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Bereavement after miscarriage: Implications for pastoral care.

Catherine L. MacKendrick
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BEREAVEMENT AFTER MISCARRIAGE:
IMPLICATIONS FOR PASTORAL CARE

by

Catherine L. MacKendrick

A Thesis
submitted to the Faculty of Graduate Studies
through the Department of
Religious Studies in Partial Fulfillment
of the Requirements for the Degree
of Master of Arts at
the University of Windsor

Windsor, Ontario, Canada

1990



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ABSTRACT

This thesis explores the dilemma women experience when they have a miscarriage. The tension between their perception of its significance and the perception of those around them, create difficulties for them as they attempt to integrate the event into their life-pattern.

The social and psychological setting for miscarriage, the dynamics of perinatal bereavement, and models of care are reviewed. The theological and philosophical background of dualistic attitudes towards women and their bodies is examined in the work of traditional and feminist theologians.

An examination of the results of interviews with twenty women who had miscarried within the previous four years shows dramatically the tension and difficulties with integration. Some main factors that lead to a measure of integration are explained.

The implications for pastoral care, based on the previous information and an analysis of pastoral care theory as it relates to bereavement, produces several concrete suggestions for changes in the type of pastoral care women who miscarry receive.

ACKNOWLEDGEMENTS

With a different focus, a portion of the research in the first three chapters was delivered in a paper called: "The Suffering of Miscarriage: How Can We Care?" at the Conference, Supporting the Bereaved, Carleton University, Ottawa, May 18, 1990.

This thesis would not have come to completion without the valuable assistance of many people. I would like to particularly thank my Director, Dr. Maureen Muldoon who asked the perfect questions at just the right times. She gave me the freedom to be creative and the direction to do that in an acceptably structured manner. The comments of my other two readers, Dr. Norman King and Dr. Mary Louise Drake, assisted in the focusing and presentation of the material.

My husband, Kim, read and re-read the work as it progressed and his editing of my English helped to make it a readable piece. My sons, Kenneth and Andrew, gave me the time on the computer so that I could get the writing done.

To Dr. Drake, Pat Friesen, and Dr. W. McLeod I owe a debt of gratitude for referring or encouraging volunteers to participate in the research. To the members of St. Matthew's Prayer and Share group I am grateful for their encouragement and support.

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FOR

Kim

Kenneth and Andrew

Sarah and Miriam

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It Should Have Been a Lullaby

The birth of a dream -
A conception of love.
Nine months to hope and dream,
To nurture you with love,
As the quickly growing bond
fills the depths of my heart
with the expectancy of motherhood.

And then without a warning
the dream disintegrates before my very eyes.
A slow quiet death -
such a merciless destiny.
'Just a matter of time', they say,
My brave facade slowly crumbling to the ground,
and my heart aches for the torment to end.

Gone without a proper burial.
No one understands as my body trembles
with inconsolable grief,
Left with empty, longing arms,
And with a broken, shattered dream.

Seven months of mourning,
Silently weeping a mother's lament.
It should have been a lullaby.

JoAnne Synnott
December 10, 1986

INTRODUCTION

Miscarriage¹ is a significant event in a woman's life, but it is generally considered an insignificant, non-event by most other people. This tension between the view of the significance of miscarriage creates difficulties with the integration of the event into the life-pattern of the woman so that the miscarriage is a part of the life-pattern and not exterior or peripheral to it.

The impetus for working on the topic "Bereavement After Miscarriage: Implications for Pastoral Care" came both from my personal experience with two miscarriages and from the years that I worked in the field of bereavement with a speciality in perinatal bereavement.² In the eight years that I worked in this field few women or their partners had wanted to discuss their miscarriage. Those women that I had counseled about their experience of miscarriage felt that they needed to explore this event. A common theme that I observed in these conversations was a lack of understanding on the part of everyone involved. I wondered if there was some role that should be played by pastors in the care of women who experience a miscarriage.

¹ For the purposes of this study the lay term 'miscarriage' is used, as opposed to the technical term 'abortion'. All pregnancies that end prematurely are technically referred to as 'abortions'. What the general public refers to as 'miscarriage' is called a 'spontaneous abortion' by the medical community. The general public assumes that their term 'abortion' means 'premeditated intentional abortion'. Since a value judgment is made about the term 'abortion', the term 'miscarriage' will be used.

² Perinatal Bereavement is commonly defined as the state of bereavement caused by the death of a human fetus anytime from conception to 28 days after birth.

In recent years the significance of stillbirth and neonatal death have been discussed in detail with attention to pastoral care. The literature has very little about the theological or pastoral implications of perinatal bereavement. As well, the topic of miscarriage is seldom exclusively used in the material on perinatal bereavement.³ The pastoral literature addresses this issue with even less frequency.⁴ The hypothesis in this thesis is that women who have experienced a miscarriage have a different point of view on miscarriage than do most of society and its caregivers, including pastoral persons.

There is more emphasis on the timing of pregnancies today. With the increase in the use of reproductive technology, such as birth control, and fertility drugs, the regulation of the number and the timing of pregnancy is often the expectation of couples. Improved medical technology, such as home pregnancy tests and ultrasound, means that more bonding with the newly conceived fetus is occurring sooner than in previous times.⁵

³ Specific to miscarriage: Hager and Owen, Joy and Marvin Johnson, Ann Oakley, Hank Pizer and Cristine Palinski, Nancy Rue, Mabelle Seibel, Jack Stack, C. Wall-Haas, M. Welch, and D. Hermann, R. Corney, and P.T. Horton. Those that include miscarriage: Nancy Berezin, Susan Borg and Judith Lasker, Rochelle Friedman, and Bonnie Gradstein, Candice Harris, Sherokee Ilse, Alice Lovell, Larry Peppers and R.J. Knapp.

⁴ Cox, A. James, "Aunt Grace Can't Have Babies", Journal of Religion and Health, 25 (1), Spr 1986, 73-85; Hunt, J.H. "Pastoral Care and Miscarriage: A Ministry Long-Neglected", Pastoral Psychology, 32 (4), Summer 1984, 265-278.

⁵ There has been extensive study done about the process of 'bonding' between the mother and the infant as well as the father and the infant. The work of Klaus and Kennell refers to the mother-infant bonding while the work of Peppers and Knapp refers to the bonding between both mother and father and infant in relation to the length of pregnancy.

For many women miscarriage has a far greater significance than most family members, friends, medical personnel, and clergy assume. These caregivers often think that a miscarriage is an unfortunate event or a 'blessing in disguise' since 'the baby would have been deformed anyway'. Often it is thought that the woman will not feel deeply about something that she did not know, since many people do not view an infant as a person until it is at the stage of needing hands-on care. It is also an experience that few women who have had a miscarriage are asked to 'name' or describe. It could be that they are simply not asked to share their 'narrative' or that the listener is having difficulty with the 'Surrogate Suffering Syndrome.'⁶ The listener may feel that this is the woman's private affair or that the story will include much messiness related to the biological function of the woman's body.

Pastoral people should be concerned with the effect that the experience of miscarriage has on a woman's spirituality. More precisely it may affect her perception as woman, a unique creation of God. Her attitude towards herself, which is sometimes extreme guilt,⁷ and her attitude towards God are often re-evaluated. How the woman perceives

⁶ The surrogate suffering syndrome is a defense mechanism used by either friends or care-givers to reduce their own feelings of helplessness and sympathetic emotions by attempting to shield the vulnerable by excluding them from decision-making. They reduce their own distress by assuming that they are reducing the griever's when they are actually adding to the intensity of the pain. Glen Davidson, Understanding the Death of the Wished-For Child (Springfield, Illinois: OGR Service Corporation, 1979), p. 14.

⁷ Larry Peppers & Ronald Kaapp, Motherhood and Mourning (New York: Praeger, 1982), p. 38.

God after such an event may give some direction for pastoral use of God-images.

In Christianity there has been a perception that the body and the soul are really separated, which stems from the influence of Greek philosophical thought on Christian theology. Woman has been traditionally equated with the body while man has been identified with the 'higher element', the soul. With this type of thinking being so pervasive within our culture, the medical and clerical professionals, who are predominantly male, may come with some preconceived attitudes towards the event of a miscarriage which represents a failure in the biological function of the woman's body to reproduce. One such attitude, noted by Ann Oakley, is that the mental and emotional behaviour of women during reproduction is basically reactive, with the stimulus being the woman's biology.⁸ The women's psychological and social reactions during reproduction are interpreted as being simply a reaction to her 'nature' as a biological reproductive mechanism, and excluding the dimension of women as social beings. Feminist theologians view this dualism as detrimental to the recognition of women as full persons.

OUTLINE OF THESIS

The first chapter will discuss the psycho-social

⁸ Ann Oakley, Women Confined (Oxford: Robertson Press, 1980), p. 57.

dimensions of bereavement, and perinatal bereavement. After outlining the typical reactions that can be expected, an overview will be given of the societal attitudes towards women, their bodies, and their reproductive functions. Here the medicalization of motherhood will be discussed. Finally, the nature of suffering and the care for those who are suffering will be explored in order to determine what model or type of care would be helpful to women who experience a miscarriage.

Chapter Two will give an overview of the theological perspectives about women and their bodies. The major issue that has affected women is the development and influence of dualism, the separation of the body and the spirit. First, the woman/body/nature issue will be examined. This discussion will be followed by the responses from the traditional and the current authors. The traditional responses will include Plato, Aristotle, Augustine, Thomas Aquinas, and Rene Descartes. The current responses will include Tristram Engelhardt, James B. Nelson, Benedict Ashley, Elizabeth Spelman, Rosemary Radford Reuther, and L. Shannon Young. After these responses to the women and their bodies, there will be an exploration of the theology of embodiment and pregnancy. Finally, the chapter will conclude with some of the theological implications for miscarriage.

Chapter Three will be a discussion of the primary research with the subjects. There will be an outline of the

research methodology. Using the women's responses, areas of concern will be discussed under the topics: psychological, social, medical, pastoral, and personal perceptions. After these topics are discussed there will be an examination of the responses of those women who showed an integration of the event of miscarriage into their life. These topics will then point towards some questions that might be relevant for pastoral care.

Chapter Four covers the implications for pastoral care. The use of 'personal narrative' in pastoral counseling will be discussed. After pastoral care theory is examined, there will be a discussion of clergy biases based upon the theological and social scripts that have been written for women. After a brief look at grief and spirituality, the role of the pastor in bereavement will be examined. The closing portions of this chapter will deal with the pastoral role in bereavement after miscarriage, and rituals for miscarriage. The final section of the chapter will contain some further suggestions for pastoral care.

The last section of the thesis will be the conclusion. The various relevant insights of the previous chapters will be drawn together to give suggestions for the improvement of pastoral care for women experiencing a miscarriage. Further topics or questions that have grown out of this research will be put forward.

RESEARCH METHOD

The research with the women subjects was qualitative in nature. An unstructured interview style was used; it is one type of qualitative research preferred by researchers in the field of women and woman's roles.⁹ The three major areas of interest for the focus of topics for discussion were 'personal narrative', self-image, and the medical and pastoral treatment. The women subjects were also asked if they had any suggestions for improving the care of other women who have had a miscarriage. From their comments came some insights about how they perceive themselves, the event of the miscarriage, the caregivers' attitudes, and the intervention techniques that were a part of their particular experience of miscarriage.

All people behave according to 'scripts', personal and societal. There are mother, father, and child scripts that determine private life. There are student, employee, teacher and employer scripts that determine the fields of learning and employment. The scripts that have been 'written' for women experiencing a miscarriage may, in fact, be harmful for a number of these women. The script is almost always that the woman has the right to feel either sad for a short period of time or to be relieved.¹⁰ There is no script

⁹ Ann Oakley, "Interviewing Women: A Contradiction in Terms" Doing Feminist Research, ed. Helen Roberts, (London: Routledge & Kegan Paul, 1981).

¹⁰ The referring doctor told me that if the woman is still distressed at six weeks after the miscarriage then there is pathology and he has a referral system to a social worker.

to cover the symbolic closure for the woman who feels that this was a child that she lost and who needs some recognition. Using medical terms, the 'aborted fetus' is simply sent to the pathology lab and then disposed of at the convenience of the hospital. The comments made by the women point to ways that the scripts can be changed so that they may behave in ways that are more conducive to wholeness.

CHAPTER ONE
PSYCHO-SOCIAL DIMENSIONS

No human event happens in a vacuum. Thus it is important to understand the social setting and the psychological consequences of a miscarriage before discussing the role of the pastoral person in the care of the woman. In this chapter the psycho-social dimensions surrounding miscarriage are discussed in the following categories: bereavement, perinatal bereavement, the concept of women: body, and reproductive functions, nature of suffering, and care for the suffering.

PSYCHOLOGICAL/SOCIAL IMPLICATIONS OF BEREAVEMENT

The terms bereavement, grief, and mourning are used in the field of thanatology, which is the study of death, dying, and bereavement. Bereavement is a term used to describe an objective fact, a change of status, after the death of a loved one, which generates increased vulnerability and stress. Grief is the emotional and physical¹ response to the state of bereavement. Mourning is

¹ Jerome K. Fredrick conducted studies that show that in states of bereavement people's pituitary gland releases more ACTH as a part of the body's response to stress. This in turn stimulates the adrenal cortex to release excess corticosteroids which then depress the immune mechanism. If this high activity of corticosteroids continues there is a risk to the physical health of the bereaved person, Jerome K. Fredrick, "The Biochemistry of Acute Grief with Regard to Neoplasia", Acute Grief: Counseling the Bereaved, ed. O.S. Margolis, H.C. Raether, A.E. Kutscher, J.B. Powers, I.B. Sceland, R. DeBellis, D.J. Chericco (New York: Columbia University Press, 1981), pp. 111-117. Also found in Robert Kastenbaum, Death, Society, and Human Experience, 3rd Edition (Columbus, Ohio: Charles E. Merrill, 1986), p. 137 and in Bereavement: Reactions, Consequences and Care, ed. Marian Osterweis, Fredric Solomon, Morris Green (Washington: National Academy Press, 1984)pp. 163-168.

the term used to describe the culturally patterned expression of the person's grief.² There have been many definitions for grief. Colin Murray Parkes describes grief as a "process of realization, of 'making real' the fact of loss."³ Elisabeth Kubler-Ross began to examine the phenomena of grief in connection with her studies about the dying in the late 1960s and early 1970s. Her classic five stages of dying were adapted to grief before any real analysis of the grieving process had begun. Her model of grief described stages identified as denial and isolation, anger, bargaining, depression and acceptance. John Bowlby was the first to talk about grief as a process rather than a set of stages. His model described four phases of this process: numbness, yearning and searching, disorganization and despair, and reorganization.⁴ Colin Murray Parkes has adapted these four phases, renaming them numbness, pining, disorganization and despair, and recovery. Pining is a poignant term for Bowlby's equivalent category and much more descriptive of this phase of grief.

