not relate to the loss and grief of pregnancy patients. Many providers exhibit empathy and compassion for their patients, which patients often underappreciate because of their own suffering until they have healthily processed their grief.[67] However, as clarified in chapter one from the statistical

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[62] Pelin Palas Karaca and Umran Yesiltepe Oskay, "Effect of Supportive Care on Psychosocial Health Status of Women who had a Miscarriage," *Perspect Psychiatric Care* 57, no. 1 (January 2021): 179; Ariella Lang et al., "Perinatal Loss and Parental Grief: The Challenge of Ambiguity and Disenfranchised Grief," *OMEGA* 63, no. 2 (2011):191.

[63] Hiefner and Villareal, "A Multidisciplinary Family-Oriented Approach," 1.

[64] Karaca and Oskay, "Effect on Supportive Care," 178.

[65] Ibid.

[66] Ibid.

[67] Ibid.

occurrence of miscarriage, the nature of the provider's work frequently exposes obstetrical healthcare workers to early pregnancy loss and grief.[68] This secondary grief experience can lead to burnout and resultant trauma that is detrimental to their career longevity and mental and physical health.[69] In their awareness of the suffering experienced because of loss, some healthcare workers, purposefully or not, distance themselves from a patient's loss and grief to protect themselves emotionally and focus on treating the patient.[70] This form of self-preservation may be interpreted as uncaring or cold.[71] Over time this behavior will impact the personal well-being of providers and nurses.[72] Self-care for healthcare providers includes faith traditions, debriefings, defusing, individual counseling, peer support, talking one-on-one, regular exercise, diet, and leisure activities promoting good mental and physical health. Healthy self-care connects providers and nurses to a healthier awareness of the patients' experiences which can foster compassionate care, improved patient satisfaction experiences, and longevity in the healthcare profession.[73]

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[68] Statistics as high as one in four pregnancies results in miscarriage. "Miscarriage" March of Dimes, last modified in 2017, https://www.marchofdimes.org/complications/miscarriage.aspx; and "Miscarriage," StatPearls Publishing National Library of Medicine, last modified May 8, 2022, https://www-ncbi-nlm-nih-gov.ezproxy.liberty.edu/books/NBK532992/. "Miscarriage," World Health Organization, https://www.who.int/news-room/spotlight/why-we-need-to-talk-about-losing-a-baby.

[69] Carmela Mento et al., "Secondary Traumatization in Healthcare Professions; A Continuum on Compassion Fatigue, Vicarious Trauma and Burnout," *Psychologia*, (February 2021): 2-3.

[70] Dilshad Nathoo and Janet Ellis, "Theories of Loss and Grief Experienced by the Patient, Family and Healthcare Professional: A Personal Account of a Critical Event," *Journal of Cancer Education*, 34, (2019): 833.

[71] Ibid.

[72] Mento, "Secondary Traumatization," 3.

[73] Nathoo and Ellis, "Theories of Loss and Grief Experienced," 833.

One example of an organization that promotes healthcare workers' awareness of their own well-being and mental health is the Schwartz Center For Compassionate Healthcare.[74] Mercy Springfield utilizes this organization to foster healthy coworkers. This organization offers three valuable "Quick Tips" to raise awareness of the effects of secondary trauma and stress in the healthcare industry. The "Quick Tips" begin with remembering self-care.[75] They suggest taking breaks, exercising, and even getting outside to promote physical strength. Secondly, staying connected with peers, leaders, colleagues, family, and friends to support each other is also important.[76] This eliminates feelings of isolation and thinking that one's stress and secondary trauma experience is unique. Finally, the Schwartz Center recommends healthcare workers practice compassion toward others and themselves.[77] These three tips promote not only coworker health and longevity but also the mission, values, and charisms of Mercy Healthcare.

Close Family and Friends

Another dimension of awareness and understanding of miscarriage grief relates to the patient's social network. Close family and friends attentiveness to the potential impact of miscarriage grief on parents is helpful in the grief recovery process. In addition, it can influence a healthy journey for the patient by providing acceptance and understanding.[78] Mindfulness of pregnancy loss and grief allows family and friends to consider the magnitude of a patient's

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[74] "Mental Health and Well-being Resources for Healthcare Workers" The Schwartz Center for Compassionate Healthcare, last modified in 2023, accessed February 27, 2023, https://www.theschwartzcenter.org/mentalhealthresources/.

[75] Ibid.

[76] "Quick Tips," The Schwartz Center for Compassionate Healthcare, https://www.theschwartzcenter.org/mentalhealthresources/.

[77] Ibid.

[78] Donna Rothert, *At A Loss: Finding your Way After Miscarriage, Stillbirth, or Infant Death* (Oakland, CA: Open Air Books, 2019), 28.

connection to this unique loss while providing a safe space to grieve, share stories and feelings, or share silence without judgment or fear of degradation.[79] Social awareness can impact the disenfranchisement and ambiguity of miscarriage grief.[80]

In their study, "Perinatal Loss and Parental Grief," Lang et al. discovered, as other researchers, that patients perceived the family and community support as lacking awareness of miscarriage grief. Further, they portrayed the patient's feelings as insignificant.[81] Patients wanted to talk with friends and family about their experience and did not know what to say, or they sensed others wanted to avoid the whole experience and move on.[82] Family and friends further demonstrate a lack of cognizance by attempting to give a type of comfort that tries to move a patient through the grief process by making well-intended statements such as "everything happens for a reason" or "the baby was not going to be normal, anyway," or "at least you have other children," or "God needed your baby more than you did."[83]

Extended Family

Miscarriage grief can also be present in the extended family. Grandparents, aunts and uncles, and siblings may also be affected by the loss causing the patient added concern for their well-being. The extended family's grief may be carried as a silent grief, and the patient should be aware that others who are close may also grieve the loss of their own hopes and dreams in

[79] Ariella Lang, et al., "Perinatal Loss and Parental Grief: The Challenge of Ambiguity and Disenfranchised Grief." *OMEGA* 63, no. 2 (2011): 184.

[80] Ibid.

[81] Ibid., 192

[82] Ibid.

[83] Riecke, *No Matter How Small,* 134-35.

silence. [84] Responsiveness to this possibility provides an opportunity to process grief together in a supportive manner.[85] Being present with others after a miscarriage is essential to reduce the sense of isolation in grief. While family awareness of the possibility of miscarriage grief is vital in the patient's grief journey, their lack of understanding and their own silent grief can complicate the recovery process and multiply the social implications.[86]

Among Couples

Related to family, no couple's relationship is more vulnerable than the couple experiencing this event. Sunita Osborn, the author of *The Miscarriage MAP Workbook,* reminds couples that although they are mourning together over the same event, the experience of mourning may be entirely different for each.[87] Couples studied in Angela Hiefner's investigation of dyadic coping and couple resilience after a miscarriage reported awareness of both negative and positive aspects of the miscarriage experience in their relationships.[88] She further elucidates that a couple's understanding of how the other processed grief and what it means to cope with reproductive loss promoted attunement in their relationship and their emotions.[89] They developed tension and strain as well as closeness and strength through their consciousness of this experience.[90] Hiefner concludes that a lack of research on how coping as a couple raises

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[84] Hiefner and Villareal, "A Multidisciplinary Family-Oriented Approach" 4.

[85] Rana K. Limbo and Sara Rich Wheeler, *When a Baby Dies: A Handbook for Healing and Hope* (La Crosse, WI: Bereavement and Advance Care Planning Services, 2010), 93-100.

[86] Sunita Osborn, *The Miscarriage MAP Workbook: An Honest Guide to Navigating Pregnancy Loss, Working through Pain and Moving Forward*, (Eau Claire, WI: PESI Publishing, 2021), 49-53.

[87] Ibid., 67-8.

[88]Angela Hiefner, "Dyadic Coping and Couple Resilience After Miscarriage," *Interdisciplinary Journal of Applied Family Science* 70, (February 2021): 64.

[89] Ibid.

[90] Ibid.

awareness of miscarriage would be essential to help couples cope. Studies have proven that grief can cause stress, misunderstanding, and the potential for blame and isolation.[91] The knowledge of difficulties associated with miscarriage grief allows couples to grieve in their manner and appreciate the grief process of the other, then move together through the circumstances of miscarriage in partnership. The relationship dynamics of a couple or family can negatively or positively influence the patient's grief.

Psychosocial Implications

Grief from a miscarriage can be complicated, lasting from a few weeks to years.[92] Literature is filled with reminders that pregnancy loss is a physiological, emotional, and sociocultural experience. Phenomenological consideration of miscarriage experiences in the literature proves this, and it is seen explicitly in the distinctive ways patients react and respond to miscarriage grief.[93] Furtado, Hernandez, and Fernandez discuss the psychosocial implications of miscarriage grief from an integrative view as they strongly encourage care providers to focus on psychosocial well-being. This integrative approach considers complicated grief, cultural influence, the influence of medical providers on decision-making, the possibility of multiple losses, and pressure from family.[94] In her writing *The Brink of Being: Talking About Miscarriage*, Julio Bueno begins this discussion experientially as she shares the psychosocial effects of her perinatal loss. She states that after an early pregnancy loss of twins, she "then

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[91] Rothert, "At a Loss," 99-105.

[92] Pelin Palas Karaca, and Umran Yesiltepe Oskay, "Effect of Supportive Care on Psychosocial Health Status of Women who had a Miscarriage," *Perspect Psychiatric Care* 57, no. 1 (January 2021): 179-88.

[93] Robin Wallace, Angela DiLaura, and Christine Dehlendorf, "'Every Person's Just Different: Women's Experiences with Counseling for Early Pregnancy Loss Management," Women's Health Issues 27, no. 4 (2017): 456.

[94] S. Furtado-Eraso, P. Escalada- Hernandez, and B. Marin-Fernandez, "Integrative Review of Emotional Care Following Perinatal Loss," West Journal of Nursing Res. (2021) 43: 489-91.

stepped back out into the world as a woman who had just had a miscarriage. This was a world that would struggle to understand both the physical process that I had been through and the agonizing nature of my everlasting grief. A world that didn't want to know the details of what had happened, let alone remember them."[95] In their writing on ambiguity and disenfranchisement of perinatal loss, Lang et al. observed that miscarriage loss represents not merely physical nonexistence but a loss of the psychological existence of the critical bond of mother and child.[96] Jennifer Scuro presents another experiential view of her pregnancy loss of entanglement from the social pressure of the "just get over it and move on" mantra from medical staff, family, and friends.[97] These statements align with the urging to "just try again," other parents report.[98] Randolph et al. feel that when examining the social aspect of perinatal loss, participants experienced isolation and loneliness, including feeling awkward around others, especially when others were trying to be helpful but ended up saying something hurtful, such as, "At least you weren't that far along."[99]

From a phenomenological and historical perspective of women and pregnancy, Shannon Wythecombe's writing reveals her surprise at the variety of responses to miscarriage.[100] She perceives that nineteenth-century social and cultural pressures set criteria for getting pregnant when she writes, "[issues] such as family size, financial concerns, geographic environment, personal desires, and religious beliefs" took center stage in historical consideration of

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[95] Bueno, *The Brink of Being*, 20-21.

[96] Lang et al., "Perinatal Loss" 185.

[97] Scuro, *The Pregnancy Childbearing Project*, 223.

[98] Randolph, "Women Who have Experienced Pregnancy Loss," 423.

[99] Ibid.

[100] Shannon Withycombe, *Lost: Miscarriage in Nineteenth-Century America* (New Brunswick, NJ: Rutgers University Press, 2018), 163-72. ProQuest Ebook Central.

pregnancy.[101] While some issues have radically changed in our modern century, such as gender roles, reproductive planning, and family economy, the nineteenth-century social influence is not distant. For example, Wythecombe continues, "women still have pregnancies that they want, ones that they dread, and ones about which they feel uncertain."[102] A study conducted in Turkey by Pelin Palas Karaca and Umran Yesiltepe Oskay on the psychosocial health status of women who had a miscarriage gave one affirmation of the similarities in varying cultures related to the social perception of miscarriage grief.[103] They found that grief support offered to patients after a miscarriage contributed to their psychosocial well-being and improved their ability to cope with psychosocial symptoms.[104]

Integrative Emotional Support

In addition to the role that healthcare professionals play in the physiological care of patients, much of the literature suggests they also hold an important place in emotionally supporting patients in their miscarriage grief. For example, in their writing on perinatal post-mortem support and understanding in Ireland and the United Kingdom, Daniel Nuzum et al. agree with others that the discussion of miscarriage grief heavily focuses on obstetrical providers and their challenges emotionally caring for patients in this circumstance.[105] Jennifer Scuro agrees with Nuzum et al. and others that while providing compassionate care is essential to providers in the overall quality of care of patients, it has not always been proven to be adequate and is

[101] Withycombe, *Lost: Miscarriage in Nineteenth-Century America*, 163.

[102] Ibid., 164.

[103] Karaka and Oskay, "Effect of Supportive Care," 187.

[104] Ibid.

[105] D. Nuzum, et al., "Maternity Healthcare Chaplains and Perinatal Post-Mortem Support and Understanding in the United Kingdom," *Journal of Religion and Health* 60, (2021): 1924-36.

sometimes hurtful.[106] Julia Bueno continues to add a unique understanding to this literature review by suggesting that tension might be present when the analytical nature of medical practice meets the organic emotional and spiritual needs of miscarriage grief.[107] She further feels that additional training is needed for healthcare professionals to understand the importance of vocabulary when guiding patients through miscarriage.[108] She surmises that listening and thinking carefully about personal communication skills is easy to suggest. Nevertheless, it might go against how providers have been trained in self-preservation to distance themselves from emotional situations.[109] Many researchers agree that healthcare providers should sympathetically acknowledge grief.[110] Further, reassuring bereaved parents that their responses are appropriate and that recovery can take a few months to more than one year is valuable to patients.[111] There is also much agreement that healthcare providers must respect and remain vigilant about the long-term effect of grief on patients during this difficult time.[112] A literature review of the implications of psychosocial elements of miscarriage grief follows, including phenomenological records of patients' unique experiences of perinatal loss. These will reveal the essence of the complicated and distinct effect of perinatal loss grief.

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[106] Jennifer Scuro, *The Pregnancy [does-not-equal] Childbearing Project: A Phenomenology of Miscarriage* (London, EN: Rowan & Littlefield, 2017), 24 and 182.

[107] Bueno, *The Brink of Being*, 15.

[108] Ibid.

[109] Ibid., 103-104.

[110] Karaka and Oskay, "Effect of Supportive Care," 187

[111] Ibid.

[112] Ibid.

Silent/Disenfranchised Grief

Grief has many faces, one of which is obscure or unacknowledged by culture or others nearby.[113] In fact, the grief of perinatal loss is often referred to as silent grief.[114] In the literature review, silent grief can be labeled disenfranchised grief. In "Disenfranchised Grief and Non-Death Loss," Kenneth Doka defines it as "the grief that results when a person experiences a significant loss where the resultant grief is not openly acknowledged, socially validated or publicly mourned."[115] Doka goes on to emphasize the physiological and psychological impact that disenfranchised grief can have on an individual. Additionally, Lang et al. concluded in their study of ambiguity and disenfranchised grief that three categories of experiential and relational disenfranchisement exist "within the marital relationship, when communicating with healthcare professionals, and when interacting with extended family and community.[116] Both Doka and Lang et al. are an appropriate summary of other literature. Julie Bueno also describes miscarriage grief as silent grief. "[W]e have been long unable to talk about miscarriage in any adequate breadth or depth. If we do, we tend to do so awkwardly, quickly, and in the most general terms. We squirm, we whisper, and we avoid asking questions--we just don't understand the experience well enough or the nature of the complex grief that can hit hard in its wake."[117] In Bueno's experience with maternal silent grief, she says, "very few people around me took the time to find out the details of what had happened before, during and after my miscarriage, and I felt intense

[113] Kim Kluger-Bell, *Unspeakable Losses: Healing from Miscarriage, Abortion and Other Pregnancy Loss* (New York, NY: Quill, 2000), 18-27.

[114] Kenneth J. Doka, "Disenfranchised Grief and Non-Death Losses" in *Non-Death Loss and Grief Context and Clinical Implications.* ed. Darcy L. Harris, (New York, NY: Routledge Taylor and Francis Group, 2020), 26.

[115] Doka, "Disenfranchised Grief and Non-Death Losses," 6

[116] Lang, et al., "Perinatal Loss," 190.

[117] Bueno, *The Brink of Being*, 8.

pressure to move on and get pregnant again. I felt desperately, painfully alone."[118] In his book *Good Grief,* Granger Westberg enters the conversation about silent and disenfranchised grief by saying, "emotion is essential to a person, and to try to repress it is to make one less than a person."[119] He also suggests, as others do, that what we learn in our childhood about expressing emotion can be helpful and hurtful.[120] This suggestion implies that the way one processes miscarriage grief is influenced by one's childhood experiences. Randolph et al. added to the conversation on miscarriage grief when they revealed that patients felt pressure to keep their loss silent, a "forget about it and move on" scenario.[121]

Ambiguity

Researching the phenomenological discussion of miscarriage grief reveals sources of ambiguity that complicate the initial and long-term grief process. In the literature, various studies interviewing patients' experiences give specific examples of frustration and heightened anxiety where communication among the healthcare team conflicted.[122] In many cases, the time between receiving a nonviable diagnosis and the medical intervention was days or even weeks.[123] Other patients revealed the ambiguous nature of the medical jargon used to describe the nonviable diagnosis as condescending and confusing, further complicating the patient's understanding of

[118] Bueno, *The Brink of Being,* 16.

[119] Granger E. Westberg, *Good Grief: A Companion For Every Loss* (Minneapolis, MN: Fortress Press, 2019), 22.

[120] Ibid., 24.

[121] Randolph et al., "Women Who have Experienced Pregnancy Loss," 423.

[122] Lang, et al., "Perinatal loss," 188.

[123] Ibid.

pregnancy loss and self-worth.[124] In addition, the patient was waiting or not expecting what would come, which increased anxiety and shock with the final outcome.[125] In other experiences, patients verified they would have found an early conversation about possible outcomes and pregnancy management beneficial before conclusive results arrived. However, providers were not willing to do so.[126]

Shame and Guilt

Shame and guilt are common emotions present in miscarriage grief. Affirming this reality, Sunita Osborn notes that the silence of miscarriage grief perpetuates many different emotions, namely shame.[127] She and others remind readers of the connection between shame and miscarriage and say it is one of the main reasons the silence about pregnancy loss can lead to disenfranchised grief.[128] Julia Bueno similarly shares a story of a woman who experienced a traumatic miscarriage while at home. She wondered what to do, and in her shock, she flushed it down the toilet, later regretting her action, and losing the baby twice, which caused more guilt.[129] Although this is a common experience of miscarriage at home, communicating the details of this experience can be challenging, leading to regret, shame, and guilt. Hiefner adds, "Many women may also place blame on themselves for the loss, experiencing significant guilt and feelings of

[124] Robin Wallace, Angela DiLaura, and Christine Dehlendorf, "'Every Person's Just Different': Women's Experiences with Counseling for Early Pregnancy Loss Management," *Women's Health Issues* 27, no. 4 (2017): 460.

[125] Ibid.

[126] Erin E. Wingo et al., "Anticipatory Counseling About Miscarriage Management in Catholic Hospitals: A Qualitative Exploration of Women's Preferences," *Perspectives on Sexual and Reproductive Health* 52, no. 3 (Sept. 2020): 171.

[127] Osborn, *The Miscarriage MAP Workbook*, 104.

[128] Ibid., 101.

[129] Bueno, *The Brink of Being*, 56-57.

failure as a woman [and] or as a mother."[130] Miscarriage grief, in a phenomenological light, connects the experiential similarities and the uniqueness of perinatal loss and regards them in the range of social, cultural, and psychological impacts on patients. Understanding the silent grief of miscarriage and the inferred ambiguity, entanglement, and disenfranchisement informs the grief support of patients. It is a critical component of both short and long-term emotional and mental health.

Dimensional Perspective

With a patient's cognizance of miscarriage grief must come a deeper awareness and understanding of how grief affects individuals in a multidimensional way. In a theological sense, the greatest commandment reminds humanity of its multidimensional nature when Jesus advised others to love God with all of one's heart, soul, and mind.[131] To this end, care for each of these components of self can be seen as essential in the grief process and the theological framework of this project. No matter the ailment, more significant healing comes from receiving medical care and a well-rounded type of care that considers humanity's physical, spiritual, and emotional makeup as God's created.[132] In the context of miscarriage grief, spiritual support is one way to help patients and families process tough questions and complex relationships and find meaning in the suffering.[133]

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[130] Hiefner, "A Multidisciplinary Approach," 2.

[131] "You shall love the Lord your God with all your heart and with all your soul and with all your mind" (Matt 25:37, NRSV).

[132] ACPE, "The Impact of Professional Spiritual Care," 1-2.

[133] Kristen and Patrick Riecke, *No Matter How Small*, (Fort Wayne, IN: Emerald Hope, 2020), 228-32.

First Thessalonians 5:23 further verifies that humankind was created with three parts, a spirit, a soul, and a body.[134] In this tripartite view, the body is created as humanity's physical and outward structure, containing the five senses to experience and understand the world.[135] The human body houses the soul, which is the second of the three. The soul manifests the human personality, the thinking and reasoning, the emotion rendering, and the decision-making part of one's being.[136] The soul houses the third dimension, the spirit; the human spirit is the innermost part of the self. No other creature is known to possess a spirit.[137]

Humankind's complexity is not missed in the effects of loss and grief, and the three dimensions of self can be established. Because body, soul, and spirit are inseparable, the needs of one will influence the needs of all.[138] Much is seen in the literature from a soul or psychological perspective and addressing the body or physiological perspective, but little is emphasized from the spiritual perspective.[139] In light of this connection, including the body, soul, and spirit in supporting patients through grief is essential to understanding the patient's needs.

Van Denend et al., chaplains for the Veterans Administration, investigated the possibility of integrating the spiritual domain when treating mental health issues.[140] One of the issues they considered was a case study of grief and what would be lost in treating grief when the spiritual domain was not considered. They concluded that grief was more than just something to manage

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[134] "Now may the God of peace himself sanctify you completely and may your whole spirit and soul and body be kept blameless at the coming of our Lord Jesus Christ" (1 Thess 5:23, ESV).

[135] Philip Wijaya, "How Are the Body, Soul and Spirit Connected?" Christianity.com October 6, 2021. https://www.christianity.com/wiki/christian-life/how-are-the-body-soul-and-spirit-connected.html.

[136] Wijaya, "How Are the Body, Soul and Spirit Connected?"

[137] Ibid.

[138] Ibid.

[139] Holder, Jennifer Sutton, and Jann Aldredge-Clanton, *Parting: A Handbook for Spiritual Care Near End of Life* (Chapel Hill, NC: North Carolina Press, 2004), 6-8.

[140] Ibid., 7.

or learn to cope with.[141] Grief is a vital aspect of living, providing an array of possibilities to learn about oneself. Grieving is also a powerful reminder of the feelings one has for others and the value of life and experiences.[142] It is an opportunity to examine the hope that inspires one to keep going. If the spiritual component of the patient is overlooked, and especially if they do not identify with a specific religious tradition, the opportunity to be curious about grief as more than a loss but a spiritual journey will be overlooked, and the possibility to deepen the understanding of a patient's silent suffering will also be overlooked.[143] Asking why and searching for meaning in suffering during the grieving process are attempts to reconcile the psychological dimension of self with faith and spirituality amid heartbreak.

Professional Support

While care for the patient's physical being after a fetal loss is the medical professionals' responsibility, professionally trained pastoral care professionals generally oversee the emotional and spiritual support. Daniel Nuzum et al., in their writing on perinatal post-mortem support and understanding in Ireland and the United Kingdom, agree with others that the discussion of miscarriage grief is heavily focused on obstetrical providers and the challenges they have with emotionally caring for patients in this circumstance.[144] Jennifer Scuro agrees with Nuzum et al. and others that while providing compassionate care is essential in the overall quality of patient

[141] Jessica Van Denend et al., "The Body, Mind, and the Spirit: Including the Spiritual Domain in Mental Health Care." *Journal of Religion and Health* 61, (2022): 3571-3588.

[142] Ibid.

[143] Ibid.

[144] D. Nuzum, et al., "Maternity Healthcare Chaplains and Perinatal Post-Mortem Support and Understanding in the United Kingdom.," *Journal of Religion and Health* 60, (2021): 1924-36.

care, it has not always been proven adequate and is sometimes considered hurtful.[145] Further lacking in the literature is consideration of the importance of professionally trained spiritual care providers to lead this crucial discussion. For example, in a study by registered nurses Charlotte Wool and Anita Catlin, 100 percent of nurses surveyed desired to have a chaplain present to care for patients experiencing loss compassionately and meaningfully.[146] D. Nuzum et al. further confirm chaplains' value in end-of-life care for bereaved parents on matters of spirituality and faith, especially when in emotional and spiritual distress.[147] Counselors, therapists, nurses, and doctors have a strong voice in the emotional support of miscarriage patients. Still, professional chaplains have specific training in patients' spiritual care, which is valuable to those who have experienced loss.[148]

Specified training to provide for the spiritual care of patients required of the professional chaplain at Mercy Healthcare includes a minimum graduate-level degree and units of clinical pastoral education (CPE), which mandate a "rigorous certification process to learn a comprehensive skillset."[149] CPE weaves practical patient care experience investigated through self-exploration, self-reflection, and other action and reflection learning methods. The key to this training is understanding the self better and appropriately caring for others. A deeper exploration of theories and theology of dying, death, suffering, and grief are significant occasions in CPE to

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[145] Jennifer Scuro, *The Pregnancy [does-not-equal] Childbearing Project: A Phenomenology of Miscarriage* (London, EN: Rowan & Littlefield, 2017), 24 and 182.

[146] Charlotte Wool, and Anita Catlin, "Perinatal bereavement and Palliative Care Offered Throughout the Healthcare System," *Annuals of Palliative Medicine* 8, no.1 (2019): S26.

[147] D. Nuzum et al., "Maternity Healthcare Chaplains," 1925-6.

[148] ACPE: The Standard for Spiritual Care & Education et al., "The Impact of Professional Spiritual Care," https://www.professionalchaplains.org/Files/resources/The%20Impact%20of%20Professional%20Spiritual%20Care_PDF.pdf.

[149] ACPE: The Standard for Spiritual Care & Education "The Impact of Professional Spiritual Care," section 2, slide 10. https://indd.adobe.com/view/2d555e8f-5d1a-47bf-ad94-760092053d0b.

gain a more robust understanding of how humanity processes loss and grief. In CPE, learned standards of care promote patient interactions centered on active listening with a non-judgmental presence to benefit the patient's needs. Using spirituality and theological perspectives to care for patients unites the chaplain's calling, training, and role, informing the vigorous care provided to patients.

Quality of Care

Because this project will assess the quality of patient care received in follow-up grief support after experiencing a perinatal loss, it is essential to consider the conceptual and theoretical aspects of fostering quality patient care in the spiritual and emotional dimensions. As mentioned in the ministry context of this project, Mercy Healthcare sets for itself a high standard of caring for patients through its mission, vision, and charisms. Further, the current industry trends reveal the importance of measuring patient satisfaction with their care experience, which influences quality improvement related to healthcare industry standards.[150] This conversation is not overlooked in the literature. Ogrinc et al., in a study on guidelines for quality improvement reporting, affirm that the science of improvement studies in medicine are primarily based on what is learned from the patient's experience.[151] Further, it is "a process of change in human behavior" and reflective of how the government adjusts its programs according to societal needs.[152] Beyond this, those who are prescribing the study of patient care may not be the ones

[150] This relates directly to the healthcare industry's responsibility to the government for service reimbursement and compliance with state and federal laws, as mentioned in chapter one in Missouri Statute 194.387.2.

[151] G. Ogrinc, et al., "The SQUIRE (Standard of QUality [Sic] Improvement Reporting Excellence) Guidelines For Quality Improvement Reporting: Explanation and Elaboration," *BMJ Quality & Safety* 17, (2008): i13.

[152] Ibid.

who are charged with implementing the changes putting at risk the patient care provided in a high-demand industry with little evidence that the improvement strategies could be effective.[153]

One instance of the healthcare industry adapting to the needs of patients and society can be seen in how the coronavirus disease of 2019 (COVID-19) pandemic forced healthcare providers to adapt their services through virtual means.[154] Information and communication technology advanced healthcare practice in the digital world in both primary care and specialized service areas to promote quality patient care and communication.[155] While the limited availability of patient access to telemedicine is sometimes the reality for healthcare institutions who wish to promote this opportunity, the overall desire of patients to receive information and services via online resources and social media has never been greater.[156]

The spiritual and emotional dimension of healthcare has also entered the world of digital health to promote quality patient care. Virtual chaplaincy or telechaplaincy has become a common method of providing for patients' spiritual and emotional needs. With the industry's emphasis on the care of patients outside the hospital setting, virtual chaplaincy has become a growing and effective practice.[157] Ministry-wide, the Mercy Healthcare Pastoral Services department has adapted its standard of patient care to include reaching patients outside the hospital setting through virtual chaplaincy platforms. However, Sprik et al., and their study of telechaplaincy show there are some limiting aspects of telechaplaincy, including the patients'

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[153] Ogrinc, et al., "The SQUIRE," i13.

[154] Fabian Winiger, "The Changing face of Spiritual Care: Current Developments in Telechaplaincy," *Journal of Healthcare Chaplaincy* 29, no. 1 (2023): 114.

[155] W. Barbosa et al., "Improving access to Care: Telemedicine across Medical Domains," *Annual Review of Public Health* 42, no.1 (2021): 463.

[156] Ibid., 467.

[157] Petra Sprik, et al., "Chaplains and Telechaplaincy: Best Practices, Strengths and Weaknesses—A National Study," *Journal of Healthcare Chaplaincy* 29, no. 1 (2023): 41.

limited availability to and trust in technology, the cost of the technological modalities, and the comfort of chaplains in adapting their practice to provide spiritual and emotional support to patients.[158]

With respect to engaging patients to foster the quality of patient care, healthcare institutions are developing innovative methodologies that expand their means of communication with patients in a manner that keeps them informed of their care.[159] Creative and frequent communication with patients includes established standards of care for pre and post-diagnosis and procedures, including print media, phone calls, text, Facebook, and other social media usage.[160] Patient perks offered, such as valet parking, personalized escorts, and hospitality, are also methodologies put in place to promote a positive patient experience.[161] One interesting approach to encouraging and assessing quality patient care developed by Khan, Rahman, et al., created a framework for critical social support through social media in Australia.[162] The Australian study linked the use of healthcare social media to patient empowerment which improved health outcomes leading to a potentially higher patient satisfaction rating.[163] The development of this Australian theoretical model was designed to show the associations between various dimensions of social support and patient empowerment. Giving patients the resources to improve their self-care and health outcomes. Because vast amounts of information can be given

[158] Sprik, et al., "Chaplains and Telechaplaincy," 42-43.

[159] Irfanuzzaman Khan, et al., "Social Media and Social Support: A Framework for Patient Satisfaction in Healthcare," *Informatics* 9, no. 1 (2022): 1.

[160] Ibid.

[161] Ibid., 2.

[162] Ibid., 1.

[163] Ibid., 11.

in the social media context, it stands to reason that social media could also be a helpful influence on grieving patients.

The use of social media as a modern method to enhance the quality of patient care has become an affordable and prevalent technique in the healthcare industry. Evidence in the literature demonstrates that social media has been used successfully in healthcare to connect with patients, increasing patient satisfaction.[164] With respect to this line of thinking, maternity patients surveyed on satisfaction with birthing experience suggested that the primary factors important for their satisfaction are the health and well-being of the mothers and babies.[165] Promoting the health and well-being of obstetrical patients, including perinatal loss patients, could therefore be considered through a social media approach.

Social Media

A literature review of using social media to promote processing grief presents a double-edged sword. To the young Millennials and the older Generation Zers, social media is a main form of connecting with others.[166] It is only natural they would look to this avenue to get grief support. It can offer challenges as it invites others into a journey that the patient may not be ready to share. A literature review both promoted and provided caution to this approach. The private nature of miscarriage and the vulnerability associated with the vast emotions of grief, shame, guilt, and loss of hopes and dreams, combined with the unpredictability of social media

[164] Rachel Stork Poeppelman, et al., "Correlations Between Hospitals' Social Media Presence and Reputation Score and Ranking: Cross-Sectional Analysis," *Journal of Medical Internet Research* 20, no. 11 (November 2018): 6.

[165] Cristina A. Mattison, et al., "Midwifery and Obstetrics: Factors Influencing Mothers' Satisfaction with the Birth Experience," *Birth Issues in Perinatal Care* 45, no. 3 (September 2018): 322.

[166] Young Millennials and older Generation Z patients fall into the scope of childbearing age for this project. It is also important to note that for some Millennials and Gen Zers, this may be their first experience with loss or a scenario that manifests and complicates past loss experiences.

response, invite reactions that may or may not assist in grief support or make grieving more difficult.[167] Virtual memory pages and organizational chat sites offer options to peruse the thoughts of others and post feelings in a relatively safe and anonymous manner. Platforms such as Facebook, Twitter, Instagram, YouTube, and others provide opportunities to announce loss, post pictures and videos, and connect with others for social support in a collective experience, which is especially helpful to those who do not have familial support.[168]

King and Carter, in their study, "Young Millennials' Motivation for Grieving Death Through Social Media," agree with some that feelings of dissension can develop about online grieving related to the unpredictability of the responses to postings and to the fact that some perceive grief postings as making the death more about attention seeking than honoring the dead.[169] Further, Carla Sofka adds when considering modern support for death and grief that, the constant change in technology and the vastness of the world wide web provide an overwhelming amount of resources to consider, including their reliability and a discussion of ethics.[170] It is clear in the literature that to reach and support the target group of patients for this project, social media must be a part of the academic discussion.

The initial section of chapter two and the literature review evaluated the critical conversations related to the awareness of miscarriage and miscarriage grief support, including integrative emotional support and the psychosocial implications of grief. The psychosocial implications were further explored by intertwining the phenomenological accounting of silent

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[167] Rachel King and Pelham Carter, "Exploring Young Millennials for Grieving Death Through Social Media," *Journal of Technology in Behavioral Science*, 7 (August 2022): 567-77.

[168] Ibid.

[169] Ibid., 577.

[170] C. J. Sofka, "Social Support 'Internetworks', Caskets for sale and more: Thanatology and the information superhighway," *Death Studies* 21, no. 6 (1997): 553-574.

and disenfranchised grief, ambiguity, shame, and guilt. A brief dialogue included the importance of professionally trained spiritual care providers, such as chaplains. The presence of a chaplain provides a needed support system for patients experiencing miscarriage and points to the importance of the theological foundation for this project.

Theological Foundations

When considering the effects of miscarriage grief, Scripture has much to say about the sacredness of life, loss, suffering, hopelessness, and the emotional impact grief can have. Psalm 34:18 begins the conversation by reminding hurting humanity that God does not run from human suffering, "The LORD is near to the brokenhearted and saves the crushed in spirit" (New Revised Standard Version). Much of the Psalms describe inimitable aspects of God's character. Its poetry reveals a chromatic persona of human suffering, including anger, fear, distress, frustration, helplessness, worry, sadness, loneliness, guilt, shame, sorry, and grief. In his commentary on Psalm 34, Tremper Longman agrees that "God helps those who are psychologically and emotionally vulnerable."[171] He also reminds readers that the psalmist turned to God in his fear and distress, not merely as an antiquated tradition but as a resemblance of hope for future people of faith.[172] Understanding the significance God places on His created beings and how He values care and compassion for those suffering reveals a high priority on the spiritual and emotional support for patients who experience miscarriage grief. Theological consideration is a dynamic process where human living and divine truth interact to promote life transformation. Because of

[171] Tremper Longman III, *Psalms: An Introduction and Commentary* (Westmont, IL: InterVarsity Press, 2014): 170-71. Accessed September 29, 2022. ProQuest Ebook Central.

[172] Ibid.

this, miscarriage loss and grief are dynamic and unique in their experiential effect on the spirituality of living.

Of interest in the limited amount of literature on the benefits of faith, spirituality, and religion in coping with miscarriage grief, Richard J. Petts, a sociologist, conducted a study titled "Miscarriage, Religious Participation, and Mental Health." He used data from over nine thousand youths from the National Longitudinal Study of Youth 1997. Within this research, a shorter focused version of the study conducted a mental health survey in the even years 2000-2010. In this, pregnancy and miscarriage were discussed with the females. Petts described that the study's goal was to enlighten an understudied socially taboo topic of miscarriage and how it affects mental health and explore whether religion positively influences coping with miscarriage. "Overall evidence suggests that religion may be an important coping mechanism for women who deal with pregnancy loss," specifically those who have a miscarriage and then have a live birth. However, "having a live birth, and having such experiences with an infant, may make the loss of an unborn child more tangible and difficult to deal with as the 'future experiences' that are lost become more real."[173] Overall, Petts concludes that religion can be an essential mediator in grieving.[174]

In a pluralistic society, religion and spirituality take on a variety of depths and meanings.[175] A comprehensive understanding of spirituality includes an awareness of the

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[173] Richard J. Petts, "Miscarriage, Religious Participation and Mental Health," *Journal For the Scientific Study of Religion*, 57, no. 1 (May 25, 2018): 110.

[174] Ibid., 122.

[175] One example is a study on the effects of spiritual and religious interventions published by a Muslim University on complicated grief; the basis was a spiritual-religious awareness of community with God and others that could help reduce psychological struggles. See F. Mehdipour, R. Arefnia, and E. Zarai, "Effects of Spiritual-Religion Interventions on Complicated Grief Syndrome and Psychological Hardiness of Mothers with Complicated Grief Disorder," *Health Spiritual Med Ethics* 7, no. 2 (2020): 21.

presence of God, a god, or a higher power than oneself. This broad stroke of defining spirituality is an appropriate picture of the current culture. Professional chaplain training provides an awareness of the varying spiritual needs in modern culture, and attentiveness to this is valuable in finding common ground in care.[176] This awareness applies to providing spiritual support to miscarriage patients as well. While a Christian understanding of spirituality is much richer than mere awareness, and other religions might offer a similar context, it is crucial to gain knowledge of the multifaceted pluralist culture when providing spiritual support to patients suffering from the grief of miscarriage. In addition, a patient's spiritual understanding or theology will inform their personhood and how they process their loss, giving hope for the future. Finally, personal spirituality and theology are also foundational in understanding the sanctity of life and making meaning out of suffering. This project now turns to God's love for His created beings and examines the biblical value of life from the point of conception to the very end, regardless of the days, weeks, months, or years.

Sanctity of Life

In a theological reflection on the experience of pregnancy grief and, particularly, miscarriage grief, the sanctity of life is a factor.[177] While the Bible is filled with evidence of the sacredness of life, Genesis 1:26-27 declares that humanity is made in the unique image of God, or Latin, the *Imago Dei*. "So God created man [humankind] in his image, in the image of God he created him; male and female he created them" (NRSV). The implications of the *Imago Dei* concept are foundational to humanity's worth, assisting in understanding the mystery of how the

[176] Emily Cramer, M.A., Kelly E. Tenzek, Ph.D., and Mike Allen, Ph.D., "Translating Spiritual Care in the Chaplain Profession," *Journal of Pastoral Care Counseling* 67, no. 1 (2013):15.

[177] It is essential to view the discussion of the sanctity of life not as a political debate but as a theological principle that informs the design of this project.

physical, spiritual, and emotional aspects of living bear the image of God. Hamilton adds to this conversation in the New International Commentary of the Old Testament (NICOT) of the *Imago Dei* by reminding readers that the writer of Genesis does not specify what part of humanity is possibly made in the image of God. "It is clear that v. 26 is not interested in defining what is the image of God in man. The verse very simply states the fact…that to be human is to bear the image of God."[178] In light of this, one must consider that the writer of Psalm 139:15-16 elucidates the mysterious knowledge of the Creator God knowing the unformed creation. "My frame was not hidden from you, when I was being made in secret, intricately woven in the depths of the earth. Your eyes saw my unformed substance; in your book were written, every one of them, the days that were formed for me, when as yet there was none of them" (NRSV). Walker, Jacobson, and Tanner write in the NICOT on Psalms 139 that "each of us was formed and framed by God. God's eyes beheld our unformed substances. Each of us was reverently, wondrously, strikingly, remarkably, differently made --- in ways that are beyond human explanation."[179]

The theology of the Catholic Church has been a dominant voice in the sanctity of life discussion, representing a biblical perspective on the value of life and God's love for His creation. According to the Jewish and Christian faith traditions, the sanctity of life was clarified plainly in the Ten Commandments. However, there are different orders for the Decalogue or the "ten words" listed in the books of Exodus and Deuteronomy. The discussion of the commandment regarding taking another's life is of particular interest to the sanctity of life. It

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[178] Victor P. Hamilton, *The Book of Genesis, Chapters 1-17*, New International Commentary of the Old Testament (Grand Rapids, MI: Eerdmans, 1990) 121. Accessed December 4, 2022. ProQuest Ebook Central.

[179] Nancy L. DeClaisse-Walford, Rolf A. Jacobson, and Beth LaNeel Tanner, *The Book of Psalms, The New International Commentary of the Old Testament* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2014). 749.

instructs clearly in English translations, "you shall not murder."[180] In Exodus 20:13, "kill" and "murder" are both found in varying translations. The English Standard Version and others say, "You shall not murder." In Hebrew translations, the word for murder relates to causing human death through carelessness or negligence. However straightforward this may appear, the reality of interpreting this commandment in a healthcare setting is not as straightforward as the commandment would speak when end-of-life and beginning-of-life issues are considered. The Catholic Ethical and Religious Directives (ERDs) specify a foundational ethical decision-making model for healthcare anchored to Catholic theology, which assists in assuring the sanctity of human life when considering beginning and end-of-life issues.[181] The Catholic Church promotes and defends human dignity and the sacredness of human life from the moment of a baby's conception until death.

Among other theological directives, the ERDs value the care of others, considering mutual respect among caregivers that encourages service to patients inspired by "the compassion of Christ, sensitive to their vulnerability at a time of special need."[182] The ERDs further expound that humans have a duty to preserve life and to use it for God's glory. However, the duty to protect and preserve life is not unconditional, for one may refuse life-prolonging procedures that are insufficiently beneficial or disproportionately burdensome.[183] The commission of medical practitioners in Catholic healthcare is to "care even when one cannot cure." While these words

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[180] Jesus did not shy away from using this straightforward approach when instructing His followers on the sanctity of life. Jesus' own words are found in Matthew 5:21; 19:18; Luke 18:20, and further repeated in Romans 13:9 and James 2:11 emphasize the "you shall not kill" Decalogue commandment.

[181] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services, Sixth Ed.* (Washington, DC: United States Conference of Catholic Bishops, 2018), 6-7.

[182] Ibid.

[183] ERD 57, United States Conference of Catholic Bishops, *Ethical*, 21.

adequately clarify medical decision-making for adults, it is more complex when making decisions related to the life of mothers and the unborn.

Correlating to the beginning of life issues, part four of the ERDs explains, "because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their spiritual destiny, can discover and cooperate in the plan of the Creator." Specifically speaking on abortion and not clarifying whether medical or spontaneous, ERD four affirms that "health care providers should be ready to offer compassionate physical, psychological, moral and spiritual care to those who have suffered from the trauma of abortion."[184] Part Five of the ERDs voices a significance on the gift of life and humanity's responsibility to steward human life in mutuality of respect, love, and support to patients and their relatives as they face death.[185] Catholic healthcare sets a high biblical standard to provide care that values the sacredness of life and personhood.

A conversation about the theology of the sanctity of life would not be complete without an understanding of current culture. In a pluralistic society, a contrasting feminist approach can overshadow the sanctity of life. Secular humanism and pro-choice advocates represent a population that assumes a fetus is not a rightsholder and does not have value over and above the rights of the gestational mother. Consequently, the mother should not be held hostage to continue the pregnancy. Further, a pro-choice view holds that a mother has a right to decide what happens to and inside her body, even if it initiates a disregard for the fetus's life.[186] This line of thinking

[184] United States Conference of Catholic Bishops, *Ethical*, 18.

[185] Ibid., 20.

[186] Bruce Blackshaw and Daniel Rodger, "If Fetuses are Persons, Abortion is a Public Health Crisis," *Bioethics* 35, no.5 (2021): 465.

intertwines with the current conversation regarding moral and political rights and governmental oversight.[187]

While it is not meant for this project to debate the validity of this view, it is informative to understand the cultural context that patients may represent. There is no literature to affirm that a patient's perspective on the sanctity of life of an unborn fetus protects or makes the patient more susceptible to the effects of loss and grief. If one does not believe in the worth of a fetus as a living and sacred creation of God, literature does not imply that there is no awareness of loss or grief. While not considered living, the loss of a baby may be felt as a loss of being a parent or as the loss of a future family; suffering can still be present. Guilt and shame may develop over time, contributing to long-term suffering that is problematic to comprehend. A theology of suffering is a critical element of a theological foundation for this project.

Theology of Suffering

In understanding the theological aspects of miscarriage grief in this project, consideration is given to the significance of a theology of suffering. Theologian Dietrich Bonhoeffer aptly supports this in his *Letters and Papers from Prison*, "We must learn to regard people less in the light of what they do or omit to do, and more in the light of what they suffer."[188] This quote could describe the silent, disenfranchised suffering of miscarriage grief. Even though little literature explores the theology of suffering when considering the loss of a baby, it is foundational for the success of this project to understand a theological perspective of suffering.

Though unwritten on miscarriage grief, a literature review infers that many characteristics of grief can be considered a form of silent suffering. For example, shame is one psychosocial

[187] Blackshaw, "If Fetuses," 465.

[188] Dietrich Bonhoeffer, *Letters and Papers from Prison* (New York, NY: McMillan 1971), 46.

layer of miscarriage grief that can cause a patient to suffer inside themselves while silently wondering if one is defective or has made choices that have caused the pregnancy loss.[189] Julia Bueno and others describe another previously mentioned form of suffering from the disenfranchisement of miscarriage grief as silent grief. Bueno says of the suffering from silent grief, "very few people around me took the time to find out the details of what had happened before, during and after my miscarriage, and I felt intense pressure to move on and get pregnant again. I felt desperately, painfully alone."[190] Amber Randolph et al. remark in their study entitled "Women Who Have Experienced Pregnancy Loss: Implications for Counseling" that many miscarriage patients felt social and cultural pressure to keep their loss silent, a kind of expectation to "forget about it and move on."[191]

Suffering Job

As these phenomenological findings represent, silent grief and disenfranchisement promote an opportunity to explore a theology of suffering. The well-known biblical example of Job is a strong demonstration of suffering and how cultural and social influence contribute to how one processes loss and grief. In their writing, "The Sufferings of the Biblical Job as an Icon of Postmodernity," Stala, Osewska, and Bochenek regard Job's experience with suffering as a

[189] For a discussion on this, see Julia Bueno, *The Brink of Being: Talking about Miscarriage* (United States: Penguin Publishing Group, 2019), 16. Accessed May 17, 2022. ProQuest Ebook Central; Sunita Osborn, *The Miscarriage MAP Workbook: An Honest Guide to Navigating Pregnancy Loss, Working Through the Pain, and Moving Forward*, (Eau Claire, WI: PESI Publishing, 2021), 51; and Angela Hiefner and Astrud Villareal, "A Multidisciplinary Approach to Caring for Parents After Miscarriage: The Integrated Behavioral Health Model of Care," *Frontiers in Public Health* 9, (November 2021): 1-4.

[190] Beuno, *The Brink of Being*, 16.

[191] Amber L Randolph, et al., "Women Who Have Experienced Pregnancy Loss: Implications for Counseling," *The Family Journal* 29, no. 4 (October 2021): 423.

striking demonstration of the frailty of life.[192] From a Christian perspective, Job's story reminds readers that loss and grief, emotional and spiritual challenges, and cultural influences direct one's grief journey. However, it is also a hopeful reminder that through suffering, there is redemption and that God is present in the misfortunes that affect us. Stala et al. agree that out of a theological perspective of Christ, a "belief in the sacred, transcendence, theism and the hope of new, eternal life are key elements" in making meaning of human suffering.[193]

The presence of suffering causes emotional and spiritual distress as patients search for meaning in their miscarriage. Theological reflection in times such as these prompt questions such as "Why would a creative and loving God allow the death of a baby who should have the potential of a lifetime ahead?" and "Where is the hope in life after a baby loss?"[194] The pursuit of meaning in suffering leads to the examination of the spiritual aspect of humanity. It is not unnatural for patients to view their loss with feelings of guilt, whether from internal or external sources, as harsh chastisement for something they have done or not done. In Job's suffering, his contemporaries tried to convince him of his iniquities (chapters 4-23). However, chapters one and two reveal the cause of his suffering as a battle between God and Satan. The Bible further clarifies that Job was honorable (vs.1, 8, 20-22), and his suffering was incomprehensible (2:7-10). However, his suffering was demarcated, with seemingly no relation to truth, integrity, or morality, as can be justified in the social interaction and pressure from his three contemporaries

[192] Józef Stala, Elżbieta Osewska, and Krzysztof Bochenek, "The Sufferings of the Biblical Job as an Icon of Postmodernity: The 'Loneliness' of God and the Human Being in a Consumerist Paradise," *Journal of Religion and Health* 6, no. 1 (2021):1.

[193] Ibid., 3.

[194] Daniel Nuzum, et al., "Stillbirth and Suffering in Ireland: A Theological Reflection from Healthcare Chaplaincy," *Practical Theology* 10, no.2 (2017): 193.

who could not speak when they first saw his suffering (2:13).[195] In this sense, the enormity of human suffering can be very intimate and challenging to rationalize meaningful and acceptable answers. The magnificence of suffering can reveal humanity's limitations, yet there is power in this mysterious recognition that invites further discovery of one's spiritual essence. Indeed, Job's journey with suffering was more than just physiological; it was also spiritual and emotional.