Bowlby and Parkes agree that the numbness phase is relatively short and is replaced by the pining phase which is characterized by deep sighing respiration, aimless

² Found in Kastenbaum, pp. 135-138 and Richard A. Kalish, Death, Grief and Caring Relationships, 2nd Edition (Monterey: Brooks/Cole Publishing Co., 1985), pp. 181-182.

³ Colin Murray Parkes, Bereavement: Studies in Grief in Adult Life, 2nd Edition (New York: Pelican Books, 1986), p. 175.

⁴ John Bowlby, Attachment and Loss Vol 3 Sadness and Depression (New York: Penguin, 1980), pp. 85-95.

hyperactivity, and difficulty in concentrating, all aimed towards a search for the lost object of affection. It is in this phase that illusions or hallucinations, suicidal ideation, and feelings of helplessness dominate. The preoccupation with the dead loved one will bring back a repeated chain of memories⁵ which are called flashbacks. Parkes puts it well:

The world of the bereaved is in chaos. They feel as if the most central, important aspect of themselves is gone and all that is left is meaningless and irrelevant - hence the world itself has become meaningless and irrelevant.⁶

This sense of loss of self may be experienced as a great feeling of emptiness. Other dominant feelings are often anger and guilt. These phases of grief do not occur on a time line. They overlap and intermingle for various lengths of time depending upon the individual and the style of mourning.

Grief has an emotional and psychological impact on the bereaved person. It can affect those aspects of a person that give him or her identity. Roles, bodily characteristics, behaviour, and social groups may be affected by bereavement.⁷

Through a study of bereaved adults Susan L. Carter has recently addressed another aspect of the grief process which does not seem to fit into the models of typical bereavement

⁵ Parkes, pp.27-95.

⁶ Parkes, p. 96.

⁷ Parkes, p. 109.

which have been put forward in the past.⁸ She found that the grief expressed by those that she interviewed fit better into themes rather than stages or phases. She identifies core themes, meta themes, and a contextual theme. The core themes are 'being stopped', 'hurting', 'missing', 'holding', and 'seeking'. Meta themes are 'change', 'expectations', and 'inexpressibility'. The contextual theme is the 'personal history' of the bereaved. Carter describes this theme:

Personal history is the theme within which the five core themes (being stopped, hurting, missing, holding, seeking) are embedded and is essential for understanding bereavement's quality. Understanding the bereaved's history; who the loved one was; what the person meant to the survivor; how they were together; what their hopes, dreams, shared experiences were; and the nature of the events surrounding the death are critical for understanding bereavement.⁹

One of the particularly good aspects of Carter's research is that it includes both sexes, many different kinds of bereavement, and different ages. The core themes include some of the Bowlby-Parkes phases which she does not address in her paper. For instance, the theme of being stopped is part of numbness, while the themes of hurting, missing, seeking, and holding are yearning and searching. Her meta-themes of change, expectations and inexpressibility all relate to the state of role-adjustment and expectations of

⁸ Susan L. Carter, "Themes of Grief", Nursing Research, 38 (6), Nov/Dec 1989, p. 254. She particularly critiques the models of Freud, Kubler-Ross and that of existential phenomenology.

⁹ Carter, p. 357.

self for the present and the future. These themes, along with her contextual theme of personal history, are very interesting and are a valuable model to use in working with the bereaved.

Another author who discusses factors that affect the outcome of bereavement is Beverley Raphael. She terms these as the pre-existing relationship between the bereaved and the deceased, the type of death, the response of the family and social network, the concurrent stress and crises, any previous losses, and the sociodemographic factors.¹⁰ Her broader divisions would include those that Parkes has more particularly pointed out.

Bereaved people are stigmatized since they are tainted with death.¹¹ In our Western society we have come to the phase of death denial, or as Phillippe Aries says 'forbidden death'. The bereaved finds themselves in this position: A single person is missing for you, and the whole world is empty. But one no longer has the right to say so out loud."¹² Mourning is no longer a social ritual in the western world, and grief is treated by counsellors and funeral directors. Parkes notes that more bereaved people are going to their general practitioners in their grief. This is a symptom of viewing grief as an illness which can

¹⁰ Beverley Raphael, The Anatomy of Bereavement (New York: Basic Books, 1983), p. 63.

¹¹ Parkes, p. 28.

¹² Phillippe Aries, Western Attitudes Toward Death: From the Middle Ages to the Present trans. Patricia M. Ranum (Baltimore: The John Hopkins University Press, 1974), p. 92.

somehow be cured, whereas the clergyperson can only sympathize.¹³ Previously when there were socially prescribed mourning rituals there was a prescribed time for their ending.

An accepted mourning period provides a social sanction for beginning and ending grief, and it is clearly likely to have psychological value for the bereaved. The absence of any social expectations, as is common in Western cultures today, leaves bereaved people confused and insecure in their grief. A clear lead from the churches in this matter would be psychologically helpful to many bereaved people.¹⁴

This would help to change the existing culturally reinforced denial patterns about death.

Many authors have made suggestions for helping the bereaved. Parkes is one who offers many suggestions. The most valued person is the quiet person who sticks around, accepting the outpouring of anger and anguish which may sometimes be aimed at the helper. The helper needs to convey the idea that this outpouring is expected and acceptable. The helper should be willing to show his or her own feelings, without shame or being rendered useless by those feelings. The helper will not convey pity since pity makes the griever an object, not a person. Words from the helping person will come from the heart or not at all. The helper will be aware that this is a 'no win' situation in which the helper can't repair the situation and the griever can't be

¹³ Parkes, p. 189.

¹⁴ Parkes, pp. 179-180.

made better by the helper. Such helpers must be prepared to share the pain.

Reassurance that they are not going mad, that such feelings are perfectly natural, and that crying does not mean a 'nervous breakdown' can be given explicitly, and especially by an attitude that shows that the helper is not alarmed, frightened or even surprised.¹⁵

In order to do this effectively, the helper must be very aware of the grief process and reactions that can be expected from a bereaved person. The 'helper' aspect of bereavement will be discussed at further length in the chapter, "Implications for Pastoral Care".

PERINATAL BEREAVEMENT

Perinatal bereavement will cover the state of bereavement caused by perinatal losses which "include miscarriages, stillbirth, neonatal death, fatalities from Sudden Infant Death Syndrome, and others occurring between conception and the first birthday."¹⁶ An overview will be given first and then particular applications to miscarriage will be discussed.

At a recent conference in Ottawa, May 1990, Therese A. Rando PhD, described her research about the effects of the loss of a child. She concludes that the death of a child is so unique that the bereavement may seem bazaar,

¹⁵ Parkes, p. 183. The previous section from pp. 180-183.

¹⁶ Anne Clarke Smith, Sherry S. Jorgers, "Parental Grief Response to Perinatal Death", Omega, 19 (3), 1988-89, p.203.

pathological, and complicated, but that it is normal for bereaved parents. She said, "The age of the deceased child is irrelevant, although it will influence some of the specific issues to be addressed in parental grief." The societal denial of grief occurs at both of the ends of the spectrum: that is, in the case of a miscarriage and in the case of the death of an older child. Based on her research Rando thinks a new model needs to be developed for parental grief and new criteria for identifying pathological grief are necessary.¹⁷

John Bowlby uses his four phases for parents of stillborn/perinatal deaths as does Glen Davidson, who determined that for perinatal bereavement three critical times in mourning were six weeks, six months and one year.¹⁸ One of the important and interesting historical aspects of perinatal bereavement is that in our present century, particularly since the Second World War, the loss of a child has become the abnormal rather than the normal state of affairs.¹⁹

Larry G. Peppers and Ronald J. Knapp, in Motherhood and Mourning, provide an excellent overview of the characteristics of grieving mothers. 1) They found that all mothers grieved no matter what the gestational age of their

¹⁷ Therese A. Rando, "Parental Loss of a Child", a key-note speech given at the Bereavement: Helping the Survivors Conference at Carleton University, May 1990.

¹⁸ Bowlby, p. 122. Glen Davidson, Understanding: Death of the Wished-For Child (Springfield: OGR Service Corp., 1979).

¹⁹ Parkes, p. 140.

baby.

We expected that grief expression would be less intense in cases of miscarriage than in stillbirth or neonatal death. This proved to be only partially true. Emotional distance seemed to be important but its importance was found only in the length of the mourning period. Little difference existed between the conception of the reality and the pain of the loss at the time the loss occurred. In other words, the duration of grieving was generally shorter in the case of fetal loss, but the initial expression of grief was just as intense.²⁰

The difference that they noted was expressed in the larger amount of perceived guilt on the part of miscarrying mothers. 2) The mothers all experienced vivid memories of the detail surrounding the loss. 3) These mothers also found that communication channels were closed to them. 4) Often husband-wife relationships become strained, due to incongruent bonding/grieving.²¹ 5) Many mothers have unsatisfactory relationships with their physicians because of insensitivity. 6) Often unyielding hospital staff and inflexible hospital rules hindered the grief of the women. 7) For many women the total resolution of maternal grief may never occur. "The majority of women we studied also sensed that they would carry the burden of their losses throughout their lives. The emotions, feelings, and thoughts surrounding their losses had persisted, in milder form for

²⁰ Larry G. Peppers, Ronald J. Knapp, Motherhood and Mourning (New York: Praeger, 1980), p. 19.

²¹ Incongruent bonding occurs particularly in the case of miscarriage since the mother begins to bond or becomes emotionally attached to the infant right from the moment that she suspects that she is pregnant. Peppers and Knapp show that the fathers begin to bond more slowly and increase first dramatically at the point of quickening but do not reach the same level of attachment as the mothers until they have the care of the infant after birth. Peppers & Knapp, pp. 58-79.

many years."²²

One of the dynamics that the authors agree upon, in the instance of miscarriage, is a sense of failure that some women will feel.²³ Beverley Raphael feels that this is one of the stronger aspects of grief in the case of miscarriage. She notes that fearfulness, delayed grief, sadness, and guilt are also predominant. The mother may begin to feel that her body produces bad and damaged things.²⁴ She notes that "the whole episode may become a focus of unresolved grief."²⁵ This has been named as 'shadow grief' by Peppers and Knapp and described as follows:

Shadow grief reveals itself through the form of a dull, unresponsive ache or an emotional dullness in which the person is unable to respond fully and completely to outer stimulation. She can laugh and appear to enjoy life, but there is always that dull ache in the background that remains constant and, under certain circumstances, surfaces.²⁶

This phenomenon seems to be related to the inability of the woman to make some sense of reality about the entire event, as well as to her inability to process her feelings of grief in a supportive social network.

Several other dynamics of perinatal grief are mentioned

²² Peppers & Knapp, pp. 19-22.

²³ Raphael, p. 235; Maureen Rank, Free to Grieve (Minneapolis: Bethany House, 1985), p. 54; Patricia A. Witzel, Brian M. Chartier, "The Unrecognized Psychological Impact of Miscarriage", Canada's Mental Health, 37 (1), March 1989, p. 17.

²⁴ Raphael, pp. 235-236. Rank quotes a mother: "The pregnancy was mine, in my body and it didn't work!", p.54; Hank Pizer, Christine O'Brien Palinski, Coping With a Miscarriage (New York: Dial Press, 1980), p. 117; Erna Furnam, "The Death of a Newborn: Care for the Parents", Birth and the Family Journal, 5 (4), Winter 1978, p. 216.

²⁵ Raphael, p. 236.

²⁶ Peppers & Knapp, p. 47. This phenomenon is mentioned as a possibility if the mother is not allowed to grieve in Witzel & Chartier, p. 19.

by various authors. Alice Lovell says that part of the difficulty of being able to process the grief is related to the lack of memories in the case of miscarriage. Part of this lack of memories is often the lack of visual confirmation of a pregnancy loss.²⁷ Erna Furnam relates perinatal loss to an amputation in which the loss can be viewed as a body defect or an invisible amputation.²⁸ Irving Leon notes that some mothers experience intense envy of other mothers which may even be displayed as rage.²⁹ Constance Wall-Hass notes that "from the woman's point of view, the experience [of miscarriage] may seem life-threatening".³⁰

The self-esteem of the woman may be threatened by the experience of miscarriage. She may have doubts about her femininity or her competence as a woman, and her trust in herself as a woman is often disrupted.³¹ Consequently, a miscarriage may be very threatening to the whole woman.

In all of these descriptions of perinatal bereavement, particularly in the case of miscarriage, we come to see that

The bonding that occurs and the intense grief process that follows the miscarriage suggest that

²⁷ Rank, p. 30. Alice Lovell, "Some Questions of Identity: Late Miscarriage, Stillbirth, & Perinatal Loss", Social Science and Medicine, 17 (11), 1983, p. 759.

²⁸ Furnam, p. 215.

²⁹ Irving G. Leon, "Psychodynamics of Perinatal Loss", Psychiatry, 29, Nov 1986, p. 316.

³⁰ Constance L. Wall-Hass, "Women's Perceptions of First Trimester Spontaneous Abortion", Journal of Obstetric-Gynecological Nursing, Jan/Feb 1985, p. 50.