New Testament View of Suffering

From a New Testament (NT) theological perspective, Jesus is the model for suffering, and His type of suffering is considered a vital characteristic of faith. Second Corinthians 12:9 perceives suffering, given the power of the cross, not as a weakness but a strength. "'My grace is sufficient for you, for my power is made perfect in weakness.' Therefore, I will boast all the more gladly of my weaknesses so that the power of Christ may rest upon me" (NRSV). Paul brags not about his strengths in suffering but about his weaknesses in suffering to promote the power of God at work through suffering in ordinary people such as him.[196] Paul expresses the cost of suffering and his need for God's grace and power. In his NT commentary on 2 Corinthians, George Guthrie clarifies that the central aspect of Paul's undisputable ministry encompasses motive. "Paul does not minister [which included his suffering] for personal profit, (e.g., 2:17), but rather out of obedience and obligation to Christ for his glory." In consideration of the suffering of Paul, he will boast and "count it all joy" to bring glory to God through his suffering and the hardships of his life.

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[195] Stala, "The Suffering of the Biblical Job," 5.

[196] George H. Guthrie, *2 Corinthians,* Baker Exegetical Commentary on the New Testament, (Grand Rapids, MI: Baker Academic, 2015), 546-48.

The NT book of James puts suffering in a theological perspective as a testing of faith. "Count it all joy, my brothers [and sisters],[197] when you meet trials of various kinds, for you know that the testing of your faint produces steadfastness. And let steadfastness have its full effect, that you may be perfect and complete, lacking in nothing, (Jas 1:2-4, ESV). Jonathan Lamb, in his book *Godliness from Head to Toe: An Introduction to the book of James*, describes the historical writer of the book of James as authentic, which is helpful to the modern-day Christ followers not because this generation is the only generation to suffer from hardships of life or cope with death, dying, sadness, anger, and other tragedies. The book of James and its wise offerings are authentic because they relate to modernity and continue to be useable. Through James, one can view life's pain and sorrow as part of the artist's handiwork in honing a masterpiece.[198] Lamb says James admonishes, "the wise way to confront trial is to see that, however painful, it is productive. We are branches in the vine, Jesus reminds us, and we will inevitably face pruning if we are hopeful for a fruitful outcome (John 15:1-8). Of course, it is painful, but pruning is a tribute to a Christian's potential."[199] Lamb agrees with other biblical scholars that testing one's faith produces long-term benefits toward helping Christ's followers become what God intended. He elaborates that suffering builds perseverance, maturity, wisdom, and a change of perspective.[200]

One consistent and confounding question of suffering individuals is why an almighty and powerful Creator would allow His beloved to suffer. Jesus clarifies for His disciples in John

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[197] In the NT, and depending on the context, the plural Greek word *adelphoi*, translated as "brothers," may refer to either "brothers" or "brothers and sisters."

[198] "For we are his workmanship, created in Christ Jesus for good works, which God prepared beforehand, what we should walk in them" (Eph 2:10, ESV).

[199] Jonathan Lamb, *Godliness from Head to Toe: An Introduction to the Book of James*, (Carlisle, PA: Langham Creative Projects, 2018), 10.

[200] Ibid., 9-11.

16:32-33 that trouble is part of this world. “A time is coming and in fact has come when you will be scattered, each to your own home. You will leave me all alone. Yet I am not alone, for my Father is with me. I have told you these things, so that in me you may have peace. In this world you will have trouble. But take heart! I have overcome the world” (New International Version).[201] The book of James attempts to encourage suffering people by pointing them to the redeeming value suffering can have in developing the character of Christ in believers.[202]

While Paul was considered a suffering servant, and James reminds his readers of the value of suffering, the primary theology of suffering can be found in the life of Jesus. As the suffering Savior, Jesus was also known as the Son of God who knew no sin. He took on the burden of ultimate suffering as the new covenant for God’s beloved creation. Jesus consumed God’s wrath and judgment for all humankind through His suffering, yet this is not the finale. While in His suffering, He was also the perfect sacrifice for accomplishing humanity’s hope for the future. Jesus, as the sacrificial lamb, redeemed and restored the people’s suffering for the promise of tomorrow.

As has already been demonstrated, the NT writers give their unique perspectives on the suffering of Jesus, allowing readers to make sense of life’s suffering. One meaningful way this is accomplished is through conveying hope that suffering is only for a season, which infers a beginning and an ending.[203] This suffering concept is demonstrated in hope-filled literary terms such as adoption, restoration, support, and strengthening in Romans 8:23 and 1 Peter 5:10 and

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[201] The beauty of this Scripture is not merely in the honest admission of the evil in the world but in Jesus’ powerful reminder that the Father is with Him, just as He is with His beloved through the power of the Holy Spirit.

[202] This is more difficult to understand if the suffering of Christ is not personal.

[203] Edwin Blum, “1 Peter” in *Expositor’s Bible Commentary - Abridged Edition: New Testament*, eds. Kenneth L. Barker and John R. Kohlenberger (Grand Rapids, MI: Zondervan, 2017). https://go.openathens.net/redirector/liberty.edu?url=https%3A%2F%2Fsearch.credoreference.com%2Fcontent%2Fentry%2Fzonebaet%2Fchristian_s_submission_and_god_s_honor_2_11_3_12%2F0%3FinstitutionId%3D5072.

seen further in Romans 8:16-17 as being "joint heirs with Christ" and "glorified in him." Second Corinthians 4:17 elucidates an "eternal weight of glory," and 2 Timothy 2:11-12 portrays an exceptional opportunity to endure suffering and reign with Christ (all Scripture references are NRSV). This hopeful perspective on suffering is a meaningful coping mechanism to help one recognize a potential ending point knowing that the anguish of suffering will not last forever and that it points to a reward.

Another perspective on suffering comes from 1 Peter 2:21. This writing showcases suffering as an expectation for a Christ follower, a virtue of sorts realized in the life of a believer. "For to this you have been called, because Christ also suffered for you, leaving you an example so that you should follow in his steps" (ESV). *The Expositor's Bible Commentary* on 1 Peter 2 and other commentators develop Peter's idea that Christ-followers are called to undeserved suffering just as Jesus suffered unjustly for doing the will of the Father, and as Christ-following enslaved people, submissive toward their unbelieving masters, may also suffer unjustly (see 1 Pet 2:18-20). The character trait of submission goes well with unjust suffering to develop a virtue that, according to Peter, is necessary.[204] Peter also links Isaiah 53 and the "Innocent Sufferer" and the suffering of the Messiah, as Peter quotes Isaiah 53:9, to reinforce the submissive posture of the sufferer.[205]

In addition to the example and the hope given by the suffering of Jesus, the book of Hebrews reminds readers that Jesus' suffering makes Him relatable to humanity. "Because he himself was tested by what he suffered, he is able to help those who are being tested" (Heb 2:18, NRSV). Hebrews 4:15 further clarifies that Jesus, despite His position as the High Priest,

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[204] Blum, "1 Peter," in *The Expositor's Biblical Commentary*.

[205] "And they made his grave with the wicked and with a rich man in his death, although he had done no violence, and there was no deceit in his mouth" (Isa 53:9, ESV).

understands human trials. “For we do not have a high priest who is unable to sympathize with our weaknesses, but we have one who in every respect has been tested as we are, yet without sin” (Heb 4:15, NRSV). Tom Holmén, in his exegesis of Hebrews 4 in the *Theodicy and the Cross of Christ*, adds to this conversation on suffering that it is not so much about the suffering in this passage but in the temptation that occurs because of the suffering to concede to human weaknesses.[206] He further states, “as much as the texts can be said to deal with suffering, they specifically concern suffering resulting from testing and temptations that we encounter in this world and from our weaknesses that make it difficult for us to abide by God’s will.”[207]

Beyond providing a view of the suffering of Jesus as relatable, NT Scripture also reveals how Jesus had a heart for those who suffered during His earthly ministry. His care for the physically sick and the sick of heart is adequately demonstrated throughout the gospel stories. One such example is the woman with the issue of blood in Mark 5 who had suffered for twelve years. Biblical scholars agree that the author of Mark clarified this woman’s intense suffering as he inserted it in the middle of the story of a man who approaches Jesus with the urgent need to heal his dying daughter. Wessel surmises that the description of this story was amid two other detailed stories of suffering people.[208] Mark includes “vivid details including three in this story, she had suffered much, had been treated by many doctors, and had spent all she had. But her condition had gotten worse.”[209] There are countless other powerful demonstrations of Jesus’s

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[206] Tom Holmén, *Theodicy and the Cross of Christ* (New York, NY: Bloomsbury Academic, 2019), 148-49.

[207] Ibid., 150.

[208] Walter Wessel, “Mark” in *The Expositor’s Bible Commentary -Abridged Edition: New Testament*, eds by Kenneth L. Barker and John R. Kohlenberger III, (Grand Rapids, MI: Zondervan, 2017.) https://search.credoreference.com/content/title/zonebaet?tab=entry_view&heading=the_later_galilean_ministry_3_7_6_13&sequence=0.

[209] Ibid.

compassionate care for people through healing, feeding, relieving fears, and raising from the dead, but none so powerful as His greatest compassionate act of grace and mercy on the cross.

Considering this theological discussion, compassionate spiritual support to patients who experience perinatal loss by professional hospital chaplains is one expression of love for God's sacred creation. It promotes the love Jesus showed to others as He healed their physical and spiritual suffering and as He suffered Himself for all humanity. The theological foundation for this project allows for meaning-making and processing the trials and suffering of miscarriage grief. In this light, considering a theoretical foundation on grief will provide an even greater comprehensive view of the conceptual perspective of a miscarriage grief intervention for quality improvement. Combining the theological concepts of miscarriage grief with the conceptual perspective will provide a robust groundwork for this DMIN project.

Theoretical Foundations

The final task of chapter two is to present a brief dialogue on the theoretical implications of the loss and grief of miscarriage, considering the theological discussion. There is a differentiation in the terminology of loss and grief that must be clarified to begin this discussion. In perinatal loss and grief, there are unique conceptual nuances. A theoretical methodology for miscarriage grief intervention would not be complete without consideration of what loss and grief are and how to find meaning in it. Loss is saying farewell to someone or something, knowingly or unexpectedly, or severing a meaningful connection that has been developed and maintained. Grief is the actual living out or with the emotions of loss in a physical and behavioral sense when separation has occurred in a meaningful relationship.[210] Grief can be an

[210] Jakob Van Wielink, Leo Wilhelm, and Denise van Geelen-Merks, *Loss, Grief, and Attachment in Life Transitions* (New York, NY: Routledge, 2020), 14-15.

emotional, physical, behavioral, cognitive, and spiritual response to any loss.[211] The loss of someone or something loved is painful, and many emotions combine to cause grief which can be visible in psychological and physiological responses to loss. However, grief alone is not a psychological or emotional disorder because it is a natural response to loss that many people experience.[212] There is no prevailing measure of the intensity of emotional responses to certain types of losses because loss is not emblematic for anyone. Grief is a response that is an autonomous experience that can appear and disappear related to triggers, and it is not immediately solvable. Grief theories and supportive concepts that inform this project will encourage an emotional strategy, given how it relates to the theological approach.

The Old Testament (OT) book of Lamentations gives an example. It is a liturgy intended to be therapeutic to its readers who were survivors of a great tragedy together.[213] Although Lamentations is a theological writing, its inclusion in the theoretical section of chapter two is because of the social implications it portrays. Theoretically speaking, while psychological interventions seek to develop the neurological capacities of patients, which promote "psychological hardiness," spiritual support enhances the theory of strength and resilience in the face of life's difficulties.[214] Spiritual and religious beliefs are essential in the healing process of loss and grief because, theoretically, they can provide a sense of companionship, not isolation. In other words, something or someone inside and outside of oneself motivates the journey ahead.

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[211] Dilshad Nathoo and Janet Ellis, "Theories of Loss and Grief Experienced by the Patient, Family and Healthcare Professional: A Personal Account of a Critical Event," *Journal of Cancer Education*, 34, (2019): 832.

[212] Leslie Allen, *A Liturgy of Grief: A Pastoral Commentary on Lamentations* (Grand Rapids, MI: Baker Academic, 2011), xii.

[213] Allen, *A Liturgy of Grief*, xii.

[214] F. Mehdipour, R. Arefnia, and E. Zarei, "Effects of Spiritual-Religion Interventions on Complicated Grief Syndrome and Psychological Hardiness of Mothers with Complicated Grief Disorder," *Health Spiritual Med Ethics* 7, no. 2 (2020): 22.

Additionally, the presence of something greater than oneself or a "superior presence" in one's life through religious beliefs reinforces psychological processes and strengthens mental health.[215] Religion and spirituality can also escalate the adaptability of patients when circumstances of life bring disappointment, necessitating elevated self-awareness and seeking help.[216] Further, as seen in the theological discussion, a spiritual source of support in the grieving process can inform a sense of hope for the future. This is also a link to the theology of suffering concepts previously discussed. Therefore, to continue this section, A review of some of the more modern essential theories of the grieving process will enlighten the conceptual dialogue of this DMIN project.

Elisabeth Kübler-Ross Theory

Elisabeth Kübler-Ross's well-known work on finding meaning in grief anchors this project's theoretical review. She writes, "grief is real because loss is real. Each grief has its own imprint, as distinctive and as unique as the person we lost." While not directly related to the strength of the hope, joy, and steadfastness that Scripture suggests can result from suffering, Kübler-Ross adds, "grief is the healing process that ultimately brings us comfort in our pain."[217] The five stages of grief Kübler-Ross developed as a Swiss-American Psychiatrist in 1969 were meant to guide the journey of grief but not meant as a uniform process for all grief.[218] Kübler-Ross is the first to clarify that the stages are not linear. Further, she describes them as "tools to help us frame and identify what we may feel," the experienced order of and participation in each

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[215] H. Salimi, et al., "The Relationship between Death Anxiety and Spiritualty Constructs with General Health Among Nursing and Midwifery Students," *Health, Spirituality and Medical Ethics*, 4, no 2 (2017): 2-8.

[216] F. Mehdipour, R. Arefnia, and E. Zarei, "Effects of Spiritual and Religious Interventions," 22.

[217] Elisabeth Kübler-Ross and David Kessler. *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss*, (New York, NY: Scribner, 2005) 9.

[218] Ibid., 10. In the literature, it is important to note that many grief theorists have critiqued Kübler-Ross's stages of grief as a uniform process with no definitive flexibility to meet the uniqueness of the grief journey.

stage is unique to the grief experience.[219] Grief is a messy experience that can reappear in the healing process to surprise and overwhelm the one healing from a loss. Her model of grief began a discussion of the grieving process that paved the way for others to develop their theories. Denial, anger, bargaining, depression, and acceptance comprise the original Kübler-Ross model for the five stages of grief.

Anticipatory grief is a type of grief Kübler-Ross and David Kessler identify in their work *On Grief and Grieving*. It is the beginning of the end when one knows death is coming, but it is in the distance.[220] This type of grief would seem less appropriate in miscarriage, whereby the very nature of the term "spontaneous missed abortion" would seem there is no advanced awareness of the possibility. However, in complicated scenarios where patients who have previously suffered multiple losses experience another, there is unspoken anticipation or fear that loss will occur again. Additionally, complex scenarios transpire with patients where the lack of fetal heart tones diagnoses a pregnancy loss, and it is several days or even a few weeks before the miscarriage resolves completely. Living with death in the most realistic sense is feeling grief and anticipating what might come next. Kübler-Ross and Kessler say anticipatory grief is a form of silent grief that focuses not on the loss of the past but also on hopes and dreams of the future, including the culmination of the forthcoming medical intervention.[221] Anticipatory grief is a unique form of suffering related to some miscarriages that would benefit from spiritual support with a strong foundation in the theology of suffering.

Since Kübler-Ross introduced the initial stages of grief in 1969, others have added and modified her work. More recently, a seven-stage grief model brought specificity to the five

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[219] Kübler-Ross and Kessler, *On Grief and Grieving*, 10.

[220] Ibid., 5.

[221] Ibid., 10.

stages of grief. The seven-stage grief theory begins with shock and denial, moving to pain and guilt, followed by anger and bargaining. Along this journey, depression, reflection, and loneliness take over, leading to an eventual upward turn followed by reconstruction of life where the pieces of daily life begin to come together and, ultimately, the acceptance of a new normal.

Other Grief Theories

Other theories and models of grief add to the understanding of bereavement by approaching the grieving process outside the stages of the Kübler-Ross model. They argue that progressing through stages does not adequately describe the grief journey. Richard Gross, in his book *Understanding Grief*, provides a widespread view of differing models of grief that reach beyond the five or seven-stage theory. The grief work hypothesis is the perception that those who grieve must confront the experience to come to a place of good mental health.[222] Doing the grief work in Parke's psychosocial transition theory can be seen as working through the transitions of loss, where the focus is on adapting to changes in life after a loss.[223] The dual-process model of loss and restoration provides a model for managing loss with an oscillation between confrontation and avoidance of loss-oriented and restoration-oriented grief stressors instead of merely labeling the emotions attached to grief.[224] The continuing bond paradigm of grief emphasizes the importance placed on a continued internalized and externalized bond with the deceased.[225] The two-track model of bereavement created by Rubin holds to the importance of the biopsychosocial functioning of humans concerning loss and the relationship or connection of

[222] Richard Gross, *Understanding Grief: An Introduction* (London, EN: Routledge, 2015): 45.

[223] Ibid., 49-51.

[224] Ibid., 54-60.

[225] Ibid., 62-66.

the bereaved to the deceased.[226] While considering the theories and models of grief, all have served their part over the years in the development of grief study. The theories have enlightened the need to serve the bereaved with a deeper understanding of psychosociological concepts of grief. The varying theories and models also validate that the phenomenological aspects of grief are individual and that all grief, including perinatal grief, is influenced by one's life stories, social and cultural influences, and attachment to the hopes and dreams for the future. Leslie Allen creates the most basic grief theories by saying, "Everyone has the right to grieve and an obligation to respect the grief of others."[227]

Attachment Theory and Perinatal Loss

Considering the scope of this DMIN project, it is meaningful to look at how attachment theories and grief influence perinatal loss. In a normative light, attachment theory is one person connected to another who appears to provide safety, security, and even meaning in life.[228] It is consequential that loss and grief occur when there is a broken attachment. Therefore, grief from a loss of attachment is relationship-based and can be either known by others or purposely hidden and even invisible or unknown. The hidden or invisible forms of grief are a phenomenon previously discussed, relating perinatal loss as a silent form of grief or disenfranchised grief that is often ignored or hidden by the patient and their social network.

Specific to perinatal loss, it is common for patients experiencing miscarriage to have already formed a parental attachment to the baby or babies they carry. This attachment loss is the

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[226] Gross, *Understanding Grief*, 67-69.

[227] Allen, *A Liturgy of Grief*, xii.

[228] Jacob Van Wielink, et al., *Loss, Grief, and Attachment in Life Transitions* (New York, NY: Routledge, 2020), 109-111.

framework for the grief associated with miscarriage.[229] In *Grief and Loss Across the Lifespan: A Biopsychosocial Perspective,* Walter and McCoyd present three areas where a pregnant patient can experience attachment. Initially, the physiological attachment occurs as changes to a patient's body during pregnancy serve as a reminder of the human development occurring within the womb and the literal physiological attachment between the baby and the patient in the placenta. Secondly, psychological attachment occurs as the emotional demands of pregnancy ebb and flow during fetal development and can increase and decrease a feeling of attachment. The patient's need for control and fear of the unknown are common reasons for higher anxiety levels. The change in body image or any worrisome changes in the patient's health can also cause anxiety. Other considerations that could cause anxiety include financial implications, availability of healthcare, work and childcare decisions, relationship adjustments, and the pressure of parenting. Thirdly, the recollection of the emotional past of childhood may also cause anxiety for the patient during pregnancy, as well as other underlying maternal or paternal psychological factors that could affect attachment.[230] A less obvious influence affecting attachment between patient and baby is a social connection to pregnancy that includes the years of a patient's youth where playing house and babysitting were experienced, as well as other cultural, racial, religious, and generational influences that could shape parenthood.[231] When pregnancy fosters an attachment between patient and baby, it influences the grief intensity from pregnancy loss.[232]

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[229] Carolyn Ambler Walter and Judith McCoyd, *Grief and Loss Across the Lifespan: A Biopsychosocial Perspective* (New York, NY: Springer Publishers, 2015), 28.

[230] Ibid., 30.

[231] Ibid., 31.

[232] On the opposite spectrum of the discussed attachment theory, it is also important to note that unwanted pregnancy can foster negative feelings of attachment, resulting in guilt and complicated grief immediately or sometime in the future.

Richard Gross sums the attachment theory discussion up by saying, "At whatever stage of pregnancy a baby dies, a relationship with it would have begun and so needs to be grieved."[233]

A Sociological Theory of Grieving

Beyond the theoretical models of grief, the psychosocial influence of grief has been previously reviewed in this chapter. Social traditions of grieving can be traced to antiquity, also mentioned previously. Given the critical theological discussion of grief, it is of great import to briefly consider the sacred text of Psalms and Lamentations and how they give readers an OT view of the social context of grieving. Writing a pastoral commentary on Lamentations, Leslie Allen says of grief, "though its form [and journey] varies greatly, grief is a universal, cross-cultural reaction to loss and change."[234] Allen further elaborates, "older cultures gave grief much more respect, regarding it as a necessary part of lives that were potentially fragile at every level."[235]

Cultures in antiquity highly regarded grief and exhibited this esteem in varying ways. The literary details of ancient cultural writings reveal this. The Israelite's grief rituals are especially seen in Psalms, Job, and Lamentations. From these three OT writings, ancient Hebrew culture was free to express their emotions through tears, wailing, and speaking of memories to release pent-up feelings from the recesses of intense suffering and to retell the events to survive.[236] Leslie Allen writes of ancient Israeli literary tendencies in Lamentations: "apart from nonverbal mourning rituals, there were grooves, as it were within the social framework of oral

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[233] Gross, *Understanding Grief*, 136.

[234] Leslie C. Allen, *A Liturgy of Grief: A Pastoral Commentary on Lamentations* (Grand Rapids, MI: Baker Academic, 2011), xii.

[235] Ibid.

[236] Ibid., xi.

communication along which the expression of grief could move with a measure of ease."[237] They include the dirge, a public communication form that tells the grief story. It is not necessarily concerned with mentioning God but surveys the many emotions of grief. Another form of social grief expression is the lament psalm. It is expressly said to be a prayer to God. However, the city lament is found in antiquated cultures and laments not God but the deities and their devastation of a community in varying religious cultures.[238] Allen, like other commentators, contends that telling the grief story is a therapeutic ritual in remembering and expressing the pieces of loss and grief so that one can work toward acceptance.[239]

In a more contemporary observation, Kent Koppelman elaborates in his writing, *Wrestling with the Angel: Literary Writings and Reflections on Death, Dying and Bereavement*, that in the Western culture of America, the facilitation of grief comes in the form of a few brief rituals which generally take place immediately following the death and then those experiencing the loss are expected to return to their daily living. With this mindset, there are no obvious and socially acceptable practices or rituals to foster long-term grief processing through healing and reconciliation with the loss.[240] Additionally, there seems to be a social trend distancing itself from the traditional funeral service following a death. The recent pandemic played a role in this, and the exorbitant cost of a funeral, burial, or cremation often does not make sense to families who do not value the rituals. The exclusion of these rituals limits the opportunity to say goodbye, memorialize the lost through writing and reading an obituary, and celebrate a life created in the

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[237] Allen, *A Liturgy of Grief*, xii.

[238] Ibid., x. The city lament could be considered an ancient form of modern spirituality, which further connects this writing to the current religious and spiritual culture context of this DMIN project.

[239] Ibid., xiv.

[240] Kent L. Koppelman, and Dale A. Lund, *Wrestling with the Angel: Literary Writings and Reflections on Death, Dying and Bereavement*, edited by Dale A. Lund (London, EN: Routledge, 2017), 15.

image of God. It also limits the initiation of the grieving process in a social tradition. This ideology supports the value of rituals and celebrations of life events for patients experiencing perinatal loss as part of the grief process. It points to the inclusion of this in the group intervention design.

Finally, from a sociological viewpoint, it adds depth to the understanding of this work to consider three theoretical levels of external agents of social influence that affect grief. The first consideration is given to social influence at the microlevel, such as close family and friends, those in a patient's face-to-face world, who shape feelings about grief with positive and negative affect. Interpersonal influence is perceived as positive social support from close relatives and friends in personal ways and contributes to a less intense and shorter grieving process.[241] In contrast to the positive influence of social support, when a patient's close social supporters judge the patient's grief as extraneous or avoidable, feelings of illegitimacy cause experiences of disenfranchised grief.[242]

In a patient's exosytem, the second theoretical social level, various agencies, and governance systems influence a patient's grief experience. Whether these entities are legalizing and providing treatments, legislating laws, or providing spiritual and religious guidance, the exosytem influences the grieving process. Specifically, regarding pregnancy loss, the ethical conversation and most recent Supreme Court rulings on beginning-of-life issues would be a part of the exosytem's influence.[243] Belief in a benevolent world and seeking good and not evil for all would reflect the influence of the exosystem and can complicate loss and grief with questions of

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[241] R. F. Rodgers and R. H. DuBois, "Grief Reactions: A Sociocultural Approach," *Clinical Handbook of Bereavement and Grief Reactions, Current Clinical Psychiatry*. Humana Press, (2018):1-18. https://doi-org.ezproxy.liberty.edu/10.1007/978-3-319-65241-2.