³¹ Leon, "Psychodynamics of Perinatal Loss", p. 320; Witzel & Chartier, p. 17; Reva Rubin, Maternal Identity and the Maternal Experience (New York: Springer, 1984), p. 25; Penelope Washbourn, Becoming Woman: A Quest for Wholeness in Female Experience (San Francisco: Harper & Row, 1977), pp. 67-68.

the miscarriage is often perceived by the woman as the death of a person.³²

The psychological aspects of grief are very relevant since it has been found that bereavement can contribute to physical and mental illnesses. Parkes has noted that four times as many bereaved persons as non-bereaved spend some time in hospital within eighteen months of the death.³³ Because of the threat to the woman's image of her personhood, it is important to recognize other dimensions of the psychological attachment to the child that she is carrying while she is pregnant and what happens to that attachment after pregnancy loss.

In these early months of pregnancy her attachment to the developing baby is usually intense. This attachment is based upon the hopes, dreams and expectations for the child to come.³⁴ The termination of a pregnancy "does not eliminate the bonds and the investment of self in the maternal identity already achieved."³⁵ Part of this attachment is the narcissistic attachment that the pregnant woman has with her changing self. When the pregnancy is lost, it can be more difficult to mourn part of the narcissistic self than a separate individual.³⁶ This can be particularly exaggerated in the primipara mother. Leon goes

³² Witzel & Chartier, p. 18.

³³ Parkes, p. 42.

³⁴ Peppers & Knapp, pp. 28, 59, 66-70; Raphael, p. 230; Purnam, p. 124; Wall-Hass, p. 50; Witzel & Chartier, p. 18.

³⁵ Rubin, p. 10.

³⁶ Leon, "Psychodynamics of Perinatal Loss", p. 315.

on to say:

If the baby's body is regarded as a depersonalized, anonymous fetus, it will not be possible to endow the real baby with intense feelings of loss associated with the disappointment of maternal wishes and fantasies of her child-to-be.³⁷

Consequently, it may be more difficult to resolve pregnancy loss in miscarriage. Mourning a miscarriage demands a recognition of the specific wishes and fantasies attached to the infant are not going to materialize.³⁸ In this way some women may not be psychologically ready to give up their pregnancy.³⁹ What seems to be important is the recognition of the significance this event of loss has had in a woman's life.

Failure to resolve perinatal grief has several implications. As noted above, there is the phenomenon of 'shadow grief'. Sometimes unresolved grief can result in the mother having a replacement child. Leon says:

Due to the sometimes devastating blow to maternal self-worth resulting from perinatal loss the mother may have a great eagerness to become pregnant again as soon as possible to undo and repair the narcissistic damage to her femininity.⁴⁰

The danger of a replacement child is that the normal attachment between parent and child is never complete and the child grows up unable to meet the ideal that the parent expects from the replacement.

³⁷ Leon, p. 316.

³⁸ Irving G. Leon, "Short-Term Psychotherapy for Perinatal Loss", Psychotherapy, 24 (2), Summer 1987, p. 194.

³⁹ Wall-Hass, p. 51.

⁴⁰ Leon, "Short-Term Psychotherapy", p. 190.

As noted, there is a danger of becoming ill if the grief is not processed adequately. The danger for mothers is that many times they are unable to work through their anger and often become seriously depressed and withdrawn. If they do this and do not have social support systems, this will produce even further feelings of guilt. Nancy Zaiger speaks of the effect of bereavement on women:

Women describe their loss as total abandonment. Since a woman's sense of self is extremely tied up with maintaining relationships, it is not surprising that the disruption of the relationship, in our case, resulting from the death of a loved one, is perceived not just as a loss of a relationship but as something closer to a total loss of self.⁴¹

In order to understand the psychological character of the bereaved mother, it is important to recognize that women perceive themselves in relation to other people, and that they will make moral choices that do not damage their relational connections with others.

Irving Leon outlines some potentially difficult areas for the resolution of grief after perinatal loss. He says that the factors to be taken into consideration are 1) most importantly is the narcissistic nature of the loss, 2) the over-whelming self-blame experienced by the mother, 3) the lack of concrete memories that make the loss less real, 4) the unanticipated nature of the death, 5) the unique nature of a grief that involves mourning fantasies of the future,

⁴¹ Nancy Zaiger, "Women and Bereavement" Women and Therapy, 4 (4), Winter 1985/86, p. 36.

and 6) "the stunning lack of social support by the medical profession and the community at large."⁴²

Maureen Rank speaks of some of the unique aspects of miscarriage loss. She notes that miscarriage may be the first experience of death for the mother; that it is a shocking event in this world of medical miracles; that this pregnancy loss may mean the end to future chances for a baby; that this type of bereavement is not talked about; that there are no death rites for miscarriages; and finally, that the mother may be coping with this death in a weakened physical condition.⁴³ All of the above determinants should be considered when working with a bereaved mother who has experienced a miscarriage.

The most common social response to miscarriage is to do nothing, say nothing, pretend nothing has happened, and gloss over the event with reminders about the commonality of the event and the fact that the mother can try again. This is the most common type of social script that the woman experience. The first social contact that the woman has in the case of miscarriage is often with medical personnel. It

⁴² Leon, "Short-Term Psychotherapy", p. 187. The authors Witzel and Chartier have less obtuse factors to be considered. They feel that the key variables in the case of miscarriage are the gestational age of the infant, any previous incidents of miscarriage, no surviving children, the marital status of the mother since single mothers showed more distress in their study, and the woman's age since some older women seemed better able to cope with death as long as future pregnancies were possible for them. Another factor that Parkes brings out is the fact that for many of these mothers there are other young children in the home which can be an additional psychological stress. (163) This may be even more difficult if the children at home have questions about the expected sibling who has not materialized.

⁴³ Rand, pp. 17-25.

is interesting that Leon points out that until about ten years ago there was a "startling lack of sensitivity and responsiveness by the medical profession to the often traumatizing impact of perinatal loss."⁴⁴ Recent literature has made note of the concerns expressed by mothers. Nancy Rue says that the questions arising most frequently are:

1] Why don't doctors prepare a woman for the possibility of a miscarriage? 2] Why are some doctors surprised when you're upset over a miscarriage? 3] Why does my doctor treat my ectopic pregnancy as just 'major surgery'? 4] Why do some doctors immediately conclude that you have psychological problems if you've had three or more miscarriages?⁴⁵

These questions indicate that the particular dynamics of perinatal grief are possibly not understood. This fact is evident in John Speck's book Loss and Grief in Medicine in which he advises that if the pregnancy is wanted the difference between miscarriage and stillbirth is merely academic without discussing the various other factors about grief. He feels that most women "manage to cope with the experience of miscarriage without counselling."⁴⁶ It is this kind of assumption that creates the responses which give the impression that miscarriage is like the common cold in its ability to be self-curing.⁴⁷ When such a mind-set is in place there is inconsistent treatment of pregnant women. For

⁴⁴ Leon, "Psychodynamics", p. 318.

⁴⁵ Nancy Rue, Handling the Heartbreak of Miscarriage (San Bernardino: Here's Life Publications, 1987), p. 108.

⁴⁶ Peter Speck, Loss and Grief in Medicine (London: Bailliere Tindall, 1978), pp. 34-35.

⁴⁷ Ann Oakley, "Feminism, Motherhood and Medicine - Who Cares?", What is Feminism?, eds. Janet Mitchell, Ann Oakley (Oxford: Blackwell, 1985), p. 142.

instance, in recent years Labour and Delivery facilities have encouraged a support person to be present when a pregnant woman delivers her child, even a stillborn. "Yet, this is not widely accepted in the case of pregnancy loss, because miscarriage is not perceived as labour and delivery of a baby."⁴⁸

Another social attitude that is evident within the medical community is the assumption that a miscarriage is less sad than for stillbirth or a neo-natal death. Lovell says:

I found that health workers considered that the earlier the pregnancy failed, the 'lesser' the loss, making miscarriage less sad than stillbirth; and stillbirth less sad than losing a baby who had lived. It followed that miscarriage and stillbirth were not viewed as proper bereavements."⁴⁹

This social attitude towards miscarriage is seen in non-medical material as well. Nel Noddings, in her recent Women and Evil, 1989, says:

When a woman has an early natural abortion, she may experience deep disappointment, but she does not experience grief; there is no beloved being lost. (I am not suggesting that we be unsympathetic toward one who exhibits grieflike symptoms in that she has lost a possibility - a dream - not a responsive child.)⁵⁰

Anne Smith and Sherry Borgers would say that this comment is evidence of the general view within society that perinatal

⁴⁸ Ann Hager, "Early Pregnancy Loss: Miscarriage and Ectopic Pregnancy", Pregnancy Loss: Medical Therapeutics and Practical Considerations, ed. James R. Woods (Baltimore: Williams & Wilkins, 1987), p. 33.

⁴⁹ Lovell, p. 756.

⁵⁰ Nel Noddings, Women and Evil (Berkeley: University of California Press, 1989), p. 152.

death, as significant loss, is not on a par with other types of losses to death.⁵¹ It seems that the birth and the death are treated as one event rather than two events, almost as if one cancels out the other.⁵² This type of thinking denies the attachment that the mother already has for the infant that she has been carrying within her body. Ann Oakley puts this attitude very well:

Miscarriage is an integral part of woman's reproductive experience, although a hidden part in a society unable easily to confront such basic issues of life and death.⁵³

The evidence that women have accepted the social scripting is seen in an apparent need to minimize the loss from a miscarriage with such phrases as "not a stillbirth", "not like losing a real baby", and "it was just a miscarriage."⁵⁴ The grief of the parents may be swept away by others with suggestions that they conceive another child.⁵⁵ Harris found in her study that the subjects reported feeling pressured not to grieve but to act normally.⁵⁶ The messages, verbal and non-verbal seem to be very strong: this is not a death, you should not grieve, have another baby, and everything will be fine.

The helper in the case of miscarriage must be aware of

⁵¹ Smith & Borgers, p. 211.

⁵² Alice Lovell, "Women's Reaction to Late Miscarriage, Stillbirth and Perinatal Death", Health Visitor, 56 Sept 1983, p. 325.

⁵³ Ann Oakley, Ann McPerson, Helen Roberts, Miscarriage (Glasgow: Fontana Books, 1984), p. 11.

⁵⁴ Rank, p. 27.

⁵⁵ Claudia Panuthos, Catherine Romeo, Ended Beginnings: Healing Childbearing Losses (Boston: Bergin & Garvey, 1984), p. 163.

⁵⁶ Harris, p. 415.

factors unique to this situation. Smith and Borgers discuss the elements that are helpful in situations of perinatal bereavement. Quite often mothers will turn to friends or others who have had similar losses for support before they turn to their husbands. Perhaps they know that the shared experience will be a bond that over-rides the social script. These authors caution that the helper not assume that the type of loss will affect the individual grief process, that time alone will heal, that parents who have experienced more than one loss will grieve more than those who have had only one loss, that an early subsequent pregnancy will result in a prolonged reaction, or that parents want to be protected from their loss.⁵⁷ The most important thing is to accept whatever anguish is poured out.

Important medical suggestions are made by Ann Hager. She stresses that the pathology findings be explained privately to the woman as soon as possible in the presence of a support person. The D&C should be done in some place other than the labour and delivery facility with the presence of a support person, if the woman is able to be awake and wants this support. The medical people could ask if the woman would like to see the tissue. The woman may wish to be a part of the disposal, if only to know what happens and perhaps to have some more formalized death rites.⁵⁸ Harris reports that with miscarriage burial is rare

⁵⁷ Smith & Borgers, pp. 210-212.

⁵⁸ Smith & Borgers, pp. 30-35.

but some mothers described a sense of unreality when they were not informed what had been done with the baby.⁵⁹

Additional suggestions for medical persons come from Witzel and Chartier. They suggest that the woman be provided with information before and after the miscarriage. In the early part of the pregnancy the woman can be warned about the possibility of a miscarriage and told what the symptoms are. There should be some planned follow-up for these mothers. There should be some sensitivity to the women's anxiety during the subsequent pregnancy.⁶⁰ Most of all there is a need for all helpers to be accepting of these hurting human beings in the midst of their distress.

Imparting information to the bereaved mother can be done by suggesting some reading on the topic. There are many very good books on the subject of miscarriage which might be very helpful.⁶¹ This is one of the ways of providing parents with information that they may find useful in processing their grief.

⁵⁹ Harris, "p. 326.

⁶⁰ Witzel & Chartier, pp. 19-20.

⁶¹ Some of these books are: Joy & Marvin Johnson, Miscarriage: A Book for Parents Experiencing Fetal Death (Omaha, NE: Centering Corp, 1983); Hank Pizer & Christine O'Brien Palinski, Coping With a Miscarriage: How to Deal with Its Impact on You and Your Family (New York: Dial Press, 1980); Claudia Panuthos, Catherine Romeo, Ended Beginnings: Healing Childbearing Losses (Boston: Bergin & Garvey, 1984); Maureen Rank, Free to Grieve (Minneapolis: Bethany House, 1985); Nancy Rue, Handling the Heartbreak of Miscarriage (San Bernardino: Here's Life Publications, 1987); Pam V. Vredevelt, Empty Arms: Emotional Support for Those Who Have Suffered Miscarriage or Stillbirth (Portland: Meltnomah Press, 1984); Susan Borg, Judith Lasker, When Pregnancy Fails: Families Coping with Miscarriage, Stillbirth and Perinatal Death (Boston: Beacon Press, 1981); Rochelle Friedman, Barbara Gradstein, Surviving Pregnancy Loss (Boston: Little, Brown, 1982); Larry Peppers, Ronald J. Knapp, How to Go on Living After the Death of a Baby (Atlanta: Peachtree Publications, 1985); Ann Oakley, Ann McPherson, Helen Roberts, Miscarriage (Glasgow: Fontana Books, 1984).

SOCIAL ATTITUDES TOWARD WOMEN, THEIR BODIES, AND
REPRODUCTIVE FUNCTIONS

The institution of motherhood has been a relatively recent invention in the history of human reproduction. The process of human reproduction is a biological event, but its defining aspect for human life is its social character. It is normal for a woman who becomes pregnant to have ambivalent feelings towards her pregnancy. There is a time of re-adjustment of body size and relation to the world. There is a time of re-adjustment in self-image in relation to the expected child and the other people in her life who will be affected by this new arrival. This is particularly true for the *primipara* or first pregnancy. Not only is motherhood social in character, it is also relational in character rather than merely a role.⁶²

Our society has made motherhood a wonderful goal for women. It is sometimes overtly and sometimes tacitly assumed that a woman is really not a whole woman until she has given birth. Being a mother has been romanticized over the years. "Motherhood is culturally equated with the achievement of femininity."⁶³ Oakley says that the attitude that only women with children are 'proper' women is pervasive in our society. Our society idealizes motherhood, creating a view

⁶² Nel Noddings, Caring: A Feminine Approach to Ethics and Moral Education (London: University of California Press, 1984), p. 128.

⁶³ Ann Oakley, Women Confined: Towards a Sociology of Childbirth (Oxford: Martin Robertson, 1980), p. 182.

of motherhood that springs from a male, not a female, concept of women and the mothering role.⁶⁴

Today reproduction is something that women can prevent through the use of contraceptive devices. The converse of this practice is that women can control when they reproduce. The expectation is that the woman will become pregnant when she decides that the time is appropriate. The recent advances in reproductive technology have made control over pregnancy much less a natural accident and more a carefully planned event.

Ann Oakley notes that women evaluate the success of their childbirth by the satisfaction and sense of accomplishment received from their efforts of full participation in the event rather than by the medical model of concern for statistics which is a more objectively scientific approach to childbirth.⁶⁵ It would seem that this attitude could be applicable to the whole concept of motherhood and not just one aspect of it.

This medicalization of motherhood is the movement away from the use of female midwives delivering babies in the homes of the mothers towards the use of medical doctors, predominantly male, delivering babies in medical facilities. Margaret Connor Versluysen in "Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in

⁶⁴ Oakley, pp. 282-284. This feminization since the Industrial Revolution is discussed by Rosemary Radford Ruether, From Machismo to Mutuality (New York: Paulist Press, 1976), pp.43-52.

⁶⁵ Oakley, Women Confined, p. 27.

Eighteenth Century London" describes the process of male-midwives or doctors taking over from female midwives and opening up lying-in hospitals in mid-eighteenth century London. Part of their approach was to use pamphlets to increase their credibility.⁶⁶

Ann Oakley in "Feminism, Motherhood and Medicine" outlines the process of the medicalization of motherhood. She maintains that medicine has technicalized the love of mother and child. The reasons that she gives for this medicalization are a combination of three factors. First, this was the only rational route to improve maternal/child health, secondly, there was the rise of professional imperialism within medicine itself, and finally came the growth of monopolistic power among the medical professions. She notes that in the early 1900s infant mortality was defined as preventable, thus making children subjects of medical discourse. "When postpartum depression first appeared in medical language it did so as a symptom of primary genital derangement."⁶⁷ She notes that although doctors in the last century were unashamedly outspoken about the inferiority of women's biological capacities, the latter part of this century continues to see an effort to control motherhood.

⁶⁶ Margaret Connor Versluysen, "Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in Eighteenth Century London", Women, Health and Reproduction, ed. Helen Roberts (London: Routledge & Kegan Paul, 1981), pp. 18-49.

⁶⁷ Oakley, "Feminism", p. 133.

... have exchanged a vocabulary of outright domination for a softer litany that speaks of 'monitoring', of the need to watch carefully for possible pathologies, and of women's own interests in subjecting themselves and their fetuses to this systematic clinical gaze.(137)

Another manner in which motherhood has been medicalized can be seen in the phenomenon of maternal/infant bonding.

Oakley points out that the relationship between mother and infant is one of unparalleled intimacy. She says that this positive side of motherhood has been as hidden as the negative side of motherhood. It has been hidden by the 'bonding' theory which made falling in love simply another phase in the pregnancy-birth process.

In other words, the domain of motherhood deemed relevant to medicine was extended, and there was now something else that mothers couldn't do for themselves, but only with medical help.(141)

Oakley posits that the scientific recognition of this theory is actually one way of recognizing that women's ability to reproduce the human species is powerful and so must be controlled before women decide to "define their own importance in their own way."⁶⁸

Despite what Oakley says, bonding theory has at least given some validation to perinatal bereavement in the eyes of 'authoritative' medical people. Perhaps the written protocols for stillbirth found in many hospitals is another type of control over the processes of birth and death. But at least in the case of perinatal bereavement there is a

⁶⁸ Oakley, "Feminism", pp. 127-142.

recognition that it is an important event that needs to be addressed.

The major effect of the medicalization of motherhood has been to erode and devalue women's ability to care for themselves. Women are seen in two ways: as mechanisms to be controlled and as biologically 'feminine' females. In this case women are treated in an a priori fashion as representing femininity rather than humanity.⁶⁹ The danger in this model of motherhood is that the emotional and mental behaviour of the pregnant woman is seen as reactive to her biology. In this instance a miscarriage is seen as a disturbance of normal biological reproduction and "evidence of a woman's inability to achieve mature femininity".⁷⁰ Another effect of this medical model is to see the pain of childbirth as something that can be 'done right' so that there is no pain. This can be corrected by 'natural' childbirth classes. The elimination of pain is part of the romanticized expectations about childbirth.⁷¹

Perhaps one of the effects of this process of medicalization has been articulated in Jane Balin's "The Sacred Dimensions of Pregnancy and Birth". She notes that the women that she interviewed expressed a deep concern about their ability to give birth and a genuine desire to be

⁶⁹ Oakley, Women Confined, pp. 31, 51.

⁷⁰ Oakley, Women Confined, p. 57.

⁷¹ Oakley, Women Confined, pp. 283-284.

taught how to do this by professionals.⁷²

Part of the difficulty with the medical model of motherhood is that there is usually a sex-role difference between the mother and her doctor. Unfortunately sometimes that can create a communication difficulty. Carol Gilligan notes that "men and women speak different languages that they assume are the same. using similar words to encode disparate experiences of self and social relationships."⁷³

Oakley speaks of the institution of motherhood being caught in the tension between two paradigms, feminism and the scientism of medicine. She says that contemporary women want their cake and to eat it too. They want it to be acknowledged that they know what they know as women and mothers as well as to be able to demand scientific knowledge about motherhood.⁷⁴ She does not offer a solution to this issue for women. The central point of her concern is that the unique power to reproduce human beings is not acknowledged by socially powerful individuals or institutions.

Many contemporary authors are addressing the medical model of motherhood. Mary B. Mahowald, in "Sex-Role Stereotypes in Medicine", is concerned about the patient-doctor relationship. She notes that the traditional one in

⁷² Jane Balin, "The Sacred Dimensions of Pregnancy and Birth", *Qualitative Sociology*, 11 (4), Winter 1988, p. 294.

⁷³ Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 1982), p. 173.

⁷⁴ Oakley, *Women Confined*, pp. 144-146.

the case of motherhood is patriarchal and leads to sex-role stereotyping. The opposite form of relationship based only on autonomy should be called maternalistic. She rejects both of these models and presents a model called parentalism. Real parenting is life-begetting and has equal respect for the parent as well as the child. In this model the physician is a collaborator and the principles involved would be beneficence and autonomy applied through an appeal to justice, particularly distributive justice.⁷³ This model of the patient-doctor relationship respects the autonomy of both parties. It seems to be based upon moral choices that are based upon the type of moral decision-making styles that Gilligan describes as typically female. She says that women make moral choices based on the connections or relationships that exist in any situation. The aim is to do as little harm to these relationships when making a moral decision.

Ann Oakley, a feminist sociologist, has done much work in the field of women's roles in our society. She feels that feminist commentary on motherhood has mostly had the character of a response, in that feminists have used a particular view of the status quo to define a different future for motherhood. For instance, in the eighteenth and early nineteenth centuries the focus was on the political, economic, and psychological effects of women's dependence upon men. Then in the nineteenth and early twentieth

⁷³ Mary B. Mahowald, "Sex-Role Stereotypes in Medicine", *Hypatia*, 2 (2), Summer 1987, pp. 21-38.

centuries, there was little focus on motherhood since the concerns were more about public institutions.⁷⁶ In further work Oakley shows the recent approach to motherhood:

The ability of women to grow and breastfeed babies and give birth to them in pain but with satisfaction is only now beginning to be seen by feminists as a valid and valuable aspect of being a woman, a resource to be drawn on rather than a burden to be disposed of.⁷⁷

Today the unique role of motherhood in society is being recognized by women as a very powerful ability and contribution that women make to creation.

Mary O'Brien discusses human reproduction in The Politics...of...Reproduction in which she asserts that the importance of human reproduction is a valuable labour that should be recognized and claimed because it has political power. When this happens women will be given human value.⁷⁸ O'Brien calls for the type of feminist philosophy of birth that Virginia Held has proposed.

Held, in "Birth and Death", speaks about the role of giving birth in our society. She says that death has been seen as a distinctly human event whereas birth has been seen as an act of nature. Even though people fear death, there has been created a kind of possible nobility in it through valour and courage. This recognition has not happened for the other end of the life process. If we view the mother as

⁷⁶ Oakley, "Feminism, Motherhood, and Medicine", pp. 128-131.

⁷⁷ Ann Oakley, Becoming a Mother (Oxford: Martin Robertson, 1979), p. 23.

⁷⁸ Mary O'Brien, The Politics of Reproduction (Boston: Routledge & Kegan Paul, 1981).

fully human, we must acknowledge that giving birth to a new human being is a human, not a 'natural', process, in the sense that it is used in our society in relation to women and birth. To speak of human birth as primarily biological is as misleading as speaking of human death as primarily biological. In this way, Held feels that concepts about birth should be as central to our thinking as concepts about death. She concludes:

Only when the conscious experience of mothers, potential mothers, and mothering persons are taken fully into account can we possibly develop understanding that may someday merit the description 'human'. And only when human birth and mothering are appreciated as the fully human achievements they are can we expect that human death will be less often pointless, debased, and unnecessarily early.⁷⁹

The two inevitable ends of life are filled with mystery. Humans are ultimately unable to control either. We have attempted to control death because it is seen as unnatural. Perhaps if we change our attitude towards death, the attitude towards birth will change as well. This would have important ramifications for women.

Jane Balin, in "The Sacred Dimension of Pregnancy and Birth", discusses what she feels are some of signs of societal attitudes towards pregnant women which indicate that pregnancy is seen as sacred. For instance, when a woman becomes pregnant there is a social change in attitudes

⁷⁹ Virginia Held, "Birth and Death", *Ethics*, 99 (2), Jan. 1989, p. 388. The previous material from pp. 362-371.

towards her. She is special. There are certain expectations about her dietary regime and her bodily health. She is not offered the glass of wine and may be expected to quit working one or two months before her delivery. The various signs of special dietary and hygienic regulations that pregnant women observe set them apart and are "symbolic markers of their sacred status as pregnant women."⁸⁰ When compared with other social networks this may be true: however, the other authors previously discussed would say that the signs of sacredness are there but they are not given that status in a broad sense. Pregnancy is 'natural', not 'sacred'.

THE NATURE OF SUFFERING

Eric Cassel, in "The Nature of Suffering and the Goals of Medicine", proposes a paradigm for suffering that is much discussed in the literature. Although medicine has seemed to assume that suffering means pain, Cassel offers some other criteria for suffering. Human persons suffer when they perceive social threats, personal and private threats, and threats to their perception of the future. He rejects the historical dualism of mind and body. It prevents seeing the patient as a whole human being. When this is done it is possible to see suffering as being beyond the physical. In fact part of suffering can be the separation of the body

⁸⁰ Balin, pp. 283-86, 292.

from the personhood of the patient. It seems that suffering occurs when persons perceive any pain that they have as a threat to their integrity as persons. This pain can be less a source of suffering when the source of the pain is known, the meaning can be changed, and the end can be seen. Additional suffering occurs when a physician does not validate the pain that the person feels.

Cassel further discusses the factors of personhood: personality and character, past, life experiences, intensity of family ties, cultural background, personal roles, relationships, regular behaviours, perception of the body as enemy, secret life, perceived future, and spiritual life. It seems that Cassel has outlined the personal story theme that Carter speaks about. It is interesting to note that Cassel says that intense unhappiness occurs when there is a loss of future. He says that the only way to discover what the causes and nature of a person's suffering are, is to ask the sufferer.⁸¹

In response to Cassel, Frances L. Drew, in "Suffering and Autonomy", says that there is another aspect that was not used in the preceding outline of the nature of suffering. She focuses on the fact that suffering can be caused by the loss of power in whatever way the patient may have felt powerful. There is a loss of control in this type

⁸¹ Eric J. Cassel, "The Nature of Suffering and the Goals of Medicine", The New England Journal of Medicine, 306 (11), Mar 1982, pp. 629-645.

of suffering. Drew suggests that restoring autonomy to the patient will help to alleviate the suffering. This assistance can be done simply by providing information, privacy, and some choice about care. In speaking about terminally ill cancer patients she says by way of example that if medicine could tell them that there was a routine order for cyanide capsules on request, that perhaps two out of ten patients would request it. "I would remind you that not to act is itself an action, a choice, an exercise in autonomy."⁸² The suggestions for criteria of suffering offered by Cassel and Drew will be used in the analysis of the material from the women subjects in this study.

Lucy Bregman, in "Models of Suffering", discusses three types of models for suffering. The first is loss, which is caused by a death of a loved one, and its characteristic is the grief work done afterwards. The second model is one of oppression, in which the source is the injustice of the social system, and it is characterized by the sufferer being a victim. The third model of suffering, one which Bregman says is the primary one used by Christianity, is guilt and self-hatred. The source of this type of suffering model is invalid demands and restrictions; it is characterized by a great deal of guilt and self-hatred.⁸³ It seems that the case of miscarriage falls within both the loss and guilt and

⁸² Frances L. Drew, "Suffering and Autonomy", Loss, Grief and Care, 1 (1-2), 1986-87, pp. 19-24 and 23.

⁸³ Lucy Bregman, "Models of Suffering", Religion and Intellectual Life, 4, Sum 1987, pp. 78-91.

self-blame models of suffering as described by Bregman.