[242] Ibid.

[243] Ibid.

why and how. On the other hand, the exosystem can be beneficial through spiritual and religious beliefs that provide a source of loss and grief coping, including an essential hope for the future and life after death.

The final system of social interaction and influence is the macrosystem. In a broad sense of culture and western political and economic systems rooted in consumerism and constant growth, death is the opposite and is denied or hidden, resulting in nonacceptance. Moreover, there is a lack of awareness and the disappearance of rituals and social interactions related to grief processing.[244] Within the macrosystem influence, death is glossed over, and the expectation to "move on" and "get over it" fits. In reflection, the three levels of social influence in this system theory explain many of the previously reviewed psychosocial ills of miscarriage grief, including guilt, shame, disenfranchisement, lack of awareness, and ambiguity.

Through the discussion of the conceptual foundations of miscarriage grief, including a literature review, the groundwork is present to support a quality improvement project for the Pastoral Services department at Mercy Hospital. This undertaking will create an intervention for patients experiencing a miscarriage. It also includes the need for professional spiritual support to aid patients suffering from miscarriage grief to promote long-term mental and spiritual health. Theologically speaking, the value of life and a spiritual understanding of suffering are core principles to enhance this intervention. The conversation in the literature provides a strong foundation for building the next chapter's methodology of grief support intervention.

[244] Rodgers and DuBois, "Grief Reactions," 1-18.

CHAPTER 3: METHODOLOGY

While the problem and purpose stated in chapter one clarified the reason for this DMIN project, the methodology describes the approach for addressing the problem in detail. The problem at Mercy hospital is that patients do not have indicated options for follow-up support following a perinatal loss that coincides with Mercy values. The literature review suggested that patients experiencing pregnancy loss at any gestational age suffer emotionally from their loss. Through the unique grief accompanying this experience, patients inimitably understand disenfranchised grief, shame, guilt, and other emotions that, if ignored or untreated, affects mental health. Awareness of this phenomenon by the patient's healthcare workers, family, and friends is necessary to provide meaningful support and encourage the patient toward a healthy grieving process. Admittedly the literature shows that pregnancy loss grief awareness has risen in healthcare. However, the literature does not adequately reveal how to use this awareness to better support patients toward a healthy grieving process. Further, little in the literature related to understanding spirituality as a coping mechanism for patients experiencing grief from perinatal loss. Chapter three gives an in-depth description of the grief support project designed to address the problem statement of this study in a step-by-step format toward implementation.

Intervention Design

Using Mercy Hospital's mission, values, and charisms described in chapter one, this design provided faith-based grief support for patients who have experienced fetal loss. It welcomed patients of all races, religions, socioeconomic backgrounds, and cultures interested in

additional support for miscarriage grief. The designed group interaction intentionally highlighted grief and its spiritual and emotional dimensions. While Mercy is a Catholic hospital from a Christian faith tradition, great care was taken to explore what faith meant to each participant in a religious and spiritual sense. In addition, faith was explored as a coping mechanism for perinatal grief. These methods joined dialogues and activities that promoted emotional and spiritual health.

The project was to engage the implementation of group sessions held once weekly for eight weeks. Within this ninety-minute time frame, participants were to examine stories of loss and grief in a group setting which would initiate the discovery of shared experiences of grief. Group members will have opportunities to reflect in meaningful ways as they listen and share. Through avenues such as music, journaling, art, narrative, crafting, meditation, and dance, participants could consider unique methods of processing grief. Participants gave input on the topics and activities for this project, including a "celebration of life ritual" where participants assisted in planning a meaningful ritual to memorialize their losses. See Appendices O-U for weekly group outline details.

Data collection for this project included a patient experience survey at the end of the group. In addition, the project leader completed observational measures of the group each week using a Likert Scale to rate broad observations to measure the extent to which the project purpose was addressed. Mercy stakeholders included representatives from Pastoral Services, Mission Department, Obstetrics staff. Stakeholders took a survey to rate their observational opinions from participant survey results and project leader data. See Appendix J for Stakeholder Survey details.

All data collected was held on the investigator's password-protected personal Apple computer or stored on an external drive that was locked in a cabinet at Mercy Hospital. Upon

completion of the project, all data will be transferred and kept on Mercy Health System's password-protected data storage for three years. It will then be destroyed through Mercy's secure disposal process. This project has the full verbal or written support of the appropriate stakeholders at Mercy, including the leaders of Missions, Pastoral Services, and Women's Services nursing leaders and providers. A request to perform this quality improvement project has been completed and submitted to Mercy's Internal Review Board, and the Liberty University Internal Review Board (IRB) also gave written approval of this project, and their approval is included at the end of the Appendices.

Setting

The setting for this DMIN project was Mercy Hospital in Springfield, MO. Mercy is one of two leading hospitals in Springfield, MO, that serve the sick within a one-hundred-mile radius. The patient and coworker population at Mercy represents a variety of cultures, races, and ethnic backgrounds. Further, Mercy is a Catholic hospital that values a compassionate and faith-based approach to care for all patients and their families. This project leader is a female ordained minister with the Church of God, headquartered in Anderson, Indiana, employed as a Mercy chaplain II. The primary role of the project leader at Mercy is to provide pastoral support for patients and coworkers in Labor and Delivery and Antepartum Care, including high-risk pregnancy patients and patients who experience fetal loss, as well as families of patients in the Neonatal Intensive Care Unit. In addition, the Obstetrics and Gynecology clinics, which provide ambulatory care that supports the hospital, are logically attached to the ministry area of this project leader.

In this setting, an interdisciplinary team cares for each patient experiencing an early pregnancy loss. A referral for pastoral support comes from the patient's interdisciplinary team in

the hospital or ambulatory surgery center. In this setting, pastoral support included a standard of care to serve the patient in their time of need in a manner appropriate for their personal beliefs and experiences related to spirituality and emotional health. Respecting each patient for their unique needs, and through rigorous professional training, the chaplain discerns a patient's needs through active listening during patient encounters and input provided by the interdisciplinary team. This process informs the care provided to the patient in this setting and in bereavement follow-up.

Participants

The target population for this DMIN project was patients of Mercy Hospital who have experienced early pregnancy loss in the previous six months. The targeted age range is eighteen and no older than thirty-nine. The baby's gestational age at the time of the loss was understood to be less than twenty-five weeks or considered nonviable. This information is discussed further in the first phase of the project. Further, the participants' group attendance and participation were considered voluntary, and no access to individual health information or data outside of what is Mercy's standard for care for the patient experiencing early pregnancy loss was allowable for this project.

The Four Phases of the Plan

The project plan had four simple phases commonly found in quality improvement projects, and each stage of the design was a part of the methodology of chapter three. The four essential phases of the project include planning, doing, studying, and acting. Discussion of the step-by-step plan is central to clarifying the methodology and illuminating the intentionality and design that fulfilled the purpose of this project. The timeline for this DMIN project is sixteen

weeks from start to finish. Subsequently, following this project's study and act phases, the Pastoral Services department at Mercy Springfield will evaluate the potential to continue the program as a means for improving emotional and spiritual support for individuals who experience perinatal loss.

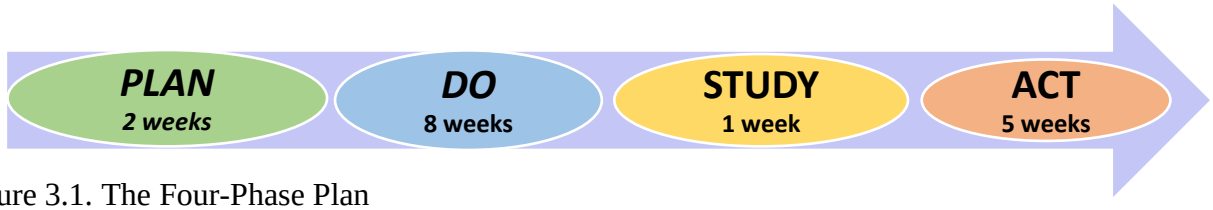

Figure 3.1. The Four-Phase Plan

Phase One: Plan

Phase one is the foundation of the project, where planning was strategic to provide the optimum implementation of the grief support group. The primary segments of phase one included securing group members and solidifying the details and preparation of the group plans. During phase one, verifying the stakeholders who participated in the observational survey at the end of phase two was also essential. Phase one took two weeks and began shortly after final approval from Mercy, Liberty University's mentor, and the university's Internal Review Board (IRB).

Figure 3.2. Plan

Project participants were solicited from three different modes. The first and primary method was through the interdisciplinary (ID) standard of care for Pastoral Services at Mercy Springfield. An ID approach to healing connected patients to the appropriate caregivers in a

collaborative setting. Referral sources for spiritual and emotional support in the ID approach included practitioners and nurses in various units across Mercy[1] who care for patients experiencing fetal loss. This joint effort of care was one example of the holistic approach to caring for patients at Mercy and is a best practice.[2]

From this referral, a standard initial chaplain encounter ensues. During this encounter, a patient would have an opportunity to explore spiritual and emotional aspects of their recent medical experience including grief as appropriate to the patient's needs. Mercy chaplains are trained professionals who respect the patient's desire to participate and receive emotional and spiritual support. The results of the patient encounter were charted in the Mercy Electronic Health Record, password-protected and HIPAA-monitored.[3] Only the patient and the interdisciplinary team had access to this information to provide privacy and continued care to meet individual patient needs.

Secondly, a patient was referred through an ID referral if a team member observed distress in the follow-up care of a patient experiencing early fetal loss. This standard of care referral would come primarily from the six-week gynecological follow-up visit or occasionally occurred in other follow-up care. The third referral mode occurred when a patient, on their own accord, engaged a chaplain following an early pregnancy loss, either while still a patient or after

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[1] Labor and Delivery, the Emergency Department, Outpatient Surgery, the Ambulatory Surgery Center, and Obstetrical Clinics.

[2] Further, the required education of this best practice to Mercy staff is inspired by Mercy's value of life, dignity, and respect for the patient, and family from ERD Four, as well as Mercy's accountability to the Catholic Church and the law in Missouri Statute 194.387.2, as mentioned in chapter one. Just as a referral to a medical specialist, such as a neurologist or cardiologist, comes through the interdisciplinary team when there is a need, so to a referral to Pastoral Services when there is a fetal loss.

[3] HIPAA -The **Health Insurance Portability and Accountability Act of 1996** (HIPAA) is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge.

being discharged. When a patient sought additional support, the chaplain engaged in appropriate spiritual and emotional support as the patient desired as a standard of care. Other unique scenarios for voluntary patient participation would be considered individually with respect to the patient's wishes and following standard pastoral care practices. No private health information was accessed to recruit or provide information to patients outside of the standard of care for chaplains, and participation is entirely voluntary. See Appendix B, C, and D for recruitment tools, including a QR code used to scan and sign up.

Inclusion Rationale

The inclusion rationale begins with Mercy patients who experienced early pregnancy loss. Because this project's scope is quality improvement for patient care, it did not consider including spouses, significant others, siblings, grandparents, other family members, or close friends. Secondly, the inclusion rationale considered creating a group and size where members have the most in common while allowing for some variability. Not every pregnancy loss followed the same path, but the shared emotions attached to the grief experience were a uniting factor among the participants.

To begin, limiting the gestational age of the pregnancy loss to less than twenty-five weeks created a group that generally did not share experiences such as holding a living baby or losing a baby after the baby was supported by medical intervention for a short time. While "early miscarriage" refers to early pregnancy loss, "early" is subjective. Therefore, setting a gestational age range provided criteria where participants shared mutual understandings. In addition, and as previously stated in chapter one, the medical viability age of a baby is between twenty-one to twenty-five weeks. As a baby's gestational age is related to its development and as technology

develops in obstetrics and neonatology, the age of viability will always be unique to each baby, which is another variable considered in the inclusion rationale.[4]

Final Details

Securing volunteers through standard practice, as explained above, and the understanding of the inclusion rationale of this project was of great significance in organizing this project. Once a volunteer was educated on the project and agreed to participate, volunteer consent forms were signed as needed and are included in Appendix A. Detailed information on the first group meeting was shared through the patient's verified and preferred form of communication. No patient records were accessed to secure this information outside of what the patient expresses as appropriate communication. Further, a QR code was given for the patient to access all the project details to protect patient privacy and for the patient's convenience (see Appendices E and F). The final preparation for this project was essential to verify important details for the project leader that reflected in each week's organizational process and emphasized quality patient care. Specifically, preparation before, during, and after securing participants ensured the project operated in a fashion that provided the most effective communication and clarification to set realistic expectations for the participants.

In the planning process, the project leader ensured the availability of all the needed resources for the group meetings, including the facilities, other essential resources, and group details (see Appendices L and M). For example, confirmation of the room reservation, the media and room setup, and securing the supplies, refreshments, and printed materials or online resources that were part of each week's discussion were crucial to ensuring that the project

[4] The baby's gestational age is known to the chaplain as a standard practice in caring for fetal loss patients to determine the baby's disposition according to Mercy burial standards and Missouri Statute 194.387.2.

leader and the group had what they needed before each session. It also decreased the number of last-minute details that needed attending.

Another aspect of the planning phase was to consider what specifics the Mercy Pastoral Services department would need when discussion of the future of this project took place. Essential elements to consider for implementation included costs associated with the project, patient privacy or other ethical issues, time commitment for planning and facilitating staffing issues, and follow-up missional resources for needed referrals for psychosocial or economic indicators that may be affecting the patient's ability to grieve appropriately, and other follow-up plans to support patients after completion. The project leader tracked these specifics in weekly evaluations and notes (see Appendix H for details).

Phase Two: Do

Phase two was the eight-week group project phase. With the group created and final preparations made, participants were ready to begin. Each week, the group was supposed to meet in the Catherine McCauley Conference Center (CMCC) Baggott Street room at the Hospital's Main (South) Entrance. In the event of an unforeseen pandemic escalation, the group could meet online using Mercy's Microsoft Teams platform. Because of the ongoing challenges of the pandemic, face masks were required while in the hospital until arrival in the Baggott Street Room. Once in the room, masks were optional per hospital policy (see Appendix F). Phase two included specifics of "doing" the actual group and the role of "doing" for the group leader.

Figure 3.3. Do

The Group

Each session of the eight weeks emphasized group interaction and reflection, either directly or indirectly. The group sessions employed a mix of opportunities to meet various learning styles and unique activities to enhance group engagement. See Appendix O-U for the detailed week-by-week plan. The group engaged as others shared to process their grief through storytelling, topic-based, and discussions in a small group setting. The activities were designed to promote grief rituals and recognition of life. In addition, this project promoted faith-based spiritual and emotional exploration through fellowship and connecting. While this grief intervention did not replace one-on-one therapy sessions, the compendium of personalities in a voluntary and private setting had significance in adding meaningful connections to the spiritual and emotional journey of grief. Because participation was voluntary, members shared at leisure as the project leader was mindful of respecting participants' desire to contribute.

This grief work provided many different occasions for growth in understanding, coping mechanisms and finding comfort and piece. It was a protected space for grief processing where participants explored their grief and journey to move towards healing and discovering purpose. It was a place where participants shared mutual experiences that divinely inspired.[5] Scripture was the foundation of truth for this project design. It encouraged strength in numbers and supporting each other. Ecclesiastes 4:12 clarifies this, "And though a man might prevail against one who is alone, two will withstand him– a threefold cord is not quickly broken." (ESV) Other scripture also emphasized supporting each other with encouragement. "Therefore encourage one another and build one another, just as you are doing," (1 Thess 5:11, ESV). Through humility,

[5] Sally, Downham Miller, *Mourning and Dancing: The Group: A Curriculum for Grief Support Groups* (Chicago, IL: White River Press, 2021): 12.

gentleness, and patience, interaction with others led to unity and the bond of peace.[6] Group sharing in humility, gentleness, and peace creates a distinctive group tapestry of healing.

Following the introductory group meeting of week one, weeks two through six tracked a consistent outline to allow group members to engage with others through voluntarily sharing and listening (see Appendix P-T). While the methodology presented common themes and planned for each week, as the Holy Spirit divinely worked, the group discovered more about grief and God's love. The overall necessity of the group project was to allow space for the Holy Spirit's work and for the group to lead the flow as they discovered opportunities to connect. The plan for each week was in place, but allowing space for flexibility was essential as the Holy Spirit worked and the group processed their spiritual and emotional needs. Participant input was valuable and assisted in informing the week-to-week discussion and activities. The support materials and information were adapted weekly as the group offered feedback, both directly and indirectly.

Along with group discussions, there were planned explorations of creative ways for the group to process grief. Music, art, dance, meditation, and journaling were outlets where grief could take on different meaning through words, sounds, images, or feelings that were once unknown. This fit with participants' personalities and lifestyles and was a powerful way to understand grief. Exploring creative opportunities was motivated by the group and was adjusted as necessary.

Depending on the topic, a faith component was incorporated into the weekly gathering each. Appendix N provided suggested Scriptures to use as faith prompts for group discussion and reflection. Time was allowed each week for prayer or reflection according to the week's topic

[6] "With all humility and gentleness, with patience, bearing with one another in love, eager to maintain the unity of the Spirit in the bond of peace" (Eph 4: 2-3, ESV).

and Scripture prompt.[7] Participation is not mandatory in any aspect of the weekly gatherings, recognizing there is an opportunity for growth whether sharing, listening, or reflecting.

Giving space for essential rituals in the grieving process was vital and was a part of this group project at various times and as appropriate. For example, the Celebration of Life event in week seven provided a moment to memorialize the babies represented in the group. The participants determined the design of the event. It was flexible to be simple and small or more formal, where attendance was open to family and friends. The goal was to offer a meaningful group ritual for the participants, which would further benefit in processing grief.

Week Eight is the final week of the group. Session eight was the culminating event to assess the experience and project a sense of hope for the future. Session eight concluded with a celebration of hope using Jeremiah 29:11-13 and the words of "The Blessing." The group was encouraged to consider their journey through the lens of their grief support experience. The patient survey was given online and assessed the participants' experience related to their grief journey. See Appendix I for more details of the patient survey.

The Leader

The group leader, a professionally trained chaplain, used professionally established standards of training and skills for group and one-on-one facilitation. Skills such as active listening, appropriate emotional and spiritual support, faith sharing, storytelling, promoting coping mechanisms, addressing fear and anxiety, instilling hope, advocating for the patient, ministry of

[7] It is important to note that professional chaplain training promotes respecting all faith perspectives and encouraging understanding others' views. While Mercy is a faith-based organization, it serves people of all spiritual views. Spirituality is a primary method of coping with grief and will be included in this group to promote group awareness of this coping mechanism.

presence, and encouragement are imperative standards of care in professional chaplaincy. The objective of facilitating this project was not to solve a patient's problems but to maintain a sharing environment to journey with the patient and point the patient in a direction that allowed the personal discovery of coping mechanisms and meaning and purpose in the grief journey.

Besides facilitating the interactions, the project leader oversaw all the details to ensure the project ran smoothly. Further, the leader observed each week as a part of the project design. No observable data was individually identifiable. However, attendance and participation in conversations that pointed toward the topics for that session were observable and recorded in a Likert scale methodology and journaled by the leader at the end of every session (see Appendix H). Each week the leader also journaled observations, personal hypotheses, and other de-identified personal reflections from the interactions that were valuable for the future determination of the project. The journaling included observations of any previously mentioned elements for future consideration. These can also be seen in Appendix H. From this point, the project entered phase three where reviewing, analyzing, and interpreting the project's data took place.

Phase 3: Study

As the end of the eight-week grief project concluded phase two, phase three initiated the study of the data in a mixed-method approach. This stage supported the DMIN project's problem, purpose, and thesis statements through the evaluation of the data collected from patients experiencing early pregnancy loss and from the project leader. The study used a quantitative approach to measure and evaluate the implemented grief support program in terms of quality patient care and observable patient participation through Likert scale measures. In a

qualitative approach, using a descriptive measure in a textual analysis of broad terms gathered by the project leader was suitable to better analyze the experiential process of this project. Observing broad topics and activities to discover associations in faith, spirituality, trauma, family, and grief experiences and utilizing spirituality as a coping mechanism was informative. It fostered evaluations of the grief support intervention toward improving patient care. For the mixed method of data analysis, SPSS software organized and analyzed the quantitative data collected from the Likert scale surveys. For the qualitative method of data analysis, ATLAS.ti software organized the descriptive data gathered from weekly observations and participation by the group leader.

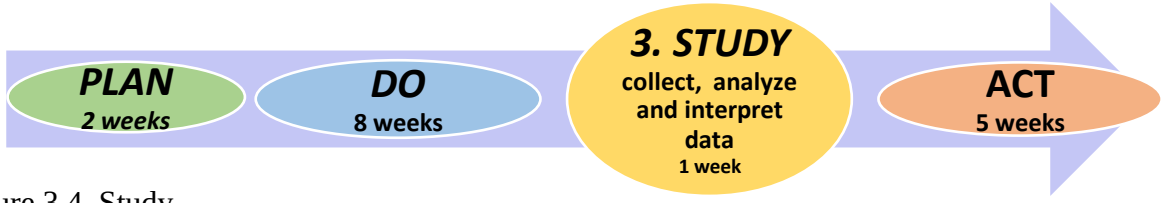


Figure 3.4. Study

After collecting and analyzing the data from the patient surveys and the project leader, the previously selected stakeholders were asked to join the project. After reviewing the patient survey results and leader reflections, the stakeholders were surveyed to offer their analysis. A Likert Scale survey completed by the stakeholders after their data review further quantified the outcome of the Patient Surveys (see Appendix J). Their survey joined with the two other survey sources to complete a three-fold approach to interpreting the data of this project. The data organization, analysis, and interpretation were completed with an awareness toward a bias-free approach and conclude in a week.

Phase 4: Act

Phase four was the culminating phase of the DMIN project. It began with taking the final interpretation of the data to summarize findings that were informative to the problem, purpose, and thesis statement. This interpretation led to the writing of chapters four and five and the final edits to the project. Working closely with a mentor throughout all four phases provided the foundation for finishing the writing in preparation for professional editing. Once professional editing took place, the mentor scheduled the defense of this project with the reader while the investigator prepared to defend. After completing the defense and all remaining edits, and after the final copy was submitted to the Liberty University Jerry Falwell Library, the mentor recommended the project leader for graduation.

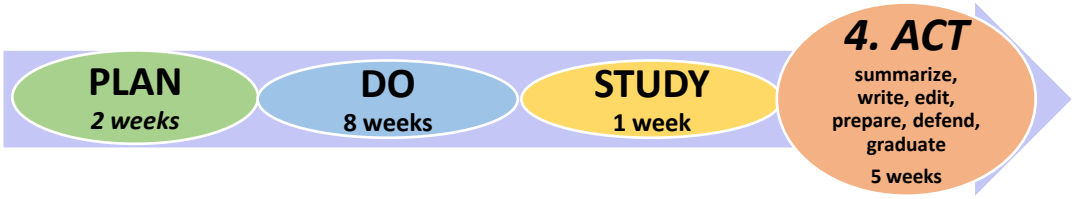


Figure 3.5. Act

Implementation of the Intervention Design

Implementing the DMIN quality improvement project began after completed IRB approvals and the timeline put into place. Gathering volunteer participants and preparation continued until the project started. As mentioned previously, data was uploaded as collected to a password-protected device and storage in preparation for final analysis and interpretation. All stakeholders were informed as the plan was implemented and surveyed upon completion of the group phase and gathering of the initial data. The project leader took notes and tracked progress

throughout each phase which was used in the final writing of the project. Once all data was gathered and phase four was complete, the project's long-term viability was evaluated.

Ethics

During the implementation of this intervention, great care was be taken to ethically maintain respect for persons, justice, beneficence, and benevolence of all participants. Further, this was a quality improvement project regarding patient care and satisfaction. No individual data was accessed or shared outside of standard care practices that violate privacy regulations or required permission or consent from individuals. Further, respect for life and family, as valued by the Catholic Church, was ensured to the highest degree. All data reported in written form was group focused and without identifiable markers of the individual participants or stakeholders. The data was and is protected digitally by a password and stored on a locked digital file.

Transparency in this project was of great value. Two factors were discussed which acknowledged any bias related to this project. First, the investigator's primary work responsibility was providing spiritual and emotional support to patients who have experienced a pregnancy or neonatal loss at the hospital and in bereavement follow-up. Therefore, some patients might have previously experienced routine follow-up support from the investigator prior to the start of the project but not related to participation in the group. This experience was limited to an initial interdisciplinary chaplain encounter preceding surgery for fetal loss, a follow-up bereavement phone call, or patient-initiated support. Secondly, the investigator has experienced a perinatal loss and used spirituality and faith as coping mechanisms in the grieving process. In the spirit of professional ethics and integrity, the researcher's experience with miscarriage informed a unique perspective to facilitate the project. However, participants were encouraged to examine

their own experiences as they processed their grief. As data is analyzed and interpreted, great care was taken to let the data speak for itself.

Finally, care was taken to eliminate bias, including race, gender, religion, disability, and culture. Participants chose to process experiences that are private and of a vulnerable nature at their own pace. This patient choice is standard practice for chaplain encounters and was voluntary. Mercy's written and verbal endorsement of this project and the project leader added further credibility to journey with patients in this scenario. Each participant arrived at this point in life from different paths. Acceptance, dignity, and respect for the person, justice, and beneficence will be the ethical standard of the group. The project leader demonstrated this by treating others as valued human beings created in the image of God.