In Women and Evil Nel Noddings says that:

we find at the bottom of each suffering event pain that cries for relief, a threat of separation that triggers an increased need for connection, and a dread of helplessness that begs for empowerment.⁸⁴

In considering these feelings for connection and dread of helplessness, we turn to methods of caring for those who are suffering.

CARE OF THE SUFFERING

Since research about the phenomenon of bereavement, perinatal bereavement, and models of caring is quite recent, it means that many present caregivers may not have received this information as part of their training. Thus there needs to be some in-service education for health care staff.

Because suffering seems to be increased when there is a lack of information and autonomy, a form should be developed in medical centres that would provide for the disposal of a miscarried baby. (See Appendix #1 for a sample form) This would give the information to the woman and facilitate the medical staff's comfort with the explanation of how the centre disposes of the fetuses.⁸⁵ This would alleviate the suffering of those women who feel that the lack of information increased their suffering.

⁸⁴ Nel Noddings, Women and Evil, p. 129.

⁸⁵ One hospital in Chatham has used such a form for a number of years and finds that less than five percent of the women select the use of a funeral home for disposal. The sample found in Appendix #1 provides for a section for the funeral director to sign when the hospital releases the fetus.

Noddings notes that caring for the physical and emotional welfare of others has been basic to women's experience. For her an ethic of caring is based on relational ontology. That means that all human beings are defined as being in relation.⁸⁶ Caring also involves an interaction between the one-caring [sic] and the cared-for. The one-caring wants to alleviate the suffering because she or he loves. A caring relation is better than other forms of relationships. This type of caring relation means feeling with the sufferer. It means more than just empathy: it means taking the essence of the other into oneself and to feel with the other. At the same time the one-caring does not relinquish the self. In this manner the one-caring becomes a duality. The one-caring is primarily committed to receiving, choosing life, and enjoying life. Noddings concludes that many women find that caring of this nature is central to their self-image.⁸⁷

When discussing this model of caring, one must understand the nature of relational love. Linell E. Cady notes that traditional Christian love is self-sacrificial love which fails to note the relational character of love. The primary nature of relational love is the process of integrations and connections that happen between human

⁸⁶ Noddings, Women and Evil, pp. 42, 236.

⁸⁷ Noddings, Caring, pp. 32-130.

persons.⁸⁸

The effect of this relational love is described by Beverley Harrison as building up the power of personhood in the other person. She says that anger is our mode of connectedness to others and that it is always a vital form of caring. The presence of a feeling of anger indicates that there is something wrong with the relational aspect of people. This anger, then, becomes a powerful motivator in making a caring corrective to improve the relational aspect which is threatened.⁸⁹

All of this means that when the relationship or connection between persons is threatened an ethic of care based on relational love should go into effect. Gilligan has shown that women make choices through the priority that they give to relationships and connections. She notes that for women a reflective understanding of care based on relational love is the most adequate guide to the resolution of conflicts in human relationships.⁹⁰ The primacy of relational love and the ethic of caring based on it are important to remember as complementary to the theological and pastoral aspects of dealing with the suffering of bereavement after miscarriage.

⁸⁸ Linell E. Cady, "Relational Love: A Feminist Christian Vision", Embodied Love: Sensuality and Relationship as Feminist Values, eds. Paula Cooney, Sharon Farmer, Mary Ellen Ross (San Francisco: Harper & Row, 1987), pp. 135-149.

⁸⁹ Beverley Harrison, "The Power of Anger in the Work of Love", Making the Connections (Boston: Beacon Press, 1985), pp. 3-21.

⁹⁰ Gilligan, p. 105.

In order to understand the reasons for some of the attitudes towards women and their bodies, it is necessary to examine the philosophical and theological attitudes upon which our society is based. Consequently, these topics will be examined next.

CHAPTER TWO

THEOLOGICAL PERSPECTIVES: WOMAN AND BODY

Miscarriage is an experience that some women have as a process of their bodies. From a pastoral point of view it is important to examine the view of embodiment¹ that Christian tradition has, both in the past and the present, in order to understand what might be some effective means of dealing with women who have had the experience of a miscarriage.

This chapter will discuss the issue of the relationship between woman, body and nature as seen in the past and in our contemporary culture and religion. This will precede a discussion of the relationship between body and mind or soul as perceived by both traditional and current thinkers.² The work of Plato, Aristotle, Augustine, and Aquinas will be examined as well as that of current thinkers, both men and women, on the same issue. The final section of the chapter will discuss the relationship between pregnancy and embodiment.

¹ Embodiment is a term that relates to the integration and celebration of the total person, body and mind. It is opposed to dualism which disembodies the intellect from the center of action for the human being. Beverly Harrison puts it well: "All knowledge is rooted in our sensuality. We know and value the world, if we know and value it, through our ability to touch, to hear, to see. Perception is foundation to conception. All power, including intellectual power, is rooted in feeling. If feeling is damaged or cut off, our power to image the world and act into it is destroyed and our rationality is impaired." Beverly Harrison, "The Power of Anger in the Work of Love" from Weaving the Visions, ed. Judith Plaskow, Carol Christ (San Francisco: Harper & Row, 1989), pp. 218-219.

² I will not attempt to deal with the intricate arguments of individual philosophers and theologians, but rather examine their conclusions.

THE WOMAN / BODY / NATURE ISSUE

Dualism developed in culture, philosophy, theology, and society from the early beginnings of civilization to the present day. There developed an understanding that the mind and the body were separate and yet somehow connected entities. To explain that relationship has been the task of thinkers for millennia. The most extreme form of this splitting of the body from the mind or soul is seen in the work of Rene Descartes. His explicit form of dualism is called Cartesian Dualism. It has been described as follows:

Persons are a composition of two substances: mind and body. These substances are inherently distinct, independent, and complete, however intimately bound together they may be in the lives of human beings. Considered in themselves, apart from their actual association in a human life, neither of these substances bears any essential relation to the other; rather, each possess essential characteristics that are excluded from the other. The essential characteristic of matter, or body, is extension in space. The essential characteristic of mind is 'thought', broadly understood to embrace all the contents and operations of consciousness. The distinction between mind and body is radical: it is a distinction between substance that is thinking and unextended on the one hand, and substance that is extended and unthinking on the other.³

Cartesian dualism has been under attack in contemporary philosophy and theology. What happened with the analysis of the relative importance of the mind and the body in theology has had implications for human beings who inhabit female bodies. The intimately related by-product of

³ Thomas F. Tracey, God, Action and Embodiment (Grand Rapids: William B. Eerdmans, 1984), p. 47.

classic dualism is sometimes called sexual dualism. Dualism has been a persistent motif in philosophy. The series of oppositions that can be seen include mind / body, spirit / matter, subject / object, individual / social, culture / nature and past / present. Mary O'Brien suggests that men have a need for two natures in that they perceive that men have two natures, biological and socio-cultural, whereas women have only one nature, biological. "Women have been perceived as integrated with the first nature so completely that they do not need a second nature."⁴ The roots of such thinking go back to the beginnings of Western civilization.

Within the cultures of the world women have been identified with nature while men have been identified with culture. Sherry Ortner's work has outlined this equating of nature with women, particularly their bodies.⁵ She describes how women are seen as closer to nature because their bodily functions seem closer to nature. Women's social role is relegated to their 'natural' nurturing functions. Although women are no more closely related to nature than men, they have been so labelled because of their bodies. Consequently, women are related to the inferior work of

⁴ Mary O'Brien, The Politics of Reproduction (Boston: Routledge & Kegan Paul, 1981), p. 118.

⁵ Sherry Ortner, "Is Female to Male as Nature is to Culture?" Woman, Culture and Society, ed. Michelle Zimbalist Rosaldo, Louise Lamphere (Stanford: Stanford University Press, 1974), pp. 67-87. Other works that discuss this phenomenon are Rosemary Radford Ruether, Sexism and God-Talk (Boston: Beacon Press, 1983), p. 72; and Lynda Birke in Women, Feminism and Biology (New York: Methuen Press, 1986), pp. 4, 18, who discusses this idea as being a prevailing assumption in our society. James B. Nelson has agreed with this alignment in Embodiment: An Approach to Sexuality and Christian Theology, (Minneapolis: Augsburg, 1978), p. 58.

nature while men are related to the superior work of culture. For theology the early use of biological arguments must be examined in order to see where these roots lie within Christianity.

Women have not only been related to nature and the earth, but also to death. This association is very normal since both nature and the earth suffer decay and rebirth. Page DuBois, in Sowing the Body: Psychoanalysis and Ancient Representations of Women, relates how in the Greco-Roman world, women, as representatives of reproduction, became the bearers of death. The ancient Greeks, for instance, referred to women as a vessel or a vase. As a metaphorical vase a woman contained life in the form of a baby. However, vases were also used to hold the remains of the dead. Then, like the Pandora dilemma, there is great potential danger in opening this vase, pithos, or box. DuBois feels that somatophobia grew to become a fear of women's bodies in particular because the biological functions of the female body could give death along with life.⁶ This relationship of woman's body with death is most dramatically seen in the figure of Frau Welt, or Dame Nature, in thirteenth century

⁶ Page DuBois, Sowing the Body: Psychoanalysis and Ancient Representations of Women (Chicago: University of Chicago Press, 1988), pp. 58-59, 147. Rosemary Radford Ruecher discusses these beginnings when she shows the correlation of women with the lower nature and men with the higher nature. In the Ancient Near Eastern mythologies "both the threatening powers of chaos or primal matter and the resuscitation of the powers of life against death are symbolized by female powers" (Sexism and God-Talk, p. 78) or goddesses. James B. Nelson expresses the thought that men felt inferior to women because of the special powers that women had to reproduce the species. Because of that reaction, men had two options; to adore women as divine or to treat women as demonic. (Nelson, p. 60)

Germany. This figure, beguiling from the front, was eaten away with worms and creatures of the grave from the back.⁷ Dame Nature contained the goodness of creative power as well as the dangers of creative power.

Although there has been much work in contemporary philosophy to refute Cartesian Dualism, it is from the work of feminist philosophers and theologians that most of the important reflections have come concerning the implications of this dualism for women. Naomi Goldenberg expresses concern for both men and women:

Feminists must study loathing of the flesh wherever it occurs - whether in individuals, in culture or in philosophical and religious theories. This direction of research is primary for our inquiry because women have come to represent the body in human culture. We cannot learn to stop hating women without learning to stop hating human flesh.⁸

In order to have a true mutuality of women and men, there must be an integration rather than a separation of the body and the mind.

Various theories about the motive for the creation of dualistic thought have been brought forward. One was that of somatophobia, or fear of the body. Another is proposed by Naomi Goldenberg in her article "Anger in the Body". She feels that

⁷ Ruether, Sexism and God-Talk, p.81; Eleanor Conno McLaughlin, "Equality of Souls Inequality of Sexes: Woman in Medieval Theology", Religion and Sexism ed. Rosemary Radford Ruether (New York: Simon & Schuster, 1974), pp. 253-254. Although there are some examples of this type of art in the Transi era of tombs for males, it is more often seen in women figures.

⁸ Naomi Goldenberg, "Anger in the Body: Feminism, Religion and Kleinian Psychoanalytic Theory", Journal of Feminist Studies, 2 (2), Fall 1986, p. 48.

the body is where religious thought has consigned human anger. While the soul has been seen as pure, valuable, loving and eternally alive, the body has been viewed as tainted, expendable, the vehicle of death.⁹

Using Melanie Klein's theory about the innateness of aggressive feelings towards objects and people that all humans experience, Goldenberg suggests that dualism is really a separation of anger and love. Following Kleinian thought, these two elements of the human psyche can, when integrated, be a source of great vitality and creativity. Goldenberg goes on to say that this splitting of love and anger produces a need for a scapegoat. She suggests that in Christianity this scapegoat is the Devil in mythology and woman in reality. This interpretation can be seen through the development of the tradition about the Temptress Eve, as an instrument of the serpent. Goldenberg makes a startling statement:

I suggest that Christianity has found it impossible to cherish bodies in general and female bodies in particular because the anger felt to reside in the body poses a threat to images of an all-perfect God.¹⁰

An example of the consequences of this type of thinking is the development of the Virgin Mary, denied her sexuality, into a disembodied female as seen in the Roman Catholic tradition.

Gradually there was a change, particularly in Greek

⁹ Goldenberg, p. 44.

¹⁰ Goldenberg, p. 45.

thought, towards an alienation between male consciousness and nature. The work of Page DuBois on the development of early Greek images of women shed some light on the change of the view of women from adoration to loathing.¹¹ DuBois explains this transition very well through an examination of the metaphors used in ancient Greece for woman's body. She shows that initially those metaphors were very positive, powerful and autonomous, but that they changed from the eighth century to the fifth century bce as the economy moved from a pre-agricultural one to an agricultural one. The increase in the city-state system of government added to this movement. Originally woman's body was seen as a fruitful, spontaneously generating earth. Gradually this changed from a metaphor of a parthenogenetic earth to a metaphor of woman as a field that required ploughing, then, in succession, as a furrow, as a vase, as an oven, as a stone and finally as a blank tablet upon which knowledge must be inscribed. Part of this development is that the reproductive abilities of the woman were denigrated. DuBois gives many examples from Greek literature. One that is particularly enlightening is from Aeschylus' Oresteia in the fifth century bce:

The mother is no parent of that which is called her child, but only nurse to the newly-planted seed that grows. The parent is he who mounts. A stranger she preserves a stranger's seed, if no god interfere.¹²

¹¹ James B. Nelson, p. 61; Page DuBois.

¹² DuBois, p. 32.

It is of particular interest that this ancient author claimed male responsibility for the child but blamed the gods for anything that went wrong.

The relation of woman to the earth and man to higher or spiritual matters is seen in the mythical version of Creation as seen in Genesis 2-3. The image of Adam is soul since God breathed the breath of life (Genesis 2:7) into him, whereas Eve is created from the matter or flesh (Genesis 2:21). Evidence for the view that women are the weaker 'vessel' is seen in 1 Peter 3:7: "woman as the weaker sex" (RSV), "weaker partner" (NIV), "weaker" (NEB). There is evidence of the Greek generative theory on the reproductive thought of the writer of Hebrews:

By faith even Sarah herself received strength to conceive, though she was past the age, because she judged that he who had promised would keep faith; and therefore from one man, and one as good as dead, there spring descendants numerous as the stars or as the countless grains of sand on the sea-shore. (Heb 11:11-12)

Here there is evidence of Aristotle's theory that women are the passive containers while men are the producers in generation.

Anna Goldman-Amirav, in "Behold, The Lord Hath Restrained Me from Bearing", argues that the reason that there is the repeated motif in Hebrew scriptures of elderly infertile women is not accidental. These matriarchs come from a Mesopotamian culture that worships Goddesses, and where the reproductive power of women is venerated. When the

Hebrew peoples moved into a different cultural milieu and adopted YHWH (Yahweh) as a new sexless, yet male God, the people had to be shown that the ancient maternal Goddesses were less powerful than the new God. He shows his greater power by usurping their powers over reproduction, making young women barren and opening elderly women's wombs at His wish. Thus the attitude towards fertility and women was established in the mythology.¹³ Once established in the mythology this view became a basic part of that culture and religion.

Another author who has dealt extensively with the concept of woman in early Greek philosophers as well as early Christian thinkers is Prudence Allen.¹⁴ She discusses the view of women in relation to men from four aspects. These are sex-unity in which there is no difference between men and women, sex-polarity in which men and women are opposed, sex-complimentary in which men and women are different but complimentary, and sex-neutrality in which the differences between men and women are ignored. Allen looks at the early philosophers and theologians whose work affected Christianity from these points of view in analyzing the way that they looked at generation, wisdom and virtue. She attempts to show that although Aristotle's thought is

¹³ Anna Goldman-Amirav, "Behold, the Lord Hath Restrained Me From Bearing", Reproductive and Genetic Engineering, 1 (3), 1988, pp. 275-279.

¹⁴ Prudence Allen, The Concept of Woman: Aristotelian Revolution 750 BC - Ad 1250 (Montreal: Eden Press, 1985).

perceived as being similar to Plato's in regard to women, there is really a difference in their attitudes on some points. However, several other scholars feel that this may have been true in the early work of Plato but that his later view of women was very similar to that expressed in the work of Aristotle.¹⁵ In spite of this difference of opinion, Allen's four categories are helpful in examining the attitude of various authors towards women in relation to men.

TRADITIONAL RESPONSES

PLATO

Plato (ca. 428-355 bce) was the first Greek philosopher to attempt to describe the function of women in any real way. Being a product of his environment, he used many of the metaphors present in the Greece of his time. DuBois feels that with Plato the final appropriation of the ancient metaphors for the female powers of reproduction to the mind of the male philosopher can be seen.¹⁶ An example of this use of the metaphors of the time is found in the Laws: "female field ... you would desire to harvest".¹⁷ This is also evident in the way that Plato describes the body/mind relationship. Plato sees the human being as a mind-in-a-body

¹⁵ Anne Dickason, "Anatomy and Destiny: The Role of Biology in Plato's Views of Women", The Philosophical Forum, 5, Fall-Winter 1973-74, pp. 45-53. DuBois agrees with this analysis of change in Plato's evaluation of women on p. 171.

¹⁶ DuBois, pp. 173-178.

¹⁷ as quoted in Allen, p. 65.

and the body variously as a tomb and a prison.¹⁸ He also felt that the true human self is the spirit which was trapped in an earthly body. The body had less "truth and essence" than the soul.¹⁹ The soul also is prior to and older than the body.²⁰ The body keeps humans from real knowledge, the world of reality and the virtuous life. It is only through the soul that humans are in touch with reality. Thus bodily death is not to be feared since only the body decays.²¹ These basic concepts about the relationship between the body and the soul are important when Plato's concept of woman is examined.

Allen maintains that from the view of the soul it was first apparent that Plato stood for sex-unity but from a body viewpoint he stood for sex-polarity. Thus from the aspect of soul woman and man are equal but from the body aspect woman is inferior to man.²² To him the visual evidence of a woman's inferior body was her physically weaker incarnation. It also took a woman longer to attain the same level of wisdom as a man.²³ Allen says that it is ironic that although Plato seems to be an advocate of sex-unity, subsequent thinkers felt influenced by him to

¹⁸ Benedict M. Ashley, Theologies of the Body: Humanist and Christian (Braintree, Massachusetts: The Pope John Center, 1985), p. 61, 103; DuBois, p. 81; Elizabeth V. Spelman, "Woman as Body: ancient and Contemporary Views" Feminist Studies, 8 (1), 1982, p. 114.

¹⁹ Martha Lee Osborne, "Plato's Unchanging View of Women: A Denial that Anatomy Spells Destiny" The Philosophical Forum, VI (4), Summer 1975, p. 447.

²⁰ Ashley, p. 61.

²¹ Spelman, "Woman as Body", p. 111.

²² Allen, p. 62.

²³ Allen, p. 74.

advocate a sex-polarity theory in relation to women and men.²⁴ Plato's views about generation, and reproduction of the species, show that he understood the theories of Hippocrates but that he felt that the woman is the receiving principle while the man gives the form or action to create.²⁵ Plato felt that souls fell into bodies. Sometimes they were male bodies and other times they were female bodies. Thus for him, souls were sexless in nature.²⁶ The male seed was the vehicle through which the soul became resident in the body.

Anne Dickason discusses this very issue in an earlier article in which she shows that the sex-unity ideas were evident in Plato's earlier work but that his later works show that he favoured the sex-polarity theory. She even suggests that the possible exposure to his young student Aristotle may have had some influence upon his thinking. For instance, in the later Timaeus Plato says that only males were created by the gods. They were given souls. Those who were not given souls became females. Men were complete beings in themselves while women begin life as religious inferiors who could only hope to become a man in the next life. The argument given by Allen and Osborne comes from the political position of guardian in the Republic where women can become equals in this superior public role. However,

²⁴ Allen, p. 78.

²⁵ Dickason, p. 51.

²⁶ Allen, p. 62.

Plato says that women may accept these official appointments when they are 40 while men may accept when they are 30.²⁷ According to Elizabeth V. Spelman, Plato seems to be saying that in actual fact "we are our souls" and that "our bodies are not essential to our identity."²⁸ She feels that this evidence of misogyny is a sign of Plato's somatophobia and that his negative views about women were connected with his negative views about the body.²⁹ Thus, Plato's later work did not have a positive view of women whereas his early work was neutral towards women.

ARISTOTLE

Plato's student Aristotle (384 - 322 bce) had a firmer opinion of the relationship between body and soul and about the place of women in this dichotomy. For Aristotle, the body was the substance or particular individual entity and the soul was the form which constitutes the substance.³⁰ The soul is the essence of the living substance.³¹ These earthly realities of life were the existential embodiments of the ideal or mind.³² The soul becomes the form of the body in

²⁷ Dickason, pp. 45-51. Nicholas Smith in "Plato and Aristotle on the Nature of Women", Journal of the History of Philosophy, 21 (4), Oct 1983, pp. 468-474, joins the debate about the concept of women seen in Plato's Republic and Tinaeus as well as Politics. He maintains that one does not relate to the other. However, Dickason seems to be the one who brings in the factor of the more explicit view of women seen in the later works of Plato.

²⁸ Spelman, "Woman as Body", p. 117.

²⁹ Spelman, "Woman as Body", pp. 118-119.

³⁰ Peter Smith, O.R. Jones, The Philosophy of Mind (Cambridge: Cambridge University Press, 1986), pp. 75-78.

³¹ Edwin Hartman, Substance, Body and Soul (Princeton: Princeton University Press, 1977), pp. 133-134.

³² Ashley, p. 167.

Aristotle's thinking. Contrary to Plato, Allen says that Aristotle felt that

rational thought depends for its content on our bodily sense organs, yet conceded to Plato that reason, since it attains the universal and essential in our particular, concrete experience, cannot itself be the act of a bodily organ. Aristotle, however, never made clear what this 'spiritual', 'agent intellect' might be.³³

Allen articulates the difference between Plato and Aristotle's thought on body/soul:

The idea that "the soul is the action of the body brings about a unification of the person that was absent in Plato's philosophy. For Plato, the soul and body were entirely distinct; the soul, containing human rationality, existed prior to and after the body, which expressed materiality. ... Aristotle's philosophy brought about a unification of soul and body, form and matter, of rationality and materiality. He argued that a person was a unified existent with both rationality and materiality. If either of these factors disappeared, then the person no longer existed."³⁴

In this way Aristotle tried to unify the person. However, the problem here is that his view of women does not fit into this ideal of humanness. Some contemporary Aristotelian philosophers also do not deal with what this view means in terms of how Aristotle viewed woman.³⁵

For Aristotle woman contributes matter or catamenia or menses to generation while the man contributes the form of

³³ Allen, p. 154.

³⁴ Allen, p. 125.

³⁵ Some works examined: Thomas Nagel, The View From Nowhere (New York: Oxford University Press, 1986); R.J. Nelson, The Logic of the Mind (Boston: Dordrecht Press, 1982); Smith and Jones; Hartman; H. Tristram Engelhardt, Mind-Body - a Categorical Relation (The Hague: Martinus Nijhoff, 1973); Thomas Tracey, God, Action, and Embodiment (Grand Rapids: William B. Eerdmans, 1984).

the child which exists potentially in the male soul.³⁶ Only males have rational souls. Women have the potential for this reality but not the authority; since reason must enter into the soul in order for that soul to have the authority of a rational soul.³⁷ A portion from the Generation of Animals shows this:

... the female is as it were a deformed male and the menstrual discharge is semen, though in an impure condition ie., it lacks one constituent, and one only, the principle of soul.³⁸

For this reason Aristotle proposes that men should rule over women. Spelman points out that Aristotle makes the classic assumption that nature explains woman's inferiority without attempting to prove this assumption, so that his argument for natural subordination is unsubstantiated.³⁹ Allen notes that because women and men appear different in body, Aristotle concluded that they really were different in nature.⁴⁰

Like Plato, Aristotle discussed political roles. He believed that courage was the criterion for participation in politics. However, he maintained that courage in women is different than courage in men.⁴¹ Aristotle takes a sex

³⁶ Linda Lange, "Woman is Not a Rational Animal: On Aristotle's Biology of Reproduction", Discovering Reality, eds. Sandra Harding, Merrill Hintikka (Dordrecht, Holland: D. Reidel, 1983), p. 5.

³⁷ Lange, p. 6 and Smith, p. 475. This is also found in Shadia B. Drury, "Aristotle on the Inferiority of Women", Women and Politics, 7 (4), Winter 1987, p. 58.

³⁸ As quoted in DuBois, p. 184 and in Allen, p. 97.

³⁹ Elizabeth V. Spelman, "Aristotle and the Politicization of the Soul", Discovering Reality, ed. Sandra Harding, Merrill Hintikka (Dordrecht, Holland: D. Reidel, 1983), pp. 17-30.

⁴⁰ Allen, p. 88.

⁴¹ Spelman, Drury, p. 57.

polarity stance to describe the relationship between women and men. Part of this sex-polarity is the implication that women have a naturally passive nature and thus cannot be judged by the same criteria as men.⁴² In Politics Aristotle writes:

... it is natural and expedient for the body to be governed by the soul and for the emotional part to be governed by the intellect, the part possessing reason, whereas for the two parties to be on an equal footing or in the contrary positions is harmful in all cases ... as between the sexes the male is by nature superior and the female inferior, the male ruler and female subject.⁴³

When the role of woman came into Aristotle's thinking there seems to be a problem with the unity that he describes for body and soul. It seems that his unity applies very nicely to men but not to women.

In order to understand how sexual dualism became a part of dualism, we need to look at the biological reasons given by the Greeks for the inferiority of women. The generative theory of Aristotle affected later thinking and science as well. Aristotle felt that women and men had different kinds of blood because of a heat factor. Women had colder blood. This is shown in men's semen which is white because of their hotter blood while women's menses are coloured because of the colder blood. Because of this lack of heat the material that the woman provides to generation

⁴² Allen, p. 112.

⁴³ As quoted in DuBois, p. 35.

is not potent but passive matter and thus not really seed, like semen.⁴⁴ Because of this phenomenon the seed is provided only by the male and the soul is present in the semen making the male the primary cause of the child.⁴⁵

The first theorist after Aristotle who affected subsequent thoughts about generation was Galen (130?-200). He corrected Aristotle's theory about the difference in the contribution of seed from the male and the female. Aristotle thought women did not contribute seed. Galen insisted that women had similar parts as men but that they were inside the body because of a defect in heat in utero. Thus women had seed as well as men. The true development of genitals is evident in the male form of genitals. The lack of heat during development produced a "half-baked" female human being.⁴⁶ Galen thus felt that women did contribute inferior seed in generation because of a difference in the anatomical structure of the blood vessels connecting the ovaries and testes with the circulatory system. According to ancient theory handed down from Hippocrates, the female child was produced from seed from the left testicle and the left ovary and resided on the left side of the uterus. Galen maintained that the blood vessels from the left ovary and teste did not carry purified blood from the kidney as it did

⁴⁴ Nancy Tuana, "The Weaker Seed: The Sexist Bias of Reproductive Theory", *Hypatia*, 3 (!), Spring 1988, pp. 35-38.

⁴⁵ Allen, pp. 98-100.

⁴⁶ Tuana, p. 42.

on the right side. Thus this less pure, less hot blood caused the production of imperfect seed. This anatomical error by Galen gives an explanation for women's deficiency in heat.