Participants

Participant selection occurred from patients referred for spiritual care following an early pregnancy loss as the standard of care at Mercy Springfield. Participants selected were between the ages of 23 and 39 who had experienced perinatal loss under twenty-five weeks gestation and within the last six months from the project's start date. All patient recruitment was within HIPAA standards, and results were reported in general terms to protect the participants' privacy. Each participant had been in previous contact with a chaplain from the Pastoral Services team, but not necessarily the project leader. This initial contact resulted in essential emotional and spiritual support, including all or some of the following: a spiritual assessment, guidance in determining the disposition of the baby, other appropriate spiritual and emotional support, and follow-up bereavement care initiated by a take-home packet of grief support materials.

Of the fifteen patients invited to participate, six consented, and of the six, one exception to the above criteria was made. The patient had received a lethal pregnancy diagnosis.[8] Furthermore, the physician made the initial referral in anticipation of the pregnancy outcome. Following the loss, the patient recognized a need for additional grief support and decided to proceed with the project. In general, there was a mix of pregnancy loss experiences. Figure 3.6 indicates the breakdown of pregnancy loss experiences of the patients who participated in this study.

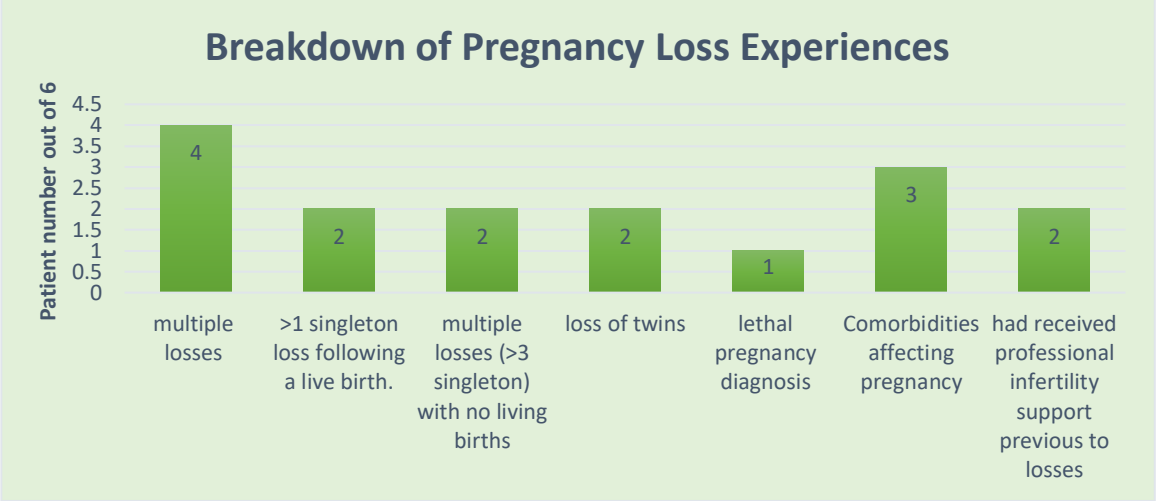


Figure 3.6. Breakdown of Pregnancy Loss Experiences

The Grief Intervention

The original plan was to create a grief support group where the participants interacted weekly, which included sharing their life stories and considering their faith experiences as a coping mechanism for pregnancy loss. A week-to-week detailed group plan provided the outline

[8]A lethal pregnancy diagnosis occurs when the baby, through testing, is found to have multiple physical anomalies that would prohibit the baby from living outside of the mother's womb and can demise prior to full term.

that guided the project. Nevertheless, the project leader hoped to be flexible enough to allow the participants to have a voice in what was most meaningful to them in this grief support experience, with little expectation for them to fit into a preplanned model of grief support. This approach would yield more appropriate spiritual and emotional support and respect each patient's grief journey and spirituality. Therefore, each week's plan was designed to be flexible based on the group's desires. Along with the group dynamic, this project included an optional design to meet online and optionally one-on-one in person, online, or via texting with the project leader to provide a personal experience when needed and beneficial to the patient.

The project's implementation did not reflect the original group plan but benefitted from its content and adaptability. Once the participants were secured, it became clear that individual interactions between them and the project leader would be the foundation of this project, not group meetings. Most patients expressed their desire to meet individually for three reasons:

1. The nature and vulnerability of early pregnancy loss and its silent grief can make it challenging to communicate individual experiences and feelings, which add to a patient's shame and guilt. Overwhelmingly the patients did not feel comfortable sharing these private experiences with people they did not know.

2. Some participants wanted to avoid returning to the hospital where their loss experience took place to participate in the group.

3. Finding a suitable time and location for all to gather based on the various work schedules, travel time, and family demands was difficult.

Therefore, a modification was made within the project scope after the project mentor and Mercy IRB approved the change. The new detailed plan was to connect with each patient at least eight different times through weekly one-on-one meetings and online, via telephone and text check-ins. The hope was to have at least one group gathering during the eight weeks. Unfortunately, the group gathering never occurred, and although three patients expressed an interest in doing so, the scheduling complexity prevented it. While it was occasionally

challenging to connect with the patients each week, phone calls, video chatting, and texting helped the leader foster connection and relationship-building with each person. Meeting one-on-one in person and through video chatting allowed meaningful space and time for each patient to reflect, share and grow more personally and confidentially. The phone calls and texting provided opportunities to affirm and encourage patients, to follow up and reinforce previously discussed topics in person or invite the patient to contemplate further about something.

The discussion topics were taken directly from the group plan in the intervention design and modified to meet each patient's unique experiences and needs. This strategy was beneficial in making this project more individualized. Throughout the eight weeks, some patients discussed multiple topics from the group plan, while others desired to go deeper with a few topics. From a leader's perspective, both approaches were meaningful to quality patient care.

Chapter three has detailed the prospectus for the DMIN project designed to address the problem at Mercy Hospital that miscarriage patients do not have an opportunity for ongoing spiritual grief support to promote a healthy grieving process. It has presented the timeline, an eight-week intervention outline and the modifications that were made. It included details to encourage grief processing and applying a faith-based view of coping with grief through a narrative approach, realizing everyone has a story. Further, an overview of how data was collected and analyzed with awareness of possible bias leads to this intervention's interpretation and final report. Finally, chapters four and five will summarize the intervention results and the conclusions drawn from the data collection for evaluating this as a quality improvement project for Mercy Pastoral Services.

CHAPTER 4: RESULTS

The purpose of this DMIN project was to create a grief support intervention for Mercy patients who had experienced perinatal loss which provided them an avenue to process their grief experience that intentionally promoted emotional and spiritual health. The conceptual significance of this problem was clarified in chapter two's literature review, showing a deficit in the literature related to the spiritual dimension of coping with perinatal grief. In chapter three a description of the methodology outlined an intervention plan to address the problem at Mercy Hospital and the literature's deficit of relevant spiritual support. After implementing the intervention and collecting, analyzing, and interpreting the data, chapter four highlights the results gleaned from this intervention.

Generally, the anticipated result was that the project would demonstrate the value of grief support in a group setting where participants would find opportunities to express and process some of their feelings related to miscarriage grief Additionally, it was believed that the group experience would also enable the participants to realize solidarity in their experiences of early pregnancy grief. While the initial plan was designed for a group setting, it did provide the project leader with enough flexibility to offer support to patients in a manner that met their spiritual and emotional needs. The focus of the grief support was on encouraging patients to contemplate their grief experiences considering their life stories and how faith-based spirituality can provide a vital coping mechanism. Although group and individual sessions were originally offered, The apparent unanticipated need for and success of the one-on-one meetings led to a necessary

adaptation of the group meeting plan. Rather than offering individual and group sessions, the entire eight weeks were spent meeting and communicating with patients one-on-one.

Chapter four elaborates on the results of these interactions. The evaluation of the project came by analyzing the results of the patient survey at the end of the experience, the project leader's observational data, and the stakeholder feedback. All data gathered, whether qualifiable or quantifiable, is shown and discussed in this chapter. Patient privacy and data interpretation with negligible bias were prioritized in analyzing the results.

Patient Results

The six patients who participated in the project were able to complete a ten-question patient survey at the end of the eight weeks to express satisfaction with the intervention experience. This survey was modeled after other patient satisfaction surveys and adjusted to fit the parameters of this project. Five of the six patients completed the entire survey. One of the six completed only a partial survey. Those results were quantified for each question and are presented in figure 4.1 as accumulated patient results for each of the ten questions.

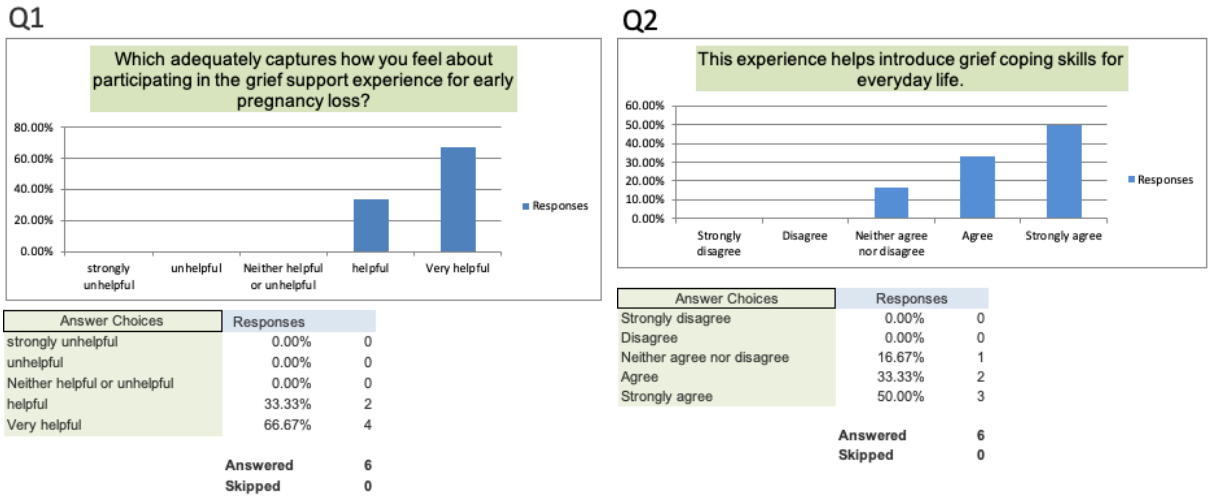
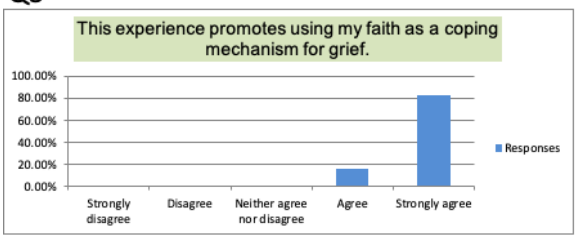


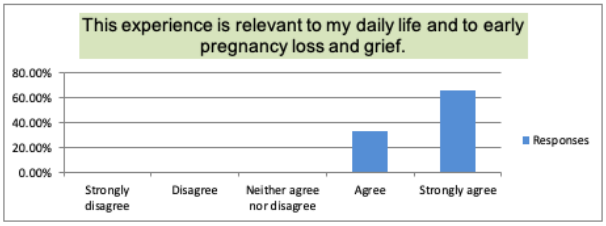
Figure 4.1. Accumulated Results from Patient Survey – By Question

Q3



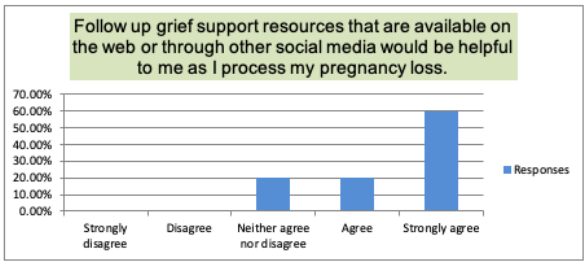
Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	16.67%	1
Strongly agree	83.33%	5
Answered		**6**
Skipped		**0**

Q4



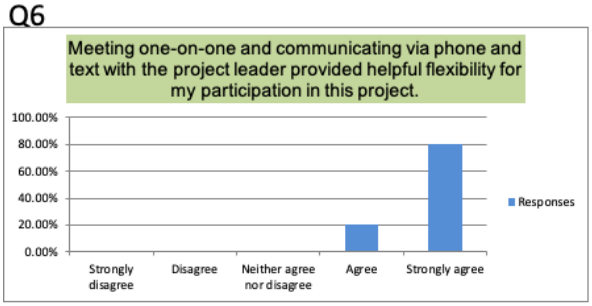
Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	33.33%	2
Strongly agree	66.67%	4
Answered		**6**
Skipped		**0**

Q5



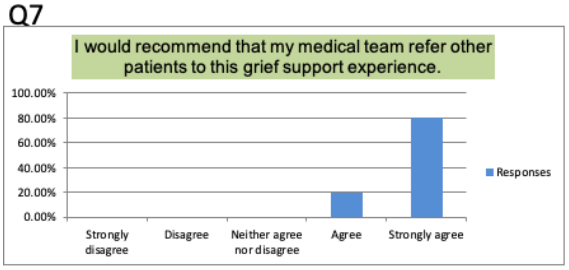
Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	20.00%	1
Agree	20.00%	1
Strongly agree	60.00%	3
Answered		**5**
Skipped		**1**

Q6



Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	20.00%	1
Strongly agree	80.00%	4
Answered		**5**
Skipped		**1**

Q7



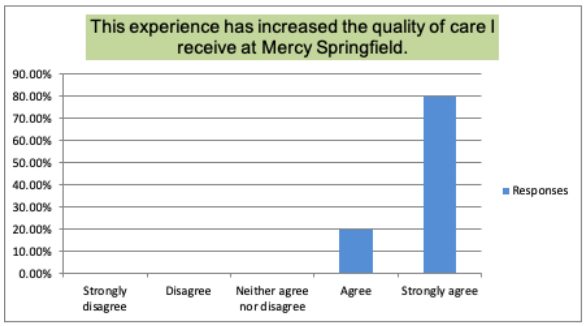
Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	20.00%	1
Strongly agree	80.00%	4
Answered		**5**
Skipped		**1**

Q8

Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	20.00%	1
Strongly agree	80.00%	4
Answered		**5**
Skipped		**1**

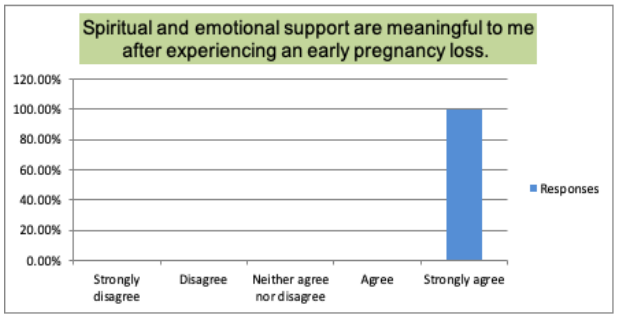
Figure 4.1. Continued

Q9



Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	20.00%	1
Strongly agree	80.00%	4
Answered		**5**
Skipped		**1**

Q10



Answer Choices	Responses	
Strongly disagree	0.00%	0
Disagree	0.00%	0
Neither agree nor disagree	0.00%	0
Agree	0.00%	0
Strongly agree	100.00%	5
Answered		**5**
Skipped		**1**

Figure 4.1. Continued

The overall results of the survey were favorable from the patient surveys. First, however, it is helpful to look closer at the intent of the survey questions and how that affected the overall conclusions of this project. Questions one through six and ten are inward-focused, they invited patients to evaluate their feelings and respond to how the project affected them. Questions seven through nine asked the patient to determine if their feelings would be strong enough about this project to influence others or reflect on the overall organization of Mercy.

A closer look at questions two through six initiate this discussion. Question two covered grief coping and received one neutral response and the rest agreeing or strongly agreeing. Question three addressed the project's emphasis on faith as a coping mechanism for grief which was a significant part of the purpose of this project. Patient responses agreed or strongly agreed that it was present in the project. Question four asked about the relevance of the project to the patient. All agreed or strongly agreed that it was relevant to them. Question five related to the Pastoral Services department and the possible new, more modern opportunities to support early

pregnancy loss in the future. The question queried where a patient in this demographic might go for grief support independently. This information will be necessary for implementing new grief support approaches by the Pastoral Services department. Question six speaks to the change in the original project design from a group setting to one-on-one meetings and if it was meaningful to the patient. Four patients strongly agreed it was helpful, and one agreed.

Questions seven, eight, and nine addressed the project experience from an outward perspective. Patient responses on questions seven and eight either agreed or strongly agreed to recommend this grief support program to their medical team as a referral source and to other people who have experienced early pregnancy loss. Question nine addressed the quality of patient care, influencing important patient satisfaction scores necessary for healthcare systems from a business perspective. Four of the five respondents strongly agreed that the experience of this project improved the quality of patient care at Mercy, with one patient agreeing.

Questions one and question ten are the culmination of the patient experience. Question one revealed that all patients answered in agreement. Two patients agreed that the experience was helpful, while four strongly agreed. All participants who answered question ten strongly agreed on the importance of spiritual and emotional support following early pregnancy loss. Overall, the patient responses were favorable for their participation in the experience of early pregnancy loss support.

Project Leader Results

Despite the change from the original plan, the project leader's responsibilities remained steadfast to facilitate this project upholding a patient-centered and sharing environment. This commitment also included actively listening to the patient and pointing them in a direction that would allow the personal discovery of meaning and purpose in the grief journey. In addition, the

project leader observed each patient meeting through the scope of professional chaplain training, carefully extracting the results.

At the end of every patient meeting, the project leader completed a five-question survey incorporating a Likert scale from one to ten, with one being low and ten being high. The project leader survey related to how the weekly communications with the patient met the goals of this project, which included evaluating the patient's level of engagement in the discussion, grief awareness, and willingness to consider a faith discussion. The weekly rankings were observational and subjective, based on the leader's professional opinion of the interactions and discussion. In addition, keywords and phrases that described the emotional and spiritual inclination of the patient that day were noted. The project leader deidentified and generalized the observed data to protect the participants' privacy. Finally, it was compiled and qualitatively analyzed using ATLAS.ti software to aid in coding and grouping data for consideration.

The data analysis of the project leader's weekly observations began with the emotional self-awareness of the patients following a miscarriage. Figure 4.2 showed a straightforward word accumulation that adequately portrays the broad range of feelings recorded by the project leader over the eight weeks.

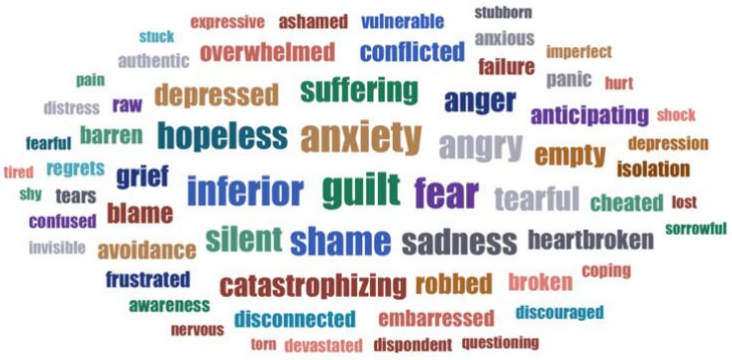


Figure 4.2. The Emotions of Pregnancy Loss

These words, either heard or observed by the project leader, represent a portrait of the patient emotions of pregnancy loss and grief, and many are referenced in chapter two's review of the literature.

While much of the patients' emotions reflected distress in their grieving process, a few responses not included above revealed a shift in the spiritual and emotional perspective. While "awareness" was listed above, the use of "awareness" in terms of "awareness of self and others" was noticed toward the end of the project. It further included feeling an "awareness" of suffering that the patients had not previously identified. Also observed was a new "awareness" of the internal struggle of wondering if the babies suffered and further an "awareness" of one's own "compassion" toward the lost baby and its suffering and the "awareness" of the development of more "compassion" for other people who experienced pregnancy loss. Compassion for self and others is also a shift in processing the emotions of grief. Other emotive words such as "hopeful," "grateful," and "thankful" were used on two occasions toward the end of the project and are significant signs of movement in the spiritual and emotional dimensions of self-awareness.

Participants in this intervention were invited to describe one feeling that could best depict their grief from pregnancy loss on that day. This was an exercise to promote emotional self-awareness. Figure 4.3 represented the frequency of feeling words most used by patients in this discussion. Interestingly, anger and angry are listed separately, but combined, they top the data at eighteen. When considering the dictionary meaning of each word, it clarifies a distinction in emotion. For example, anger as a noun means "a strong feeling that makes you want to hurt someone or be unpleasant because of something unfair or unkind that has happened."[1] Angry is an adjective describing "having the feeling people get when something is unfair, painful or bad

[1] "Anger" from Cambridge Dictionary. https://dictionary.cambridge.org/us/dictionary/english/anger?q=Anger.

happens."[2] Out of the presence of anger, one becomes angry. Through leader observation during this project, these definitions apply to grieving an early pregnancy loss where patients expressed their felt anger, kept it silent to others, or did not know how to express it. In saying one feels angry, patients felt safe expressing their silent anger through actions or words that felt to them more like being angry. The object of the patient's anger most generally was directed at themselves for the failure. In the various models of grief processing discussed in chapter two, anger, to some degree, is discussed in all the theories. However, it is found at differing points in the grieving process. Considering this, it is no surprise that the feelings of anger and being angry are represented so heavily in this data chart.

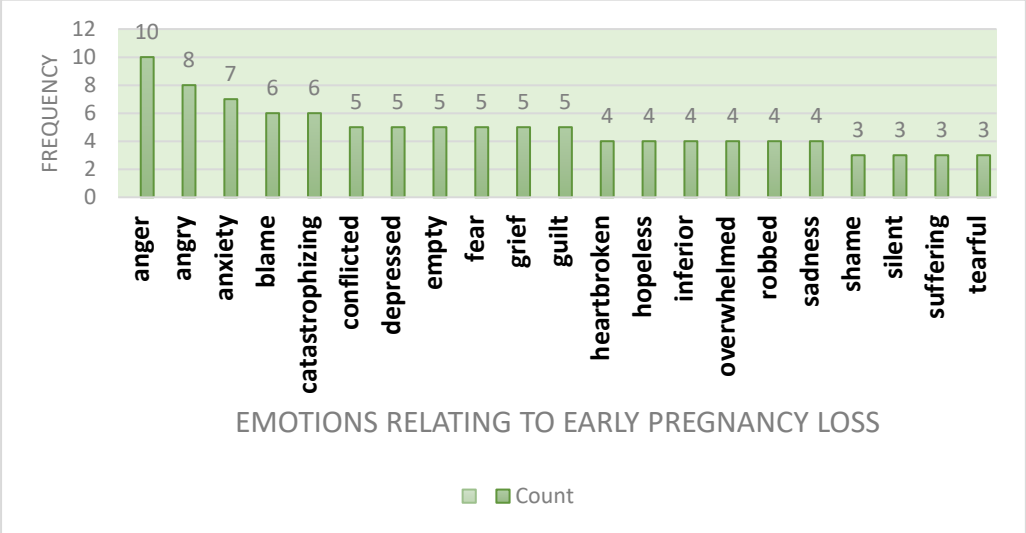


Figure 4.3. Most Used Emotion Words Relating to Early Pregnancy Loss

Conceptual Analysis

Because this project was a quality improvement project for Pastoral Services at Mercy Springfield, it is necessary to understand the concepts of pregnancy loss support that were present in the analysis of this project. The conceptual information benefits the Pastoral Services

[2] "Angry" from Cambridge Dictionary. https://dictionary.cambridge.org/us/dictionary/english/angry?q=Angry

department by providing a framework to promote appropriate spiritual and emotional health to early perinatal loss patients. The information garnered from the feeling words was heard or observed by the project leader. Figure 4.4 revealed the most relevant concepts of this project, and most are not surprising in the spiritual care of patients who have experienced early perinatal loss. From a chaplain's perspective, many of the concepts overlap with each other. For example, guilt, anxiety, anger, grief, avoidance, suffering, and failure may cause isolation. Additional clarification between avoidance and isolation, as well as discussing catastrophizing, is needed.