This error carried authority for centuries. It gave scientific evidence to the belief that a female human being was inferior to a male human being. Tuana points out that Vesalius (1514-1564), who used nine female cadavers, created a drawing that perpetuated Galen's error. It was a case of belief being stronger than physical evidence. Another anatomist of the time, Niccolo Massa (1485-1569), recognized Galen's error but insisted that the weaker seed from the left side was still the reason for the generation of a female human.⁴⁷ Such was the strength of the belief in sexual dualism. A very popular eighteenth century medical book called The Experienced Midwife (1700), written in English probably by William Salmon, became extremely popular. It was almost identical to a spurious document called Aristotle's Masterpiece, which was based on the work of Aristotle. Midwife says:

It is true that Galen and Hippocrates did erroneously imagine that the stones in women did contain and elaborate seed as those do in men, but it is a great mistake; for the testicles of women are as it were no more than two clusters of eggs which lie there to be impregnated by the most spirituous particles.⁴⁸

⁴⁷ Tuana, pp. 47-51.

⁴⁸ As quoted in Allen, p. 459.

The popularity of both of these works led to the perpetuation of Aristotle's dualistic view about woman as being related to the passive body.

AUGUSTINE

From this heritage of Greek philosophy and the successive biblical themes and thoughts come the theologians' views of body and soul and about woman. The greatest of the Church Fathers was Augustine (354-430), who was influenced by the works of Plato. According to her analysis Allen feels that Augustine developed a fragmented view of human identity that led to a multi-type concept of woman in relation to man. At the spiritual level there was a sex-complementary dimension. At the worldly level there was a sex-unity dimension when the orientation was only towards the higher part of the mind and spiritual existence. Finally there was a sex-polarity stand when the body and mind were oriented towards temporal existence.⁴⁹ Added to this, however, was the stand that woman stood for the temporal, whereas man stood for the spiritual, since "man only is the image and glory of God."⁵⁰ Only with her husband is the woman in the image of God. In terms of wisdom this sex-polarity aspect of Augustine's thought affects woman's ability to gain wisdom since the only way that she can do

⁴⁹ Allen, pp. 218-219.

⁵⁰ Augustine as quoted in Allen, p. 222.

that is to rise above her body. Augustine's gynophobia is evident in his belief that woman is the temptress simply by the fact of her body which must be controlled, either by herself or by her husband.⁵¹ Augustine was the first theologian to develop a theological approach to woman and her body.

Augustine's thought is important because of the vast influence he had upon the developing, institutionalized church and future generations of theologians and church leaders. The influence of Greek philosophy and Augustine may be reflected in the way later women spoke of their bodies. For instance, in the writings of Roswitha (935-1002) we read:

(God) has given a perspicacious mind, but one that lies fallow and idle when it is not cultivated: that my natural gifts might not be made void by negligence I have been at pains, whenever I have been able to pick up some threads and scraps torn from the old mantle of philosophy, to weave them into the stuff of my own book, in the hope that my lowly ignorant effort may gain more acceptance through the introduction of something of a nobler strain, and that the Creator of genius may be honoured since it is generally believed that a woman's intelligence is slower.⁵²

Although women did not participate in the development of a sex-polarity theory about women and men, the influence of this thought can be seen in their writing.

Augustine's influence is evident in both St.

⁵¹ Allen, pp. 222, 233 & 228.

⁵² From The Plays of Roswitha (New York: Cooper Square Publishers, 1966), pp. xxix-xxx, as quoted in Allen, p. 257.

Bonaventure (d.1274) and in Duns Scotus (d. 1308).⁵³ The influence of Platonic thought and Augustine's interpretation of it is evident in the Renaissance when there was a neo-Platonism with the idealization of the body: it was still considered the tomb of the soul but a beautiful reflection of the inner beauty which is neither defective or perishable. Evidence can be seen in the work of the great Renaissance artists like Michelangelo.⁵⁴

THOMAS AQUINAS

Before the Renaissance there was a return to an interest in Aristotelian philosophy by St. Thomas Aquinas (1225-1274). His work is important because he mediated the work of the patristic theology, particularly that of Augustine, and the metaphysics and natural science of Aristotle.⁵⁵ Aquinas considered that the body and soul were two entities that were needed for someone to be a whole person. He thought that although the intellect or mind is the higher element it is dependent on the bodily senses for the data that would make for knowledge. The body was necessary for the sake of the soul.⁵⁶ His type of hierarchy of soul and body is also seen in his attitude towards woman. He differed from Augustine in that he believed that woman

⁵³ Ashley, p. 157.

⁵⁴ Ashley, p. 165.

⁵⁵ McLaughlin, p. 215; also Ashley, p. 152.

⁵⁶ Ashley, pp. 157 and 167.

was made, in her body, in the image of God. Unfortunately, she reflected this image less perfectly than man. In the Summa Theologica he says:

God's image is found in man in a way in which it is not found in woman; for man is the beginning and the end of woman, just as God is the beginning and end of all creation. Thus after saying that the man is the image and glory of God, while the woman is the glory of man, the Apostle goes on to show why he says it, and adds: for the man was not from the woman, but woman from the man; and the man was not created for the woman, but the woman for the man.⁵⁷

Aquinas is using the Genesis 2-3 version of Creation to support his argument for woman's imperfect reflection of the Divine.

Aquinas thought that the body was part of the identity of the individual and the species in general, and thought that at the resurrection each soul would have its own specific body.⁵⁸ Thus, he disagreed with Plato about the sexlessness of the soul that his predecessor had expounded.

When it came to the generation of the species, Aquinas thought it was God's will that there be two sexes to provide for generation. He agreed with Aristotle that the woman's role was to provide the matter in a purely passive nature. She provided the material, the man provided the "vegetative and sentient soul", and God provided the rational soul.⁵⁹ His scientific theory of gestation was that

⁵⁷ As quoted in Allen, p. 389.

⁵⁸ Allen, pp.391-392.

⁵⁹ Allen, p. 394.

at the beginning there was merely a vegetative soul and gradually there was a movement first from a sentient soul to a rational soul. This is apparent in On the Power of God:

By the formative force that is in the semen from the beginning, the form of the semen is set aside and another form is induced, and when this has been set aside yet another form induced, and when this has been set aside yet another comes on the scene, and thus the vegetal form makes its first appearance; and this being set aside, a soul both vegetal and sensitive is induced; and this being set aside a soul at once vegetal, sensitive, and rational is induced, not by the aforesaid force but by the Creator.⁶⁰

Aquinas' "metamorphosis of souls" in the stages of fetal development has never been absolutely overthrown. From this position there developed a further theory that at 40 days of gestation there was a rational soul. But in 1621 a Roman physician, Paolo Zacchia, argued that the rational soul was infused from the first moment. This theory did not outweigh the earlier metamorphosis theory but did gradually receive more support from the papacy over the years.⁶¹ There seems to be a conflict about when ensoulment takes place in the theological background of the Church.

RENE DESCARTES

Towards the end of this period the work of the

⁶⁰ As quoted in Allen, p. 394.

⁶¹ John T. Noonan Jr., "An Almost Absolute Value in History", The morality of Abortion: Legal and Historical Perspectives, ed. John T. Noonan Jr. (Cambridge: Harvard University Press, 1970), pp. 34-38.

philosopher Rene Descartes (1596-1650) gained prominence.⁶² That he believed he existed separate from his body shows in this quotation from his writings:

Accordingly this 'I' - that is, the soul by which I am what I am - is entirely distinct from the body, and indeed is easier to know than the body, and would not fail to be whatever it is, even if the body did not exist.⁶³

Recent scholars have attempted to place Descartes' dualism within the context of his time and situation.

Two of those scholars are Benedict Ashley and Margaret Wilson. Ashley notes that Descartes was a committed Christian and was influenced by the Platonism of Augustine in relation to body and soul. Thus his thought is the final *reductio ad absurdum* of this dualism.⁶⁴ Margaret Wilson maintains that this dualism was a natural expression of the view of the physical world that was part of the scientific thinking of his time. Nature was simply physical.⁶⁵ Avner Cohen expresses the view that Descartes' dualism shows that he was very obsessively concerned about his own body in

⁶² One author who looks at the context of Descartes writing is Susan Bordo. She suggests that before the Renaissance, the medievals thought that reason was a human faculty, neither inner or outer but rather part of two human faculties, intellect and sense. With the advent of the Renaissance philosophers began to image intellectual life as an inner arena, deeply interior yet capable of objective examination. At the same time there was a general objectification of scientific thought in which subject and object did not mix. In this mind-set all sense experience is illusory. She also notes that the century 1550 to 1650 was particularly gynophobic with the production of such works as *Malleus Maleficarum* so that mother earth becomes an object to be controlled. Susan Bordo, "The Cartesian Masculinization of Thought", *Journal of Women in Culture and Society*, 11 (3), 1986, pp. 443-453.

⁶³ Smith and Jones, p. 37.

⁶⁴ Ashley, pp. 207-210.

⁶⁵ Margaret D. Wilson, "Body and Mind from the Cartesian Point of View", *Body and Mind: Past, Present and Future*, ed. R. W. Rieber (New York: Academic Press, 1980), pp. 36-38.

relation to the world, and in order to deal with his own high anxiety he objectified, rationalized and canonized the external world within the intellectual context.⁶⁶ Thus philosophy and the world received the legacy of Cartesian Dualism.

Later philosophers, such as Kant, developed Descartes' thinking. For instance, Kant viewed the 'object' or body as something that does not have intrinsic order or light but is merely data. He felt that all illumination must come from the human psyche, first at the perception levels and then at the thought levels.⁶⁷ Although Locke was uncomfortable with Cartesian dualism, his work still has a "sense of the old doctrine of a Great Chain of Being"⁶⁸ which has negative consequences for women since this is usually based on the Genesis 2-3 hierarchical order.

CURRENT RESPONSES

In more recent works about body and mind there is a definite reaction to Cartesian Dualism. But in the works I examined there was no comment about the role of women. In the works that offer alternatives, with the exception of James B. Nelson, it is only women philosophers and theologians who are offering some form of alternative that

⁶⁶ Avner Cohen, "Descartes, Consciousness and Depersonalization: Viewing the History of Philosophy from a Strausian Perspective", Journal of Philosophy and Medicine, 9 (1), 1984, pp. 21-22.

⁶⁷ Ashley, p. 218.

⁶⁸ Smith and Jones, p. 50.

addresses the sexual dualism so intrinsic to Cartesian dualism.

TRISTRAM ENGELHARDT

Tristram Engelhardt says that the problem of body and soul is best explained in a categorical way. He maintains that the problem of the past has been a mistaken labelling or categories given to the two elements. He feels that

the body reveals itself as one's embodiment in the world of physical objects as well as in the society of other men.⁶⁹

He goes on to say that the body experiences itself in the senses which represent involvement with the world. This embodiment is temporal as well as spatial. It is this involvement that expresses the unity of body and mind.⁷⁰ The importance of the body is shown in his thought that

the body is one's first possession. This possession cannot be diminished without essentially compromising one's presence in the world. ... it is through identification with the body ... that mental life gains objective spatiotemporal location and significance.⁷¹

Thus the mind, as it is in the world, is also a physical object. As a consequence, for Engelhardt the identity of body and mind is not a formal logical identity but an interidentification of categories of being.⁷² As he sums up this interidentification,

⁶⁹ Engelhardt, p. 1.

⁷⁰ Engelhardt, pp. 1, 42, 44.

⁷¹ Engelhardt, pp. 43, 45.

⁷² Engelhardt, pp. 47-49.

both mind and body are co-determining since a) mind is the higher truth of the body and that to which the body must conform if its significance is to be fulfilled and b) the body is the necessary moment of the mind and that to which the mind must conform if its significance is to be concretely present in the world.⁷³

He appears to have comprehended the relationship in a way that the dualists were not able to do. He does not give a full explanation of this. His inter-relationship sounds very much like the terms that Nelson uses.

JAMES B. NELSON

Nelson says that dualism refers to two elements that "may live together in an uneasy truce but are frequently in conflict", whereas duality is "two harmonious elements essentially belonging together are yet distinguishable and may exist in creative tension."⁷⁴ The term duality seems to be a continuation of the phenomena of opposition found in dualism. This differentiation might merely be a restatement of dualism since 'creative tension' is often creative for only the winner within the tension.

BENEDICT ASHLEY

Benedict Ashley's book Theologies of the Body is a defense of Aristotelian thought about the body, which argued integration if only men were considered. Ashley does not

⁷³ Bogelhardt, p. 144.

⁷⁴ James B. Nelson, p. 37.

deal with the woman issue in his book except when he says

Woman is Humanity in its subjectivity and inwardness as Adam is Humanity in its outward control over the world.⁷⁵

The support that he gives for this conclusion is an analysis of Genesis 2-3, in which he follows the type of thinking which reinforces the hierarchical order of the world. It seems that the basic problem of Aristotle's thought has been carried on in this contemporary scholar's view of woman.

ELIZABETH SPELMAN

Elizabeth Spelman does some brief analysis of some contemporary feminists' view of the body and mind. She criticizes Simone De Beauvoir and Betty Friedan for using dualistic thinking while at the same time criticizing dualism. She feels that De Beauvoir thinks that mental activities have the highest value while Friedan's early work show an negative attitude towards the body. The assumptions that Spelman feels are negative for women are that they must distinguish between body and soul and that the physical part of existence is of less value than the mental.⁷⁶ One author who, she thinks, offers an alternative is Adrienne Rich who thinks that human experiences are not appropriately viewed when people attempt to distance themselves from their bodies. She uses the childbirth experience to show that body experiences can be viewed as a way of recognizing the

⁷⁵ Ashley, p. 381.

⁷⁶ Spelman, "Woman as Body", pp.122-125.

integrity of our experience because it is an active experience. What she calls for is an adequate theory of self.⁷⁷ One such theory is proposed by the following scholar.

ROSEMARY RADFORD RUETHER

Theologian Rosemary Radford Ruether discusses the approach of Christian feminist liberation theology to dualism. She says that this theology refuses to separate the material from the spiritual. Liberation theologies integrate the biblical messianic symbols with the secular interpretations of liberalism and socialism. Conservative Christians claim that redemption is a "purely spiritual matter and has nothing to do with socioeconomic changes."⁷⁸ Thus sin is seen as individual for conservative Christians, whereas it applies to both individuals and structural systems for liberation Christians. She says:

Feminist liberation theology bases itself on the dynamic unity of creation and redemption. This means that we as theologians reject the dualism of nature and spirit. We reject both the image of nature or matter as static immanence and the concept of spirit as rootless or antinatural, originating in another world beyond the cosmos, ever repudiating and fleeing from nature, body, and the visible world. This means that we also reject the false conflation of nature or created being with the ontological foundations of the existing oppressive social order. Feminist

⁷⁷ Spelman, "Woman as Body", pp. 125-127.