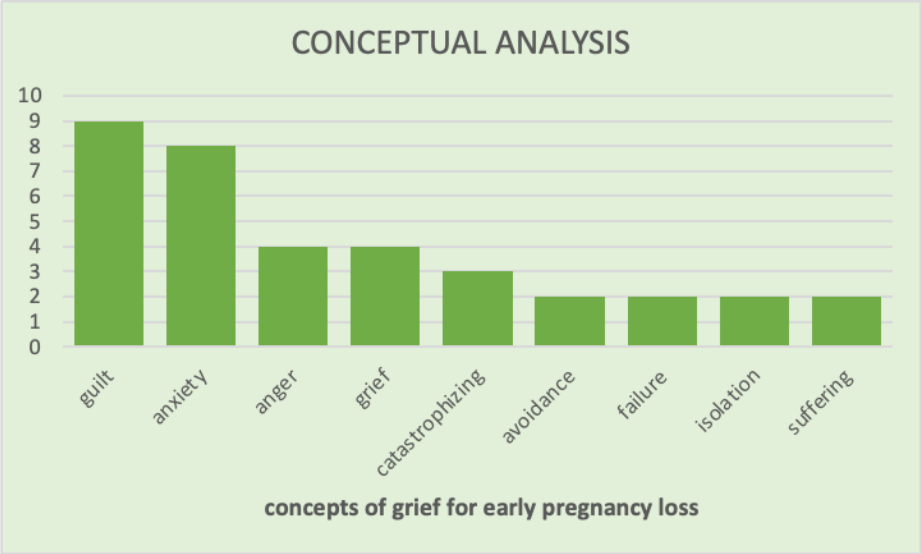


Figure 4.4. Conceptual Analysis of Grief for Early Pregnancy Loss

Considering this chart, explicating the difference between avoidance and isolation helps one's understanding of the differences in these concepts. Isolation is the act of isolating or setting oneself apart to protect oneself or others, such as how people responded to the coronavirus.[3]

[3]*Meriam Webster Dictionary* s.v. "isolation," accessed March 25, 2023, https://www.merriam-webster.com/dictionary/isolation.

Avoidance is "the action of emptying, vacating or clearing away" to protect self.[4] Both isolation and avoidance were part of the patient experience in this project. For example, when dealing with family and friends, patients avoided them to protect their hearts from further pain and avoided inflicting emotional strain on others. However, they also isolated themselves from family and friends because they did not know what to say, and it was emotionally overwhelming for the patients to converse about something so personal.

The project leader should have anticipated the concept of catastrophizing because some patients showed signs of struggling with this concept. One way was the victimization of self, where every challenging circumstance faced would always turn out for the worst. For example, the expectation was that every trip to the doctor always brought about more bad news because the doctor did not care about the patient. Further, catastrophizing is present in the loss of hopes and dreams where the loss of one baby meant no family, no grandchildren someday, and no one to carry on the family name, which would bring more shame. Finally, patients catastrophized by anticipating further pregnancy losses as the norm and expressed this concept to family members as a victim.

Weekly Survey Results

Following each weekly meeting with the patients, the leader completed a Likert survey interpreting the experiential data from a trained professional chaplain's perspective. This survey included five questions ranking each from one to ten. The project leader needed consistent observational criteria for ranking the five questions for each patient over the eight weeks. Figure 4.5 summarized the basic criteria for leader consideration when scoring the Likert scale. These

[4] Miriam Webster Dictionary, s.v. "avoidance," accessed March 25, 2023, https://www.merriam-webster.com/dictionary/avoidance.

were filtered through the professional training of the leader who attempted to remain conscious of potential bias.

OBSERVATIONAL GUIDELINES
Do they look engaged? visual cues -- makes eye contact, body language, is their phone put away, do they look comfortable, do they appear overly nervous, looking at the time
Do they sound like they are engaged? auditory cues -- are they commenting occasionally, are they speaking soft or loud, can I hear them? Are they asking questions, sharing freely about themselves.
Are they sharing their own opinions on things?
Is the patient interested in meeting again?
What feedback are they giving at the end of the meeting?
Are they consistently offering input?
If texting or calling, do they respond quickly

Figure 4.5. Leader Observational Guidelines

This observational data revealed that from the perspective of the group leader, the patients were very engaged in the activities during each meeting. They each participated sufficiently in the discussion, especially when discussing their grief. Because the patients appeared engaged in each week's meeting, the topics selected were relevant and helpful. Figure 4.6 ranked the five questions from highest to lowest by average score out of ten.

From the leader's weekly perspective talking about faith was most challenging for the patient. Those less engaged in or newer to their faith story struggled for words to engage more deeply in the faith discussion. In contrast, others with a definitive faith story felt more confident to engage in further discussion. No patient disregarded the opportunity to discuss faith as a coping mechanism for grief as inconsequential but merely looked more to the leader to direct the

discussion. Question four reflected this disparity as it ranks the lowest. However, patients grew more comfortable with faith conversations over the eight weeks.

Question	GROUP AVG.
Q1 Was the participant engaged in the activities?	9.05
Q2 Was the participant engaged in the planned discussion	9.05
Q3 Did the participant discussion mention grief and its impact?	9.47
Q4 Did the participant engage in any faith discussions?	7.77
Q5 Did the topics for this week seem relevant and helpful to the participant?	9.35

Figure 4.6. Data Summary from the Five Leader Questions.

Faith and Spirituality

The faith and spirituality component in the project leader's weekly evaluation was essential for evaluating the spiritual dimension of this project. While the overall goal was to provide patients with a weekly opportunity to examine their faith story and consider how they might use faith to cope with grief, it was necessary to understand each patient's faith story initially. All six patients had at least a basic knowledge or belief in God. While this was not a requirement to participate in the project, it was the reality of the experience. However, within this reality was a broad expanse between each patient's understanding and acceptance of God from a faith perspective. The patient's experiences with God and the church influenced some of this. One example is anger toward God for one's losses or being angry at the people who represented God or the church that did not meet expectations. Through the leader's weekly observations, the leader collected words either heard or observed relating to faith or spirituality.

Figure 4.7 revealed the most used words to connect spirituality and faith to the pregnancy loss experience.

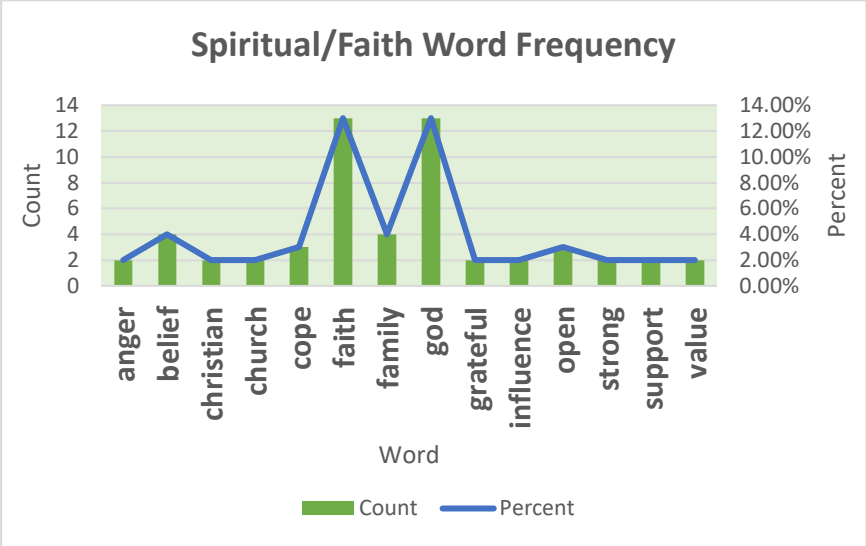


Figure 4.7. Spiritual/Faith Word Frequency

Of the patients that believed in God and understood their own faith story, there was typically a connection to a faith-based organization every week. The few patients who did not share that same depth of faith had a fundamental belief in God or expressed their anger with him or their disenfranchisement with God's people. Figure 4.8 demonstrated that the family unit, in the center of the chart, influences a patient's understanding of spirituality and faith. Intriguingly, the project leader observed this idea as having a positive and a negative influence on patients. Examples include patients who experienced the spirituality of a parent or parents and a conflicting spirituality of a beloved family member which caused diverged feelings of allegiance. Further, a lived experience of family members and friends who spoke of faith strongly, but their demonstration of this conflicted with their words, creating a hypocrisy of faith stories. When discussing how faith can be an important coping mechanism, all patients were open to

considering this. However, not all engaged in further discussion at a high level, as evidenced in data from figure 4.8.

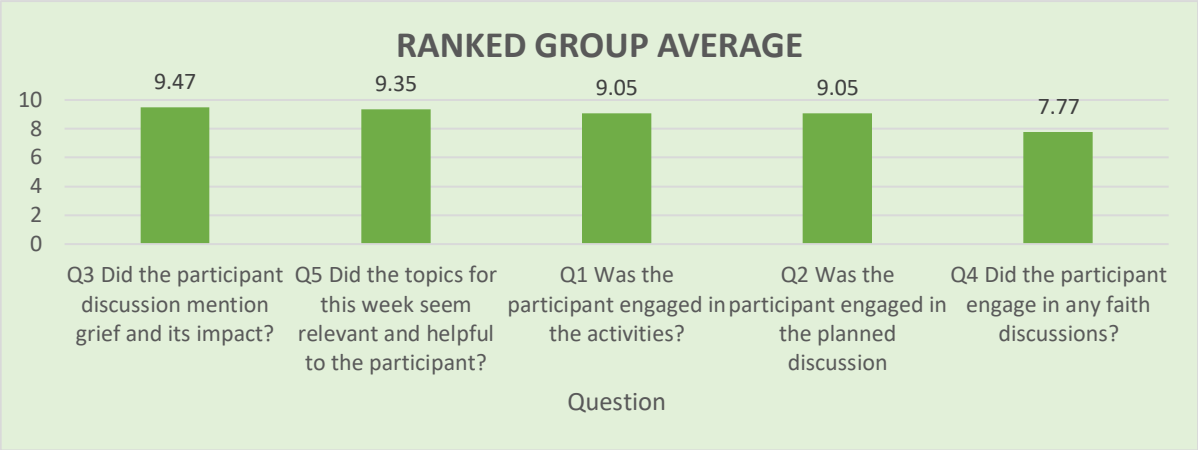


Figure 4.8. Leader Survey Questions Ranked Highest to Lowest.

Lived Experience

Everyone has a story that informs and inspires living. From a phenomenological approach, patient life stories were appreciated through their experiences with loss, trauma, and grief support observing it from a multidimensional approach of body, soul, and spirit. Knowing more about a patient's life story promoted appropriate spiritual and emotional support and quality patient care. The patient's eight-week experience offered opportunities to share and examine personal experiences more closely. Consideration was given to how it influenced their grief experience and how understanding one's own experiences more fully might also be helpful in the grieving process. While each patient had unique life experiences, significant phenomenological events were observed in patient storytelling that could influence their grief experience, coping mechanisms, support systems, and overall emotional and spiritual health. Significant life events translated for this analysis into five categories, including trauma from abuse or specific childhood trauma, significant death of a loved one, significant family

dysfunction, and recent losses other than pregnancy loss. Trauma could be one-time events or events that happen repeatedly. When observing the table below, it is also critical to note that an event or experience is significant if the patient mentioned it more than once during a discussion or more than once throughout the project when referring to their life story. Figure 4.9 disclosed the phenomenology revealed in the eight-week project. The information does not limit the possibility of other significant life events not discussed. Further, it also revealed that most patients experienced more than one significant life story event, which can add multiple layers of factors that influence a patient's grieving process.

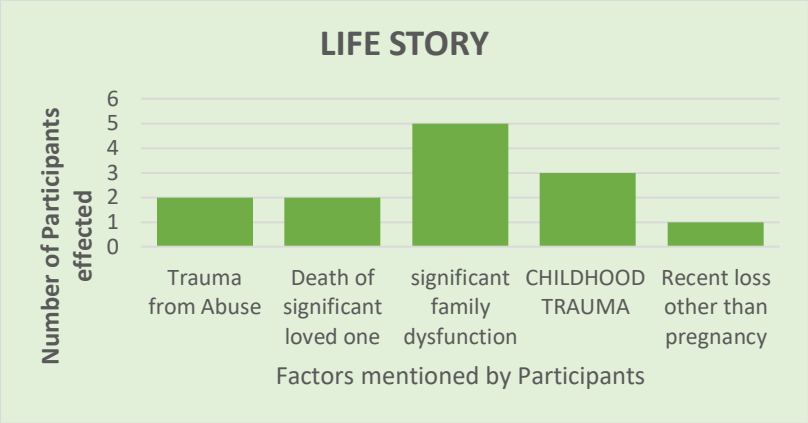


Figure 4.9. Life Story Data

Along with this discussion, some patients had been or were already engaged in ongoing professional support outside this project to process these significant life events. Others were guided in that direction by the project leader. Patients received a list of suggested and appropriate resources for consideration. Follow-up conversations to encourage additional professional support occurred during some check-ins. Most notably, the change to the original methodology was critical to this portion of the project. Meeting patients in a one-on-one setting allowed them the freedom to engage in an authentic conversation about some of these events in a safe and

private space where they had the freedom to engage at their comfort level. These results provided evidence of the value of one-on-one meetings to support the phenomenological approach.

Family and Friend Support

While early pregnancy loss patients were the focus of this project, one cannot overlook the value and influence of family and friends in the grieving process. Over the eight weeks, the project leader's observational reflections revealed that each patient affirmed the benefit of spousal awareness and support at least once and often multiple times. Patients reported that the support of their spouse in the grieving process was beneficial to them as it promoted the time and space to grieve in appropriate ways. Each patient expressed their appreciation for the companionship of their spouse in their grief journey at different times. They also observed that while their spouses grieved differently and expressed their grief in varying ways, there was still value in knowing one was not alone.

While the patients shared an overall positive opinion of spousal support, the extended family support varied. Some patients were not as close to their extended family, which made their lack of awareness of miscarriage grief either insignificant or more difficult. Some patients had not let their extended family know they were pregnant. Feeling the need to keep silent then about their loss added to the observed pain of silent grief and disenfranchisement.

There was an observable similarity to the role of friends in the grief process. Patients appreciated their supportive friends in the grieving process, some of whom shared a hidden experience of their early pregnancy loss. A few patients remarked receiving more support from their close friends than extended family. However, some friends did not appear to be aware of miscarriage grief or did not care about it because of insensitive comments and hurtful judgments that caused damage to relationships which augmented the patient's shame and blame. Other

friends did not acknowledge the loss of the baby in any way, despite knowing that it had occurred. As a result, it became awkward to be around those friends and reinforced the silent and disenfranchised grief concept and feelings of shame. Further, it promoted judgment from the patient about the friend.

The unique dynamic of being present with friends who are currently pregnant or just announcing their pregnancy challenged all the patients in this project because it reminded them of all they had lost. This circumstance propelled some patients into a spiritual crisis of asking, "why did this happen to me," and "why do they get to stay pregnant and not me." Pivoting the view from a friend's perspective, patients shared that their pregnant friends admitted guilt for getting pregnant or still being pregnant after the patient's loss. As the research indicated in chapter two, the wide scope of family and friend reactions occur in a culture where awareness of early pregnancy loss is growing. During this project, patient coping mechanisms were promoted within the friend and family discussions and additionally affirmed and encouraged during patient check-ins. Three basic coping strategies were discussed. They included how to have honest conversations with friends about one's own emotions, not settling to live in silent grief, and learning to advocate for self within friend and family relationships.

Meaning Making

As each patient shared their grief journey, they were encouraged to look for experiences to honor the life of their baby or babies. In the observational data the leader collected, while each patient's grief journey was unique, each patient selected a name for their baby or babies and decided on gender if there was not a gender identified. Interestingly, naming the babies took place on their own accord before the project started, and each patient shared this information with the leader early in the project. When asked why this was done, patients reflected that they

wanted a way to acknowledge the life that was created as a “real person” and not just a loss, a medical procedure or a “glob of tissue.”

The project leader used the baby names in conversation to acknowledge life. As part of the plan, a time was set aside to meet as a group to honor all the babies. Suggestions for meaning-making spurred many discussions over the eight weeks. The group gathering did not occur for the patients to participate together; however, every patient fully participated in planning their personal meaning-making ritual, and they were each significant to the patient. Whether going to the cemetery to lay flowers on a grave, designing a unique tattoo, planning a private memorial service, naming the babies, and talking out loud about them, or simply knowing the baby had a proper burial, the rituals chosen were as unique as the patients’ grief experiences. Some patients did more than one ritual; for others, one was challenging but essential. Overall, this experience provided a chance to recognize the baby’s life which brought meaning to the patients. After discussing the analyzed data of the patient survey and the project leader’s observational data, attention turns to discussing the stakeholder evaluation.

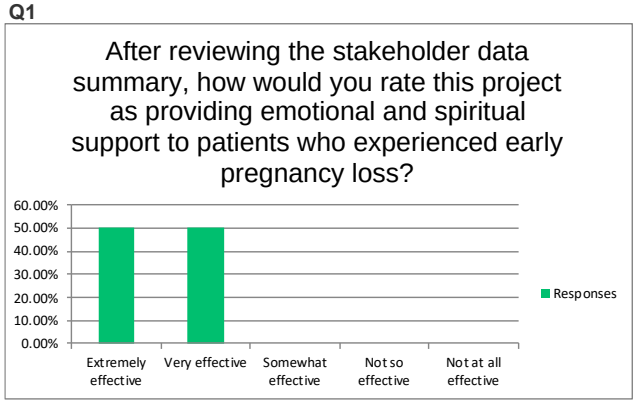
Stakeholder Results

Seven stakeholders were designated to review selected data from this project. Their purpose was to evaluate the effectiveness of the project to provide quality patient care within the framework of the project’s problem and purpose statement. Their analysis provided input from Pastoral Services and an interdisciplinary viewpoint. Three of the seven stakeholders serve in the Pastoral Services department, three in the leadership of the Obstetrical and Gynecological/Labor and Delivery Service Line at Mercy, and one oversees bereavement care for the mother/child service.

Once the stakeholders reviewed the compiled data, they completed a survey. Six of the seven stakeholders responded to the survey. The survey consisted of seven questions requiring stakeholders to give opinion answers designed in a Likert scale model. The last three questions were open-ended to allow for individual feedback. The stakeholder survey results were combined and presented by each question in figure 4.10.

Stakeholder Survey by Question

Q1

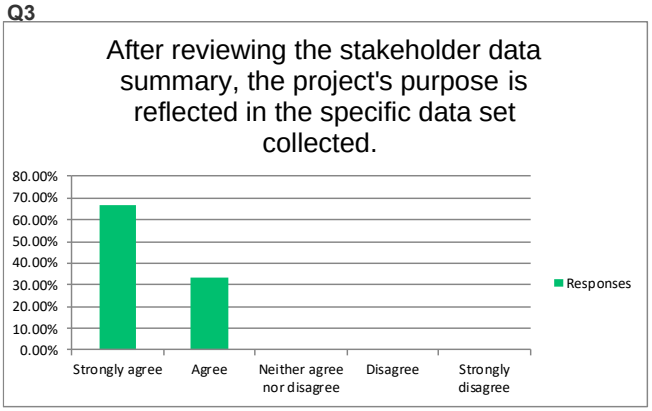


Answer Choices	Responses	
Extremely effective	50.00%	3
Very effective	50.00%	3
Somewhat effective	0.00%	0
Not so effective	0.00%	0
Not at all effective	0.00%	0
	Answered	**6**
	Skipped	**0**

Q2

Answer Choices	Responses	
Very likely	100.00%	6
Likely	0.00%	0
Neither likely nor unlikely	0.00%	0
Unlikely	0.00%	0
Very unlikely	0.00%	0
	Answered	**6**
	Skipped	**0**

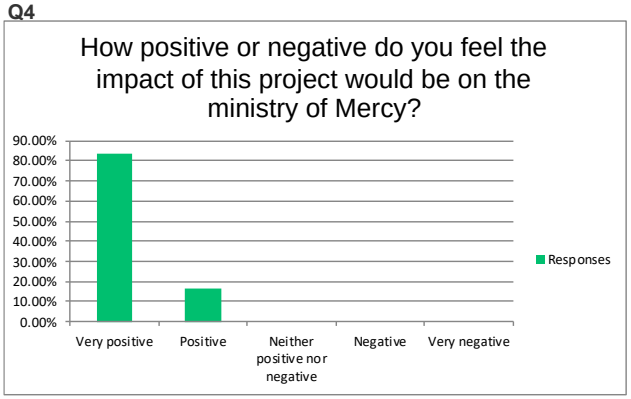
Q3



Answer Choices	Responses	
Strongly agree	66.67%	4
Agree	33.33%	2
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
	Answered	**6**
	Skipped	**0**

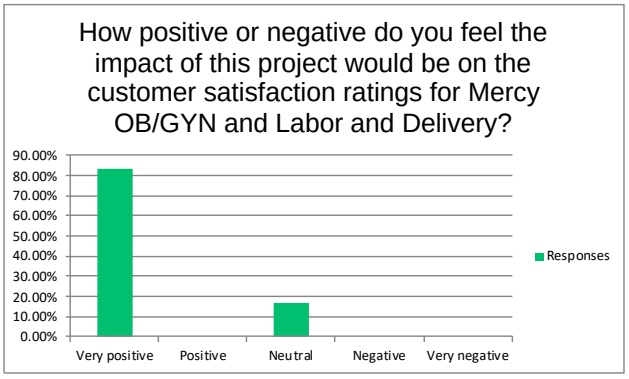
Figure 4.10. Stakeholder Survey Results by Question

Q4



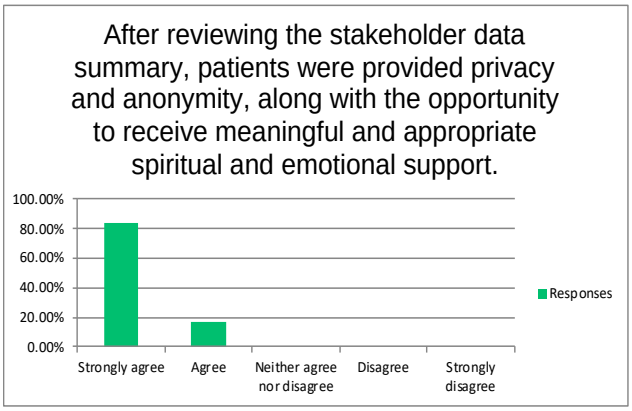
Answer Choices	Responses	
Very positive	83.33%	5
Positive	16.67%	1
Neither positive nor negative	0.00%	0
Negative	0.00%	0
Very negative	0.00%	0
	Answered	**6**
	Skipped	**0**

Q5



Answer Choices	Responses	
Very positive	83.33%	5
Positive	0.00%	0
Neutral	16.67%	1
Negative	0.00%	0
Very negative	0.00%	0
	Answered	**6**
	Skipped	**0**

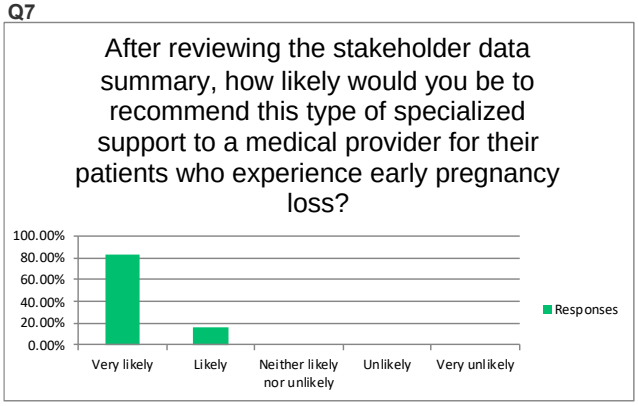
Q6



Answer Choices	Responses	
Strongly agree	83.33%	5
Agree	16.67%	1
Neither agree nor disagree	0.00%	0
Disagree	0.00%	0
Strongly disagree	0.00%	0
	Answered	**6**
	Skipped	**0**

Figure 4.10. Continued

Q7



Answer Choices	Responses	
Very likely	83.33%	5
Likely	16.67%	1
Neither likely nor unlikely	0.00%	0
Unlikely	0.00%	0
Very unlikely	0.00%	0
	Answered	**6**
	Skipped	**0**

Figure 4.10. Continued

In summary of this data, the stakeholders recognized the value and benefit of this project. Notably, the first seven survey questions covered two broad topics: did the project promote quality patient care, and what is the future of this project? Questions one, three, and six addressed the first idea and incorporate the stakeholder evaluation of the project through the data. Questions two, four, five, and seven spoke to the second broad idea and assessed the value the stakeholder placed on the project relating to others. In question one, the stakeholders rated the effectiveness of the project as both extremely effective and very effective. In question three, the stakeholders sensed the project's purpose in the summary of collected data. Their strong

ranking affirmed to the project leader that its integrity was maintained despite the change to the project implementation. The patient and project leader data results also affirmed this notion. Question six explicitly related to the ethics of the project and the commitment to protect patient anonymity. The stakeholder group is conscientious of privacy in patient care and the felt vulnerability of grief associated with pregnancy loss and its uniqueness to each patient. Together with the project leader's commitment to keeping the project within HIPAA standards and per Mercy's IRB, question six responses affirmed the protection of the patient in accordance with providing appropriate spiritual and emotional support.

Question two helped determine if the stakeholder, based on the reviewed data, valued the results enough to recommend this experience to others. A one hundred percent response of very likely was received. Question four asked the stakeholder to think of the ministry of Mercy in general, which coworkers know well. The reference to Mercy's ministry also inferred how this project reflected the organization's mission, values, and charisms, which are well-known to the stakeholders. Five of the six responses were very positive, and one was positive. This response reflected strongly on the design and intent of the project to provide quality patient care through the mission of Mercy.

Question five addressed the important customer satisfaction ratings that influence the healthcare business. Five were positive, and one was neutral. When considering the application of this project from the business perspective, these ratings were favorable for the future of all or some of this project. Question seven was critical from an interdisciplinary setting to foster the education and involvement of the providers in making referrals and understanding another benefit of holistic care for their patients. Five stakeholders agreed that the data influenced them to very likely recommend this type of support to providers and their patients. One stakeholder

agreed that likely they would. These responses also spoke strongly about the continued opportunity to raise awareness among providers relating to their patient's spiritual and emotional needs and the ease of availability to request professional support.

Questions eight, nine, and ten were open-ended, to invite stakeholders' feedback. This opportunity yielded comments that will be worthy of future consideration. See figures 4.11, 4.12, and 4.13 for the detailed responses to each question, followed by additional discussion.

Q8	As a stakeholder, what are some obstacles that you see to incorporating some of all of this project to improve patient care?
1	A more robust team of trained personnel to provide the support for this population.
2	Buy in from leadership to fund the work. Patient's that want to participate
3	Being as it was one on one. Time and availability may be an obstacle.
4	Is there an order set that invites participation? Universal adoption within ob/gyn clinic.
5	Not really an obstacle, but how long is this "support" available to the mother/family?
6	The project demonstrates how well the patients were cared for but it does not reflect the preparation of the project leaders.

Figure 4.11. Question 8 Stakeholder Survey Open Comments

Question eight responses gave quality feedback from the stakeholders who best understand the service line and the connection between spiritual and emotional support to the patient's well-being. The emphasis on personnel, preparation time, and funding is essential when considering the future application of all or part of these results. It was beneficial to consider having a specific order set that is easily accessible to providers and caregivers, directly referring a patient to Pastoral Services for early pregnancy loss support through the electronic health record. This considered the efficiency and convenience of coworkers as they chart and place orders for other patient services similarly. When regarded in this light, adding an order set for this support is sensible. However, the bulk of this support is outpatient-based; therefore, further discussion would be valuable.

Q9	As a stakeholder, what do you like most about this project?
1	The personalized approach to grieving and healing. Each patient is unique in how they process and cope.
2	Support for grieving mothers
3	It clearly demonstrated that there is a need for bereavement support and that support affects how mercy is viewed.
4	Flexibility in adapting the needs - wants of the participants.
5	This is so important in the journey through grief that is "forever," follow-up for these families would be a great service.
6	The patients were able to identify the emotions they felt and were able to express their source of healthy spiritual and emotional coping.

Figure 4.12. Question 9 Stakeholder Survey Open Comments

Question nine responses brought forward some observations from the stakeholders that emphasized the need for and impact of this project. The responses recognized the uniqueness of grief and having a unique follow-up grief support experience as a positive for Mercy and its patients. These responses also validated that given an eight-week opportunity to process grief, the patients demonstrated their ability to identify emotions and express their faith and spirituality to some degree. Interestingly, one stakeholder shared their experience with pregnancy loss and grief. It further validated the need for robust pregnancy loss support opportunities that do not end with a packet of grief support materials to send home with the patient.

Q10	As a stakeholder, do you have feedback or suggestions about this project?
1	Wonderful and meaningful work.
2	This project should become standard practice
3	It is a good beginning place. Perhaps repeating to gain a larger pool of participants would be helpful when thinking of designing, implementation, and impact of the program.
4	A larger population set. The results were, however, encouraging
5	Much NEEDED and Mercy has the spiritual backing to give these families the support they desire.
6	This was so well put together, and it helped to understand how significant the initial encounter is. And how important the follow up is to learning how to process the journey.

Figure 4.13. Question 10 Stakeholder Survey Open Comments

Question ten invited the stakeholders to offer personal feedback and suggestions. Their feedback was valuable to the project and supported the overall purpose of the project to provide quality patient care to patients experiencing early pregnancy loss. Repeating the project with a broader pool of patients to increase the data gathered is a critical observation. In addition, it would provide a greater scope of information to process this program's future design, implementation, and impact. Finally, the observation is that "Mercy has the spiritual backing to give these families the support they desire." This comment once again affirmed that this project supported Mercy's mission, vision, and charisms as much as Mercy's mission, vision, and charisms informed the creation of this project. Now from chapter four's evaluation of the data, this writing will move to the final chapter. Chapter five will address the conclusions that have been drawn from this project as well as the limitations and considerations for further research.

CHAPTER 5: CONCLUSION

The problem, purpose, and thesis statements developed in chapter one of this DMIN project express the need to develop a more relevant support system for patients experiencing perinatal loss at Mercy Hospital. In addition, the literature review revealed a need for more research on the value of spirituality in coping with perinatal loss. In chapter three, a detailed intervention addressed the problem through an eight-week grief support methodology, and chapter four revealed the results of the completed intervention. To complete this project, chapter five will discuss the conclusions from the intervention and the data, including the implications, applications, and limitations.

Research Implications

From a patient perspective, the most obvious implication of the research is the positive patient survey response corroborating the need for meaningful grief support following early pregnancy loss, to which the stakeholders strongly agreed. Further, the patients affirmed the helpfulness and relevancy of the methodology. The one-on-one approach gave patients a custom experience meeting their needs and lifestyles. For them, it was the best-case and most convenient scenario for examining private pieces of their sacred stories. In addition, it invited them to build a relationship with the project leader and a comfortable level of trust to share their experiences. In a group setting, the quieter patients can remain in the background, observing others, possibly not fully experiencing the process, or letting others into their grief experience. However, meeting with patients individually made it more challenging for introverted patients to remain on the

sidelines and allowed these same patients to feel heard in a safe space, meeting them where they were most comfortable.

The apparent agreement seen from the data results between questions seven and eight of the patient survey and questions two and seven of the stakeholder survey implies a substantial value given to the project. It is noteworthy because it relates to patients and stakeholders recommending the grief support project beyond themselves to others, including friends, colleagues, and providers. They supported the project personally and are willing to be a referral source in the future. This endorsement implies another means of corroborated support to measure the meaningfulness of providing quality spiritual and emotional patient care in the ministry and business of Mercy.

The observational data also implied that the patients were open and responsive to the opportunity to discuss the impact of their life stories and their faith as a coping mechanism. Further, this implied that being one-on-one did not hinder this. Their emotional awareness grew through the eight weeks implying their emotional intelligence also grew. Their comfort with faith conversations also grew over the eight weeks based on their willingness to talk more directly. The week-to-week upward trend of the leader's data on this subject revealed this growth. This growth also implied a measure of spiritual growth as well. The emotional awareness and the continued development of the patients' faith stories implied that the programming was helpful and relevant to the varied and unique patient experiences and stages of grief and faith development.

Finally, figure 4:9 implied that the patients who participated in this project were dealing with multiple experiences that influenced their grief in some way. Some patients carry heavy burdens, including post-traumatic stress from past trauma and loss. Others maneuver more recent

family losses in addition to their current losses. While this is common in our culture, the effects of multiple layers of grieving became more evident in the leader's observations. For healthcare workers, it implies that when caring for patients, one never fully knows what informs the reactions and responses. When patients walk into a room or come to the hospital, they are silently accompanied by many other experiences that can shape who they are in all dimensions of their being. This implication elicits more questions beyond this project's scope, but it reveals the need for sensitivity to accept patients where they are, knowing there is more to their story than is seen. In a ministry setting, it implies a spiritual and emotional need and reinforces God's continual workmanship in his beloved. This implication also reveals that the opportunity for chaplains to serve specific patients is more than incidental; it is a sacred calling and divine appointment to provide spiritual and emotional support to hurting people.

Research Applications

Applying the research results will influence the quality of care of patients who experience early pregnancy loss at Mercy Hospital. In addition, it will positively inform the continued goal to raise awareness of the presence of grief from miscarriage in modern culture. This awareness will affirm and encourage others who have experienced the silent grief of miscarriage that they are not alone. It will also influence awareness with family, friends, and the community, further providing support for patients once they leave the hospital or clinic.

Within patient care, the application of this research promotes expanded options to care for patients not only in the hospital but after leaving and before coming. A particular concern for patients who have had previous losses will include inviting them to process their experiences in a meaningful way. Connecting with patients concerned about pregnancy loss before it is medically confirmed is another application of the project that provides an opportunity to promote

meaningful processing and coping prior to the loss experience. Knowing that each pregnancy loss experience is unique makes it difficult to define "meaningful" in general terms. However, from this research understanding the uniqueness of the patient's experiences is the beginning point of care. Asking the patient, "how can I best help you right now?" is a straightforward way to define meaningful care in general terms.

This research will be applied to evaluate the standards of care in the Pastoral Services Department at Springfield Mercy. In the ever-changing healthcare industry, there is a constant need to evaluate and elevate quality care for patients. Through research, information is gleaned to support encouraging, updating, and redirecting care methods. The Pastoral Services Department will consider this project and its apparent implications and applications to better serve patients in the obstetrical and gynecological service line. One primary way is to evaluate the grief support information given to patients to take home. Is support material relevant and robust enough to be meaningful to this generation of patients? Question five of the patient survey addressed the application of this idea. It asked about relevant grief support resources through social media and the web. Three patients answered, "strongly agree" that this resource would be helpful, one patient answered "agree," and one patient answered "neither agree nor disagree." This response affirms the need to further consider other options for bereavement care outside of handing the patient more paper to take home and set aside.

As has already been stated, the research can be applied to raise awareness of the need for grief support following early pregnancy loss. It includes awareness within Mercy Central Communities as well as Mercy system wide. Beyond mere awareness, the application of this research in healthcare also creates an opportunity to continue to advocate for patient support in the spiritual and emotional dimensions. Speaking among the interdisciplinary team about the

importance of our patients' multi-dimensional health needs invites awareness and application to promote quality patient care. To begin, asking the practical question, "what does it look like to provide quality care for our patients spiritually and emotionally after they have suffered an early pregnancy loss?" initiates discussion and fosters awareness.

Raising awareness among extended family and friends could also apply to this research as encouraged by the leader's observational data. A straightforward way to apply this research would include extended family and friends discussing the pregnancy loss experience and the meaning-making rituals. Although it is not always appropriate to include extended family and friends in honoring-life rituals, it would be an applicable consideration. Further, consideration of the need for grief support for the patient's spouse or significant other is another way to apply this research in helpful ways. Supporting family can be a source of support to the patient. Applying more of the leader's observational data in this manner could be helpful.

Research Limitations

While the data analysis was favorable for this project, noticeable limitations surfaced during the intervention evaluation. To begin, the project's scope limited grief intervention to Mercy patients and did not include support for spouses, significant others, extended family, or friends. Based on observational data from this project, it could be beneficial to patients to know that others who are walking this grief journey with them could also receive support. Many patients referenced their spouse or significant other as a partner in grief, drawing strength from their presence. The limitation of patient participation narrowed this project's scope to focus on quality patient care. It could be argued from the data that to care for the patient's partner is to care for the patient.

Secondly, this project was limited to a grief intervention model for pregnancy loss before twenty-five weeks gestation. While many of the same effects on the body, soul, and spirit exist in all pregnancy loss, there could be unique needs for grief support for later pregnancy loss. The age of viability designation discussed in chapter two makes it possible that pregnancy loss after twenty-five weeks would include the baby living briefly, increasing the potential of parents holding the baby for a short time and making additional memories outside the womb. This further intensifies the unique bond between the patient and the baby. Therefore, study of hosting a grief support group specifically for pregnancy loss over twenty-five weeks is beneficial, potentially using the same structure.

The same consideration is needed for patients who are struggling with fertility issues. During this project, some participants shared their struggles with fertility issues relating that their losses occurred following infertility intervention. While Mercy Healthcare, as a Catholic entity, does not practice invitro fertilization and embryo adoption, patients attempting these methods receive obstetrical care from Mercy providers. This care includes miscarriage, delivery, and postnatal support. Further, complicated grief and social pressures from pregnancy loss were observed if the parents are experiencing infertility issues, have invested thousands of dollars, and spent years trying to have a child. This lack of intentionally designed spiritual and emotional infertility support somewhat limited this project in caring for these patients. However, through awareness and specific research, this limitation is now viewed as a possibility. Therefore, pursuing additional research to better serve patients in this demographic would not be difficult.

Thirdly, the size of the group limited the data received. A larger patient population would have made the data set stronger and broadened the scope of patient experiences. However, because of the time and staff limitations adding additional patients to the modified plan would

have needed to be simpler for the project leader to manage. Further, the number of available patients who agreed to participate was limited. Nevertheless, a new eight-week project with different patients would have strengthened the data results. The stakeholder feedback referenced this limitation on question ten.[1]

Also, patients were limited in their participation by a parameter establishing the length of time since their loss. If a patient had a pregnancy loss within six months prior to the start of this project, they were eligible for consideration. It was set as a limitation because it is most common that within six months after a loss, patients in this age demographic are trying to conceive again or likely are already pregnant. If a pregnant patient has difficulty with grief from a previous loss, there would be no reason to exclude them from one-on-one support. However, it would be generally challenging for participants to be comfortable with someone pregnant in a grief group for pregnancy loss. Based on observational data from this project, this is a valid limitation for all patients.[2] This limitation would need to be considered in part or entirely in the future for group support for the previously stated reasons. However, if support continued to be one-on-one, it would be a less critical limitation.

Finally, the original project plan was designed to match the biblical model of the disciples experiencing life transformation together as they experienced Jesus' earthly ministry and later with others in the book of Acts, where believers met together and strengthened one another. Although the original plan changed, meeting with patients in a group setting at least once was still an option. When this did not happen, it limited the project from having a broader

[1] "Perhaps repeating to gain a larger pool of participants would be helpful when thinking of designing, implementation, and impact of the program," and "I would have liked to have seen a larger population set. The results were, however, encouraging."

[2] It directly relates to one of the comments from question eight on the stakeholder survey, "How long is this 'support' available to mother/family." Further patient comments include, "It is hard to be around people who are pregnant and to experience their joy at finding out they are pregnant because I want to be that way too."

experience with one another. Meeting with patients one-on-one provided a strong individual experience for this project with good data to support it. Nevertheless, it limited the patient experience to their own and did not allow them to experience other grief stories, such as in a group setting. There is much to gain from sharing with and learning from others who have walked a similar path. While no two grief experiences are the same, sharing about one's journey of suffering and being allowed into the suffering journey of others creates a solidarity unfamiliar to others who have not journeyed the same path. In addition to the three reasons patients did not want to meet in a group listed in chapter four, it is unclear if the recent worldwide pandemic may have indirectly influenced or limited patient desire to gather in a group. Regardless of the substantial outcome of this project, the supporting "one another" portion of this project was limited.

Along this thought process, the adjusted plan also limited a group gathering or celebration to honor created life. The observational data included the observed importance for patients to begin making meaning out of pregnancy loss. One important way to accomplish this is to use meaningful rituals. The one-on-one approach limited the celebration of rituals to one-on-one experiences only. Having conversations about making meaning, finding ways to celebrate the creation of a baby, and celebrating parenthood are just a few simple things that can be ritualized to help with the grieving process. Not doing this in a group setting limited the opportunity to give honor to other parents while honoring oneself. In review, some realizations have occurred in the summation of this project that would benefit from further research and thinking outside the box.

Further Research

Further research is needed on how to include patients' spouses or significant others. Chapter two's literature review indicated that the family of a patient experiencing loss is also affected by grief.[3] Observational data from this project indicate that as the patient's family processes grief, they influence the grief process of the patient. At the same time, this is both positive and negative. One benefit came from strengthening the relationship with the spouse or significant other. A negative could be one spouse putting pressure on the other to feel or act a certain way. There is limited data to know the interest level of the target demographic to attend a couples support group, and this research would be beneficial to determine the next steps. For example, planning a mixed-gender group might delve less deeply into personal experiences. Moreover, the spouses and significant others could meet simultaneously but separately from the patients or combine both in a mixed methods approach. Research would be needed to determine what would best fit the demographic. Considering this, it could raise family awareness of the unique grief of early perinatal loss and foster stronger relationships within the family unit. Further research in this area would provide needed guidance as well.

Because Mercy is a regional hub in the patient referral process, the scope of patients reaches beyond the providers within the Springfield, MO community and Mercy Healthcare. Through this project, a need has arisen for a better understanding of how to serve the spiritual and emotional needs of patients who have received lethal pregnancy diagnoses and as they ponder the next steps. Individual grief responses from the immense weight of moral and psychological challenges involve deep shame and guilt about wrong decisions, post-traumatic

[3] Sunita Osborn, *The Miscarriage MAP Workbook*, 49-53.

stress disorder, and potential religious, familial, and social rejection.[4] It is a unique opportunity to promote emotional and spiritual health and to journey with patients in an extreme crisis.

It was observed during this study that the demands of healthcare and the specific pace of patient care could make it difficult for the medical team to be keenly aware of the impact of pregnancy loss, most notably in the clinic setting. The pace and industry demand often place medical professionals in an overwhelming daily grind. They feel pressure to meet quotas and find a way to increase their practice while reducing the bottom line. There is a constant need for chaplains to stay present and seen to remind staff of this resource. The specific question of why this is happening in the pregnancy loss area and how to effectively educate staff would be research worthy. Further study promoting a multi-dimensional staff self-care model in the clinic setting could benefit staff well-being. Including the Schwartz Rounds experience in this research is logical because Mercy endorsed this program.

In addition, research on the most effective ways to educate the Pastoral Services departments across the central community on caring for pregnancy loss patients would add to the regional effect on the quality of care provided for pregnancy loss. Other hospitals in the central community do not extensively provide spiritual and emotional support to early pregnancy loss patients through the Pastoral Services department. However, some hospitals have a Heartprints group to oversee bereavement support.[5] The staff are trained in grief support but do not necessarily support the spiritual component. Research is needed to understand better how these services could complement each other.

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[4] Kim Kluger-Bell, *Unspeakable Losses*, 71.

[5] Mercy HeartPrints is a program offered to support families who experience the loss of a baby at any time during pregnancy or the newborn period, including neonatal death, stillbirth, miscarriage, or ectopic pregnancy.

Further research is needed on raising awareness of the need for specialized chaplain training for maternity support across the ministry of Mercy. It includes raising the awareness of spiritual care providers on the effects of spontaneous and induced pregnancy loss on patients and the specific needs of patients treated in obstetrical departments. While there are many similarities to the perceived needs of patients in this area and other hospital areas, there are also specific nuances to be further curious about. Further studying the uniqueness of pregnancy loss grief and how hospital chaplains and local faith communities prepare to provide appropriate spiritual and emotional support is critical to promoting awareness and providing quality patient and parish care.

Because of its connection to the Catholic Church and their beginning of life ethics, abortion is not in the scope of practice for Mercy Healthcare. However, an opportunity exists to treat patients within Mercy who have complicated grief related to their choice of abortion. Further research would provide a better understanding of how to compassionately care as demonstrated in the life and ministry of Jesus Christ to love all and serve all. In addition, it augments the mission, values, and charisms of Mercy Healthcare to a community of underserved patients. Specifically, in the clinic setting, patients are seen for various obstetrical and gynecological issues where their history of abortion is discussed. Therefore, studying ways to make resources available for the clinic team to refer patients for appropriate emotional and spiritual support and promote staff awareness of post-abortive patients' emotional and spiritual needs could be beneficial research.

In a final summary, the project's problem, purpose, and thesis statement express recognition of the need to evaluate the quality of spiritual and emotional care offered to patients who experience early pregnancy loss, which the data affirms. This aligns with Mercy's mission,

values, and charisms as a faith-based institution where life is valued from conception to the end, no matter the days, weeks, months, or years. Caring for patients experiencing pregnancy loss relates to the four primary ethical values of justice, beneficence, nonmaleficence, and autonomy. It further supports the faith-based values of loving and serving all as Christ, caring for those who suffer, and caring for the least who have no voice to advocate for themselves. In the final review, consideration of the problem, purpose, and thesis statements of this project will once again take place.

The problem at Mercy Springfield is inadequate ongoing emotional and spiritual grief support for miscarriage patients. Early pregnancy loss, commonly known as miscarriage, is more typical than many realize, making an adequate statistical analysis most difficult. However, based on this research, it cannot be denied that as high as one in four pregnancies could end in miscarriage.[6] The experiential writing of the literature in chapter two and the project leader's observations affirm the presence of the silent suffering of miscarriage. While each experience is unique, similarities exist in grief's disenfranchisement, guilt, shame, anger, hopelessness, sorrow, anxiety, fear, and feelings of failure, to name a few. In addition, patients report receiving adequate medical support from healthcare providers but very little care from a spiritual and emotional perspective.[7] While care for the physiological needs of the patients requires the expertise of the healthcare providers, emotional and spiritual support is the expertise of professionally trained Chaplains. This statement does not infer that healthcare providers should not provide spiritual and emotional support but that it is not their primary expertise.

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[6] "Miscarriage" March of Dimes, last modified in 2017, https://www.marchofdimes.org/complications/miscarriage.aspx and "Miscarriage," StatPearls Publishing National Library of Medicine, last modified May 8, 2022, https://www-ncbi-nlm-nih-gov.ezproxy.liberty.edu/books/NBK532992/. "Miscarriage," World Health Organization, https://www.who.int/news-room/spotlight/why-we-need-to-talk-about-losing-a-baby.

[7] Julia Bueno, *The Brink of Being*, 18.

The purpose of this project was to explore the impact of a unique ongoing grief support opportunity offered to fetal loss patients. After participating in the grief support project, the patient completed a survey. The grief support experience, while initially designed as a support group project, in reality, provided one-on-one, online, and check-in support for participants. In addition, the change in design offered new opportunities to provide individualized support in a more private setting for patients to process and share at their own pace.

Finally, the thesis reflected the hope of influencing the quality of patient care in Mercy Springfield's obstetrical service line. If Mercy offers extended grief support to miscarriage patients, they will be assisted in processing their initial grief, promoting emotional and spiritual health and quality patient care. Although limited by the number of participants and stakeholders, the data analysis and interpretation supported the project thesis. It affirmed the personal need for this support, and patients and stakeholders strongly agreed that they would recommend it to others.

Whether in ministry, healthcare, or both, this project has shown strong support for a methodology to provide meaningful grief support following early perinatal loss. The research results affirmed the patient's need for support, and this project design supported the problem, purpose, and thesis statement. It remains the goal of the project leader to use this work to increase public awareness and further provide opportunities for spiritual and emotional support to patients, coworkers, and the community to whom Mercy has committed itself in the healing name of Jesus Christ.

APPENDIX A

CONSENT

Title of the Project: A Grief Intervention for Perinatal Loss
Principal Investigator: Dani Helm, candidate for DMIN, Liberty University
Co-investigator(s): Mentor, Dr. Lucien Fortier, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To be eligible to participate, you must be at least 18 years of age and a patient of Mercy Hospital who has experienced a fetal loss in the last six months. Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

For this project, the problem at Mercy Hospital is that miscarriage patients do not have an opportunity for ongoing spiritual grief support to promote a healthy grieving process. Patients are sent home to process their loss and grief independent of continuing support. The purpose of the study is to design and implement an eight-week grief support group led by a professionally trained chaplain. Following the eight-week group, participants will be asked to complete a group satisfaction survey giving feedback that will be used to determine if the grief group supports the quality improvement of support offered by chaplains to early pregnancy loss patients.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Attend eight sessions of a grief group. Each session will last for sixty to ninety minutes.
2. Be open to exploring your grief journey and supporting others in theirs.
3. Give feedback on group planning and discussion topics.
4. Pledge your confidentiality to the group.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are:

1. A group experience where you are accepted, and your grieving process is affirmed.
2. Grief support in a group setting that is designed to encourage your grief journey.
3. A group process where your voice matters.
4. An opportunity to express yourself and grow in ways that are meaningful to you.
5. A deeper understanding of how spirituality and faith can promote a healthy grieving process.
6. A better understanding of coping mechanisms that promote a healthy grieving process.
7. Opportunities to celebrate your baby's life privately and with the group.

Benefits to society include raising awareness of the effects of miscarriage grief and the emotional toll it can take on patients who experience it. This awareness includes those in the healthcare industry who serve patients and a patient's support system, which includes family and friends. Providing miscarriage patients an opportunity to explore their grief also benefits society by promoting mental health, impacting patients' quality of life, their families, friends, and communities.

What risks might you experience from being in this study?

The risks involved in this study include the risk of vulnerability and being known by others. While individuals respond uniquely to being vulnerable and being known by others, this is not a requirement to participate in the group. Otherwise, the risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

It is important to note that the research facilitator is a mandatory reporter and must report minor and elder abuse, neglect, and harm to self or others.

How will personal information be protected?

The records of this project will be kept private. Because it is a quality improvement project no personal data will be collected beyond standard care for patients. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the project leader will have access to the records.

- Data will be stored on the researcher's password-locked Apple computer and the password-locked electronic data storage of Mercy Hospital. At the end of the project all data will be transferred to Mercy's electronic data storage. After three years, all electronic records will be deleted.
- Confidentiality is expected of the project leader participants. All data gathered will be confidential once compiled.

What are the costs to you to be part of the study?

There are no expected costs to participants for this study. The project leader will cover supplies and other planned resources.

Does the researcher have any conflicts of interest?

The researcher serves as a chaplain who is employed by Mercy Health System. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study. Mercy Hospital supports this study. Mercy provides access to standard care patient information through their research application process through their Internal Review Board. Further, a meeting room and some of the resources involved in the study, including printed material, media design, and audiovisual equipment, will be provided by Mercy

Hospital. This disclosure is made so that you can decide if this relationship will affect your willingness to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Mercy Hospital, Springfield, MO. If you decide to participate, you are free not to answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Dani Helm. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or email her at [redacted]. You may also contact the researcher's faculty sponsor, Louis Fortier, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX B

RECRUITMENT TEMPLATE

Date

NAME
ADDRESS
CITY STATE ZIP

Dear [Recipient]:

As a graduate student in the Rawlings School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Ministry degree. The purpose of my study is to determine if patients who have experienced a miscarriage would benefit from an eight-week grief support group as they process their grief. This is a quality improvement project for Pastoral Services at Mercy Hospital. I am writing to invite eligible participants to join my study, and the deadline for participation is January 10th, 2023.

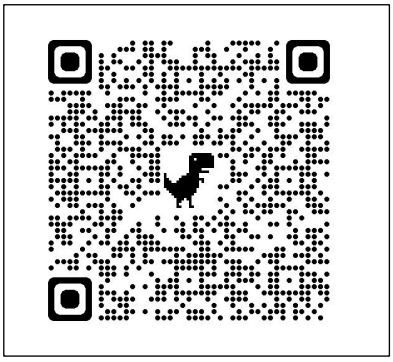
Participants must be 18 years of age and experienced a miscarriage in the last six months. If willing, you will be asked to participate in group sessions to explore loss and grief, healthy coping mechanisms, and how spirituality and faith influence the grief process. Primarily group discussions and creative and other expressive activities will be used to explore stories of grief. The group participants will plan a "celebration of life" event toward the end of the group meetings. You will be asked to complete a group satisfaction survey at the end of the project. It should take approximately eight weeks to complete the procedures listed. Names and other identifying information will not be requested as part of this study, and the information will remain confidential.

To participate, please contact me at [redacted] or [redacted] or scan the QR code.

Once you have agreed to participate, a consent document will be emailed to you prior to the first group meeting. The consent document contains additional information about my research. Please sign the consent and return copy and return it via email or return the paper copy by mail.

Sincerely,

Rev. Dani Helm, BCC
Chaplain II Mercy Springfield
Labor & Delivery, NICU, and Mother/Baby
Cell: [redacted]
Email: [redacted]
Mercy Hospital
1234 E. Cherokee St.
Springfield, MO 65804



APPENDIX C

RECRUITMENT TEMPLATE: FOLLOW UP

Dear [Recipient]:

As a graduate student in the Rawlings School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Ministry degree. Two weeks ago a letter was sent to you inviting you to participate in a research study for patients who have experienced miscarriage. This follow-up letter is being sent to remind you to respond if you want to participate and have not already done so. The deadline for participation is January 10th, 2023.

Participants, if willing, will be asked to participate in group sessions to explore loss and grief, healthy coping mechanisms, and how spirituality and faith influence the grief process. Primarily group discussions and creative and expressive activities will be used to explore stories of grief. The group participants will plan a "celebration of life" event and you will be asked to complete a group satisfaction survey at the end of the group. It should take approximately eight weeks to complete the procedures listed. Names and other identifying information will not be requested as part of this study, and the information will remain confidential.

To participate, please contact me at [redacted] or [redacted].

Once you have agreed to participate, a consent document will be emailed to you prior to the first group meeting. The consent document contains additional information about my research. Please sign the consent and return it via email or by mail; you may also bring it to the first meeting.

Sincerely,

Rev. Dani Helm, BCC
Chaplain II Mercy Springfield
Labor & Delivery, NICU, and Mother/Baby
Cell: [redacted]
Email: [redacted]

Scan to Sign Up

APPENDIX D

RECRUITMENT TEMPLATE: VERBAL SCRIPT (PHONE OR IN PERS0N)

Hello (Patient Name),

As a graduate student in the Rawlings School of Divinity at Liberty University, I am conducting research as part of the requirements for a Doctor of Ministry degree. The purpose of my study is to help the Pastoral Services Department At Mercy Hospital evaluate/develop their ongoing support of patients who have experienced early pregnancy loss and if you meet my participant criteria and are interested, I would like to invite you to join my study.

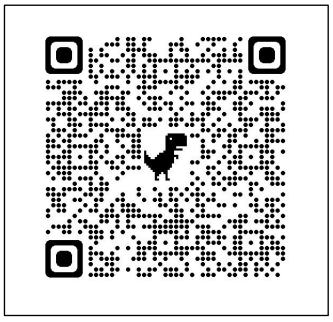
The Target age range for participants is between 18 and 34 years of age for Mercy patients who have experienced an early pregnancy loss. Participants, if willing, will be asked to participate in an eight-week grief support group where the group will journey together to explore grief related to early pregnancy loss and healthy approaches to processing grief to promote emotional and spiritual health. It should take approximately eight weeks to complete the group study. At the end of the group, the group will be asked to complete a patient satisfaction survey. Participation is voluntary and will be completely anonymous. No personal, identifying information will be collected.

Can I add your name to the list of patients who would like to participate?

IF YES: Great! Thank you so much! I have a QR code to scan for the group details and for you to sign up. Here is my card and contact information if you need to reach me in the meantime. Once you sign up, I will be in contact with you to answer any other questions.

A consent document is provided and contains additional details about the group project. Because participation is anonymous, you do not need to sign and return the consent document unless you would prefer to do so. Participation is voluntary and all needed resources will be provided. Weekly give aways will occur to show appreciation for your participation in this group project. Thank you for your time.

Do you have any questions?



IF NO: I understand. Thank you for your time and please let me know if there are additional ways, I can continue to support you. Here is my card and my contact information.

APPENDIX E

SUGGESTED GROUP COVENANT

1. Be willing to give of yourself to help others in a respectful way.

2. Have an open mind, open heart – be willing to listen to others and look deeper at yourself, even the unknown parts.

3. Recognize the commonalities of the group in shared feelings as well as shared problems. Recognizing that "I am not the only one" means you are not alone on this journey.

4. Be willing to own the responsibility for change within yourself.

APPENDIX F

FIRST GROUP MEETING INFORMATION FLYER

GROUP MEETING INFORMATION

START DATE: JANUARY ___, 2023

WEDNESDAYS AT 6:30 PM FOR EIGHT WEEKS
at
MERCY HOSPITAL
1235 E. Cherokee St.
Springfield, MO 65804

Park in front of the hospital
Enter the main entrance into the main lobby
Baggott Street room is to your right.

*Facemasks required when entering and exiting the hospital

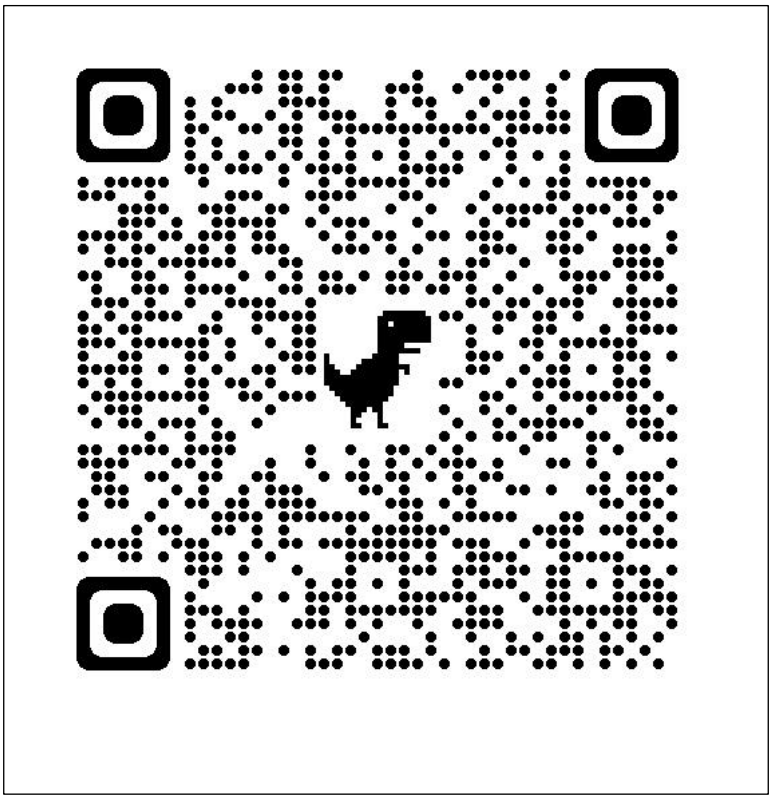
QUESTIONS?
Call Chaplain Dani Helm [redacted]
Project leader

QR CODE

GROUP MEETING INFORMATION

APPENDIX G

Scan To Sign Up for Mercy Grief Support Group



APPENDIX H

Leader's Weekly Observational Scale

1 being low and 10 being high. Make additional comments in the appropriate areas.

1. Was the group/participant engaged in the activities?

1-------2--------3--------4--------5-------6--------7---------8--------9-------10

Observations: _____

2. Was the group/participant engaged in the planned discussion?

1-------2--------3--------4--------5-------6--------7---------8--------9-------10

Observations: _____

3. Did the group/participant discussion mention grief and its impact?

1-------2--------3--------4--------5-------6--------7---------8--------9-------10

Observations: _____

4. Did the group/participant engage in any faith discussion?

1-------2--------3--------4--------5-------6--------7---------8--------9-------10

Observations: _____

5. Did the topics for this week seem relevant and helpful to the participants?

1-------2--------3--------4--------5-------6--------7---------8--------9-------10

	Y	N	COMMENTS
additional staff needed			
extended time commitment this week			
privacy issues			
ethical issues			
follow up needed			
additional costs			
facilities concern			
			attendance number:

Other observations or concerns?

APPENDIX I

PATIENT SURVEY

We are committed to providing you with the best patient experience. We welcome your feedback!

1. Which adequately captures how you feel about participating in the grief support experience for early pregnancy loss?
   - *strongly unhelpful*
   - *unhelpful*
   - *Neither helpful or unhelpful*
   - *helpful*
   - *Very helpful*

2. This experience helps introduce grief coping skills for everyday life.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

3. This experience promotes using my faith as a coping mechanism for grief.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

4. This experience is relevant to my daily life and to early pregnancy loss and grief.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

5. Follow up grief support resources that are available on the web or through other social media would be helpful to me as I process my pregnancy loss.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

6. Meeting one-on-one and communicating via phone and text with the project leader provided helpful flexibility for my participation in this project.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

7. I would recommend that my medical team refer other patients to this grief support experience.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

8. I would recommend this experience to others who are grieving early pregnancy loss.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

9. This experience has increased the quality of care I receive at Mercy Springfield.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*

10. Spiritual and emotional support are meaningful to me after experiencing an early pregnancy loss.
   - *Strongly disagree*
   - *Disagree*
   - *Neither agree nor disagree*
   - *Agree*
   - *Strongly agree*

APPENDIX J

STAKEHOLDER SURVEY

Thank you for your input.

1. After reviewing the stakeholder data summary, how would you rate this project as providing emotional and spiritual support to patients who experienced early pregnancy loss?
   - *Extremely effective*
   - *Very effective*
   - *Somewhat effective*
   - *Not so effective*
   - *Not at all effective*

2. How likely are you to recommend this experience to a friend or colleague that has recently experienced an early pregnancy loss?
   - *Very likely*
   - *Likely*
   - *Neither likely nor unlikely*
   - *Unlikely*
   - *Very unlikely*

3. After reviewing the stakeholder data summary, the project's purpose is reflected in the specific data set collected.
   - *Strongly agree*
   - *Agree*
   - *Neither agree nor disagree*
   - *Disagree*
   - *Strongly disagree*

4. How positive or negative do you feel the impact of this project would be on the ministry of Mercy?
   - *Very positive*
   - *Positive*
   - *Neither positive nor negative*
   - *Negative*
   - *Very negative*

5. How positive or negative do you feel the impact of this project would be on the customer satisfaction ratings for Mercy OB/GYN and Labor and Delivery?
   - *Very positive*
   - *Positive*
   - *Neutral*
   - *Negative*
   - *Very negative*

6. After reviewing the stakeholder data summary, patients were provided privacy and anonymity, along with the opportunity to receive meaningful and appropriate spiritual and emotional support.

- *Strongly agree*
- *Agree*
- *Neither agree nor disagree*
- *Disagree*
- *Strongly disagree*

7. After reviewing the stakeholder data summary, how likely would you be to recommend this type of specialized support to a medical provider for their patients who experience early pregnancy loss?

- *Very likely*
- *Likely*
- *Neither likely nor unlikely*
- *Unlikely*
- *Very unlikely*

8. As a stakeholder, what are some obstacles that you see to incorporating some or all of this project to improve patient care?

9. As a stakeholder, what do you like most about this project?

10. As a stakeholder, do you have feedback or suggestions about this project

QR Code to scan and complete survey online.

APPENDIX K

GROUP DISCUSSION PROMPTS

These are the prompts for group discussion which will be used according to the project leader's plan and discerning the needs of the group. The discussion starters that will help lead the group into reflection and processing their grief stories each week they are used.

Hiding grief, or grieving honestly?"

"Uncomfortable Feelings"

"What helps grief?"

"Will grief ever end?"

"Have I embraced the pain so I could let it go more easily?"

"What brings comfort in grief?"[1]

"What did people say that was helpful?"

"What media platforms are helpful in grief processing?"

"What should family and friends say during and after fetal loss?"

"What are some things you have said to yourself after grief?"

"What brings anger in the grieving process?"

"When bad things happen to good people, **NOT why** bad things happen but **when**…."[2]

[1] Adapted for group exercises from Erika Krull, MSEd, LMHP, "18 Questions About Grief (To Ask Other or Yourself)," Blog>How to Talk About Death. Updated 06/1/2022 https://www.joincake.com/blog/questions-about-grief/.

[2] Sally Downham Miller, 23-65.

APPENDIX L

FACILITIES PLANNING LIST

WEEK	THEME	LOCATION	ROOM DESIGN	MEDIA
Session 1	Welcome/Orientation	CMCC BS	circle of chairs 1 table	slides and audiovisual
Session 2	Everybody has a Story part 1	CMCC BS	4 long tables and chairs	speaker, iPhone, background music
Session 3	Everybody has a Story part 2	CMCC BS	circle of chairs 1 table	slides
Session 4	What does Grief Look Like?	CMCC BS	circle of chairs 1 table	slides
Session 5	Coping with Grief	CMCC BS	circle of chairs 1 table	slides
Session 6	Everybody has a Story: Guest Speaker	CMCC BS	circle of chairs 1 table	slides
Session 7	Celebration of Life Event	CMCC BS/TBD	chairs in rows, TBD	TBD mic, music, audiovisual
Session 8	Reflect and Focus Wrap Up	CMCC BS	circle of chairs 2 tables	speaker, iPhone, background music

APPENDIX M

RESOURCES LIST

Resources List	Where will it come from?
Pens	borrow from Mercy
markers	borrow from Mercy
paper	borrow from Mercy
craft and art supplies	purchase
glue	purchase
magazines	donate
craft paper to cover tables	donate
notebooks	purchase
scissors	borrow from Mercy
journals	purchase
folders	
speaker	from home
music	from home
QR code	make
media slides	make
Celebration of Life Event	group plan -TBD

REFRESHMENT LIST	purchase
napkins	
paper plates	
bottled water	
coffee cups	
coffee	
cream	
sugar	
stir sticks	
graham crackers	
marshmallows	
chocolate	
fondue pot	
marshmallow sticks	
munchies	
gum and candy	

Resource list continued…

WEEKLY GIVE AWAYS:	purchase
journals	
mugs	
colored markers	
picture frames	
coffee/tea	
seeds to grow	
succulents	
baby feet memory	
gift cards	

APPENDIX N

LIST OF SCRIPTURE PROMPTS

This is an initial list of scripture prompts that will guide discussion on how spirituality and faith can bring meaning and hope to the grief process. The list may be expanded based on the needs of the group.

Matthew 19:14

Psalm 147:3

John 14:27

Revelation 21:4

Psalm 73:26

Matthew 5:4

Isaiah 43:2

Isaiah 26:3

Jeremiah 29:11-13

Ephesians 3

APPENDIX O

Group Meeting Outline WEEK 1

OUTLINE WEEK 1

WELCOME!

Introductions

Introduce yourself and share one reason you came tonight.

GROUP EXPECTATIONS. (given prior)

Be willing to give of yourself to help others in a respectful way.

Have an open mind, open heart – be willing to listen to others and look deeper at yourself, even the unknown parts.

Recognize the commonalities of the group in shared feelings as well as shared problems. Recognizing that "I am not the only one" means you are not alone on this journey.

Be willing to own the responsibility for change within yourself.

General Myths about Grief.
WHAT IS ONE THING Someone SAID TO LOSS THAT IRRITATED YOU?

John H. Harvey, Give Sorrow Words, (New York: Routledge, 2016), 227.

-Grief and mourning decline in a steadily decreasing fashion over time.

-All losses prompt the same type of mourning.

-Bereaved individuals need only express their feelings in order to resolve their mourning.

-To be healthy after the death of a loved one, the mourner must put that person out of mind.

-Intensity and length of mourning are a testimony to love for the deceased.

-When one mourns a death, one mourns only the loss of that person and nothing else.

-Mourning is over in a year

What is important in this grief support group?

We are planning to create some kind of "Celebration of Life" event on week 7. What would make this event special?

WORDS: Other people's words can often speak to where we are or where we want to be:

George Eliot, also known as Mary Ann Evans, wrote in the later 1800s a poignant reminder about the importance of one another, which demonstrates the power of group grief work. *It will be used in the group intervention to clarify and promote the value of authentic connection.*

Oh, the comfort,
The inexpressible comfort of feeling safe with a person;
Having neither to weigh thoughts nor measure words,
But to pour them all out,
Just as they are,
Chaff and grain together,
Knowing that a faithful hand will take and sift them,
Keep what is worth keeping,
And then, with a breath of kindness blow the rest away.

WHEN I SAY THE WORD SPIRITUALITY WHAT COMES TO MIND?

TAKE HOME THOUGHT: **What is one word or phrase, picture or song that reminds you there is something bigger than you?**

Write prayer requests on cards and put in the Amazing Grace box.

APPENDIX P

Group Meeting Outline WEEK 2

OUTLINE WEEK 2 Everybody has a Story

WORD CLOUD

**What is one word or phrase, picture or song that reminds you there is something bigger than you? Why?*

Everybody has a Story! Discussion

*What is your grief story? Description words, draw a picture or diagram.
*What feelings am I most uncomfortable with right now? (feelings wheel)
*How has faith in something been obvious?

Group Feedback, Questions and planning for the "Celebration of Life" event.

TAKE HOME THOUGHT:
**In what ways are anger and fear a part of grieving?*

Share ways the leader can pray for you.

APPENDIX Q

Group Meeting Outline WEEK 3

OUTLINE WEEK 3 Everybody has a Story

Everybody has a Story! Discussion Activity
Art Therapy: Crafting or Drawing the feelings of your grief story: anger or fear

The Power of Journaling – discuss last week's prompt
In what ways are anger and fear a part of grieving
* THIS WEEK'S PROMPT: Identify and describe a piece of art that speaks to you about your grief story.

Group Feedback, Questions and planning for the "Celebration of Life" event, suggestions for a guest speaker: week 6.

SELF REFLECTION: Psalm 147:3 "He heals the brokenhearted and bandages their wounds" (NLT). Who does that for you?

SHOW AND TELL FOR NEXT WEEK!

Identify and describe a piece of art that speaks to you about your grief story.

Share ways the leader can pray for you?

APPENDIX R

Group Meeting Outline WEEK 4

OUTLINE WEEK 4 What does Grief Look Like?

WORD CLOUD
Everybody has a Story! **Discussion**
*Who can I count on to help me through my grief?

show and tell
*Next Week's PROMPT: What brings me comfort right now?

Group Feedback, Questions and planning for the "Celebration of Life" event, topic and guest speaker for week 6.

SELF REFLECTION: Psalm 147:3 "He heals the brokenhearted and bandages their wounds" (NLT). **Who does that for you? DISCUSS?**

Share ways the leader can pray for you.

APPENDIX S

Group Meeting Outline WEEK 5

OUTLINE WEEK 5 Coping with Grief

Everybody has a Story! **Discussion**
Music Therapy and Smores
*What does a good song do to you?
*Do you have a go-to song when you are thinking about your loss?

The Power of Journaling – discuss last week's prompt
What brings me comfort right now?
*THIS WEEK: Pick a song that is meaningful to you, look up the words and reflect/write on why. How does it connect with your grief? How does it connect with your faith?

Group Feedback, Questions and planning for the "Celebration of Life" event, topic and guest speaker week 6.
SELF REFLECTION and Discussion: Isaiah 43:2-3, 4 (NLT)
"Faith in the midst of the storm
2 When you go through deep waters,
I will be with you.
When you go through rivers of difficulty,
you will not drown.
When you walk through the fire of oppression,
you will not be burned up;
the flames will not consume you.
3 For I am the Lord, your God,
4 because you are precious to me.
You are honored, and I love you."

*THIS WEEK: Pick a song that is meaningful to you, look up the

words and reflect/write on why. How does it connect with your grief? How does it connect with your faith?

TRUST: what does it mean to you?

Share ways the leader can pray for you

Share ways the group can pray for each other.

APPENDIX T

Group Meeting Outline WEEK 6 & 7

OUTLINE WEEK 6 – Everybody has a Story

Discuss Last Week's Prompt: What song did you pick?

Guest Speaker Story

Reminders about next week's "Celebration of Life" event

Share ways the group leader can pray for you.
Share ways the group can pray for each other.

OUTLINE WEEK 7 Celebration of Life

Group planned "Celebration of Life" Event

Refreshments

TAKE IT HOME: Describe a defining moment in grief.

APPENDIX U

Group Meeting Outline WEEK 8

OUTLINE WEEK 8 REFLECTION AND FOCUS

REVIEW OF THE GROUP and Last week's journal prompt
Describe a defining moment in grief.

GROUP Quality Survey instructions QUESTIONS

1) What has it been like to participate in this group?
2) Describe one or two things about grief it is important to know.
3) Describe one or two meaningful things about faith in the grieving process.
4) What has been the most meaningful things we have done in this group?

POST GROUP SATISFACTION SURVEY

CLOSING: Jeremiah 29:11-13 11 "For I know the plans I have for you, says the Lord. "They are plans for good and not for disaster, to give you a future and a hope. 12 In those days when you pray, I will listen. 13 If you look for me wholeheartedly, you will find me."

Hope for the future!

THE BLESSING
Sung by Kari Job and Cody Carnes
The Lord bless you
And keep you
Make His face shine upon you
And be gracious to you
The Lord turn His
Face toward you
And give you peace
May His favor be upon you
And a thousand generations
Your family and your children
And their children, and their children
May the GRACE and HOPE of God transform your heart both now and forever more… AMEN

APPENDIX V

PROJECT Participants Needed

Quality Improvement Grief Intervention for Early Pregnancy Loss For Pastoral Services

- Are you a patient of Mercy?
- Are you between the ages of 18-34?
- Have you experienced an early pregnancy loss within the last six months?

*If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.*

PURPOSE

The purpose of this research study is to evaluate the follow-up emotional and spiritual support offered to patients experiencing early fetal loss.

Participants will be asked to participate in an 8-week grief support group to examine how grief from early pregnancy loss can be processed in a manner that promotes long term mental

BENEFITS

Benefits include group support, understanding grief and how it can influence long term mental health. Participants will join at no cost. All resources and group activities will be provided free of charge. Weekly giveaways will be offered.

Do not wait!

If you would like to participate, scan this QR code for more information.

A consent document may be required once participation is

Mercy Chaplain Dani Helm, a doctoral candidate in the Rawlings School of Theology at Liberty University, is conducting this study. Please Contact her [redacted] or [redacted] for more information.

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MERCY IRB APPROVAL LETTER

MERCY
INSTITUTIONAL REVIEWBOARD
14528 South Outer 40, Suite 100
St. Louis, MO 63017
phone 417-520-4647

DATE: November 17, 2022

TO: Dani Helm, M.Ed., MCM., BCC
FROM: Mercy Institutional Review Board

Project Title: [1968364-3] 23-026, A Grief Intervention for Early Perinatal Loss
SUBMISSION TYPE: Amendment/Modification - Submission for Determination of Research

ACTION: **ACKNOWLEDGED - Determined to NOT be human subjects research**
EFFECTIVE DATE: November 17, 2022

Thank you for your submission of Amendment/Modification materials for this project. The Mercy Institutional Review Board has ACKNOWLEDGED your submission. No further action on submission [1968364-3] is required at this time.

The following items are acknowledged in this submission:

- Application Form - IRB Resubmit signed November 15.pdf (UPDATED: 11/16/2022)
- Other - Appendices.docx (UPDATED: 11/16/2022)

If you have any questions, please contact Mercy IRB at (417) 520-4647 or MercyIRB@mercy.net. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Mercy Institutional Review Board's records.

Lisa K. Low, MD, MPH

Digitally signed by Lisa K. Low, MD, MPH
Date: 2022.11.17 08:22:57 -06'00'

LIBERTY UNIVERSITY IRB APPROVAL LETTER

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

December 8, 2022

Dani Helm
Lucien Fortier

Re: IRB Application - IRB-FY22-23-568 A Grief Intervention for Early Perinatal Loss: A Quality Improvement Project for Pastoral Services at Mercy Hospital

Dear Dani Helm and Lucien Fortier,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds that your study does not meet the definition of human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your project is not considered human subjects research because it will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current application. Any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. **If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.**

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office