⁷⁸ Rosemary Radford Ruether, "Spirit and Matter, Public and Private: The Challenge of Feminism to Traditional Dualism", *Embodied Love*, ed. Paula M. Coeey, Sharon A. Farmer, Mary Ellen Ross (San Francisco: Harper & Row, 1987), pp. 65-66.

theology affirms a vision of exodus, of liberation and new being, but emphasizes that these must be rooted in the foundations of being and body, rather than as an antithesis of nature and spirit.⁷⁹

Central to the reintegration of nature and spirit is the creation and sustaining of human life as being that which binds a liberated self with a liberated society.⁸⁰ Part of this integration recognizes that the reproduction of the human species has a vital economic role. Feminist theologians suggest that what has been devalued as 'natural', and thus of less importance, should be given its due worth as vital to the human enterprise. The ability to reproduce the human species is worthwhile human work.

Ruether calls for a re-vision of our society. She says:

We need a concept of deity that best organizes and integrates the religious significance and value of the relation between human life and human work. The Holy One who is the foundation both of our being and our new being embraces both the roots of the material matrix of our existence and also its endlessly new creative potential. The God/ess who is the foundation of our being and new being does not direct us back to a stifled, dependent self, nor uproot us in a spirit trip outside the earth. Rather, s/he leads us to a converted center, the harmonization of self and body, self and society, self and cosmos... We must recognize that sinfulness exists precisely in this splitting and deformation of our true relationships to all the networks of being with which we are connected.⁸¹

Ruether seems to be suggesting that we eliminate the dualism between body/spirit, culture/nature, public/private

⁷⁹ Ruether, "Spirit and Matter", p. 67.

⁸⁰ Ruether, "Spirit and Matter", p. 68.

⁸¹ Ruether, "Spirit and Matter", pp. 75-76.

and recognize everything as integrated and valuable because it comes from a holy source. From Ruether's point of view, "spirit and matter are not dichotomized but are the inside and outside of the same thing."⁸²

L. SHANNON JUNG

Theologian L. Shannon Jung discusses another way of looking at our embodiment. The concept of spatiality is central to her view of the world. Spatiality is both internal and external in that "we have a sense of ourselves as being physical and we actually are physical."⁸³ Spatiality includes embodiment which is integral to consciousness, since it is only through the body that we experience our psychic life. Sociality is another dimension of spatiality, since all human life is relational insofar as relations to others give us that sense of our individual self. Spatiality finally includes symbolization, which gives meaning to the embodiment and sociality through our consciousness. Jung claims that the recognition of human spatiality will lead to a "recovery of the full humanity of both sexes."⁸⁴ In order to do that we must be aware of the features of spatiality.

Those features that Jung feels are part of spatiality

⁸² Ruether, Sexism and God-Talk, p. 85.

⁸³ L. Shannon Jung, "Feminism and Spatiality: Ethics and the Recovery of a Hidden Dimension", Journal of Feminist Studies in Religion, 4, Apr. 1988, p. 56.

⁸⁴ Jung, pp. 56-59.

are affectivity, particularity, limitation, and relation to others. Affectivity includes sensuality, feeling and emotion, so that all knowledge is body-mediated knowledge. Particularity means the recognition of the particular or concrete nature of self or social group or environment. Limitation is the positive accentuation of the limitedness of human life. Relation to others is a focus on connections and the interdependence of sociality. In this way "feminist thought suggests that we accept our epistemological constraints and recognize them as real, as perspectives on multiple realities."⁸⁵ The goal for individuals appears to be a self-acceptance as an integrated embodied person.

When human experience is examined, it reveals that the world is understood first through the body.⁸⁶ Another way of speaking of this integrated embodiment is 'lived-body', which is proposed by Erwin Straus and Maurice Merleau-Ponty. This 'lived-body' description means that the body is what I am just as much as the soul means that too. The unity of body and mind is viewed as integral to the essential self as opposed to the dualism of body/mind. Thus this concept of 'lived-body' reunites the body and soul.⁸⁷ Another author who uses this type of concept is James Nelson (1978) who talks about an integrated body self. The major part of an integrated body self is the assumption that we think with

⁸⁵ Jung, pp. 60-66.

⁸⁶ Leder, p. 31 and Young, pp. 47-48.

⁸⁷ Leder, pp. 36-38.

our bodies as well as with our minds. Critical to an integrated body self is self-acceptance of the body which then "brings with it a profound sense that I am the body which I live ... this gives shape to the style of my relationships with others."⁸⁸ This last concept relates to Jung's view of spatiality as well.

EMBODIMENT AND PREGNANCY

Two authors who discuss the issue of embodiment particularly from the woman's experience are Penelope Washbourn and Iris Marion Young. Washbourn's Becoming Woman talks about the spiritual aspect of being an embodied female. She maintains that a woman's psychological and spiritual concept of self is affected and develops through the particular life-crises that are a part of living in a female body. These life-crises are the onset of menses, sexual initiation, marriage, pregnancy and child-birth, and menopause. At each of these times a woman must re-define her understanding of her identity in relation to that which has ultimate value.⁸⁹ Her 'lived-body' experience denies the separation of mind and body since this experience gives her a knowledge that her mind alone cannot give her. The experience of pregnancy and childbirth is a spiritual crisis because the dramatic changes within a woman's body makes her

⁸⁸ Nelson, pp. 83, 93.

⁸⁹ Washbourn, p. 2.

very aware of this event as one of creation and as a 'sacred' event. Consequently the experience of pregnancy carries with it inherent psychological and spiritual dangers.⁹⁰ A dramatic re-evaluation of personhood takes place during pregnancy. An interruption in this process is an additional crisis.

In antiquity procreation was an expression of the goddess' life-giving power. However, in our present day this is not the case. Society today does not see the ability to reproduce a human being as a uniquely creative female power. At the same time there has been an idealization of pregnancy within our culture, as can be seen in the advertisements relating to pregnancy. The danger of this can be seen if a woman expects pregnancy to give her a "transcendent status" or if she identifies that with an 'ideal figure', she may be particularly susceptible to the negative aspects of pregnancy. If the woman views her essential personhood in terms of her body alone, she may see her total self-worth bound up in her ability to reproduce. As Washbourn puts it,

Women who look to pregnancy and birth in order to prove themselves as individuals may experience deep emotional distress on having a miscarriage or on learning that they are unable to conceive.⁹¹

There is here an over-investment in the concept of self in the biological body only, which, according to Washbourn, is

⁹⁰ Washbourn, p. 95.

⁹¹ Washbourn, p. 104.

as dangerous as not being able to integrate the body into a concept of integrated self.⁹² From the point of view of spiritual growth, Washbourn's conclusion is important:

Becoming woman is a spiritual search. It involves finding a sense of one's personal worth in relation to the whole of life, even beyond death. Believing in ourselves, loving ourselves as women, is our most sacred task in and through the many phases of our sexual and personal development. Finding freedom from fear involves risking and trusting our feelings. As we risk, however, we will be given new hope, new strength, and a new love for ourselves and for others. Acting on this trust will enable us to grow in understanding through all stages of life.⁹³

Considering her concern for the process of spiritual growth throughout life, the manner in which a woman copes with the spiritual and psychological crisis of a miscarriage could affect that growth in the rest of her life.

Iris Young discusses an interesting dynamic of 'pregnant embodiment'. She says that a pregnant woman has a split type of experience. A woman feels that she is herself and yet not herself because of the bodily changes that she experiences in the process of pregnancy. Young goes on to say that in pregnancy the woman does not have a firm sense of where her body ends and the world begins because her body is in a constant state of change. Young feels that the lingering thought that true humanity is spirit does not relate to the experience of a pregnant woman. Her experience that the body changes, as evidenced in the increased mass

⁹² Washbourn, p. 104.

⁹³ Washbourn, p. 155.

of the body, can often produce a great sense of power, solidity and validity in the body.⁹⁴

IMPLICATIONS FOR MISCARRIAGE

Although there is a movement away from dualism in philosophy and theology, the effects of dualism are still evident in our culture and religions. One of the most damaging effects of Cartesian Dualism has been in the manner in which the body has been objectified. This objectification can be seen in the field of medicine where often the person is treated merely as a machine instead of a disease living within a context.⁹⁵ The medicalization of pregnancy and childbirth is an example of this. When we make the body a mechanism, we begin to remake it and feel impelled to fix it when it appears to be broken. "The desacralization of the human body submits this body to reconstruction at the will of human power."⁹⁶ This has had particular problems for women since in dualistic thinking the female body is even worse than the male body. Janice Raymond feels that medicine has always attempted to improve the biological female.⁹⁷

⁹⁴ Young, pp. 46-52. Hilde Hein agrees with this view of pregnant embodiment. A woman's experience of pregnancy is a denial of dualism and disconnection since few women who have undergone the experience of pregnancy could subscribe to the idea that their role in pregnancy is one of passive detachment. Hilde Hein, "Liberating Philosophy: An End to the Dichotomy of Spirit and Matter", Beyond Domination: New Perspectives on Women and Philosophy, ed. Carol Gould (Totowa, New Jersey: Rowman & Allenhead, 1983), p. 129.

⁹⁵ Iris Marion Young, "Pregnant Embodiment: Subjectivity and Alienation", Journal of Medicine and Philosophy, 9, 1984, 46-62, discusses how the lived-body experience of the patient who is pregnant can be in conflict with the doctor that is merely treating a mechanical object. Drew Leder, "Medicine and Paradigms of Embodiment", Journal of Medicine and Philosophy, 9, 1984, p. 32.

⁹⁶ Engelhardt, p. 177.

⁹⁷ Janice Raymond, "Medicine as a Patriarchal Religion", Medicine and Philosophy, 9, 1984, p. 199.

Another potential danger for all patients facing this attitude in medicine is that patients themselves may begin to see their own bodies as objects which always have the potential to become ill. The person moves from viewing the body as whole and good creation towards a view of the body as having a potential for illness or alienation.

One specific terminology that has grown out of the legacy of Aristotle's generative theory is the term 'blighted ovum' which is used to refer to a conceptus that does not develop at all after a certain point but the gestational sac continues to develop until the fetus is supposed to take over at which time a miscarriage occurs.⁹⁸ The use of the term 'ovum' places the responsibility of the 'matter' of the baby on the woman whereas the contribution of the man is the spirit which removes any responsibility from the man when the 'matter' does not grow. I would suggest that this can have a detrimental effect on some women. It firmly places the blame for the miscarriage on the woman at a time when she may already have exaggerated guilt feelings about the event. Since there is no medical proof that it is always the fault of the woman when a conceptus does not develop. A preferable term would be a 'blighted conceptus'. The use of this term might prevent more additional guilt being assigned to the mother, both by

⁹⁸ Ann Hager, "Early Pregnancy Loss: Miscarriage and Ectopic Pregnancy", Pregnancy Loss: Medical Therapeutics and Practical Considerations ed. James R. Woods, (Baltimore: Williams & Wilkins, 1987), p. 30.

herself and by others.

When a child is born alive there has been some kind of recognition that a child was born and died. Consequently, Christian churches have acknowledged this death with a ritual of burial and/or service. Christian churches have, in the past, not routinely offered a religious ritual of burial and/or service for instances of miscarriage and stillbirth. The current tolerance of Aquinas' metamorphosis of ensoulment presents an interesting dimension to rituals surrounding a miscarriage. The question that arises is whether a fetus that dies in utero has a rational soul. If it does not yet have a rational soul, then it does not require the usual Christian rituals. Perhaps the omission of Christian rituals for miscarried babies can be explained by the indecision about when the soul exists.

Because of the theological attitudes towards bodies, particularly women's bodies, there was the question of what type of assistance the women subjects had received at the time of their miscarriage. Were their miscarriages considered merely a physical or body experience? Were the women considered integrated human beings with a 'lived body' existence?

CHAPTER THREE
PRIMARY RESEARCH WITH WOMEN

In considering the psycho-social aspects of miscarriage and the theological aspects of attitudes towards women's bodies and their reproductive capabilities, it became evident that there was very little research into what the experience of miscarriage meant to individual women, both from a psycho-social aspect and a theological one. It was my intention to discover what the needs of these women were and to some extent using what limited research material was available, develop some theory about those needs that could be applied in a practical way, to assist other women who would experience a miscarriage in the future.

Although I knew that miscarriage was a 'forgotten' or 'unspoken' grief, I was not fully aware of what the experience really meant for many women. The qualitative method that I decided to use is based on grounded theory,¹ using the unstructured interview as the primary tool of research with the subjects.

¹ "Grounded Theory" refers to a research methodology which is used to build theory on the data collected from many different sources of data. No hypotheses or theoretical constructs are held in view before beginning the research. Rather, the first part of the research is used to 'discover' what the real research ideas or hypotheses are. Various research procedures can be used in grounded theory research, such as unstructured interviewing, direct observation, participant observation, document analysis -- in general, most forms of field work methodology." pp. 272-273 of R. Vance Peavy, "Selected References on Qualitative Research Methodology" NARCON 9, Minister of Supply and Services Canada, 1985.

METHODOLOGY OF RESEARCH WITH SUBJECTS

Following the University of Windsor's Guidelines for Research with Human Subjects, a consent form was drawn up that would be signed by each participant before the interview began. (see Appendix #2). Then an outline of the research topics to be covered with the women was developed. (see Appendix #3). These two documents went along with a research proposal to the University's Ethics Committee on March 20, 1989. (see Appendix #4). The proposal was accepted by the Ethics Committee later that month. The potential emotional risks to the subjects were very clear in the beginning of the research. It was also recognized that there could be a potential risk to myself due to over-involvement in the topic. This risk of morbidity is well recognized in the field of thanatology.² However, the benefits to the women, the referring doctor and to others through the conclusions of the research were considered to significantly outweigh the potential risks.

The consent form invited the women to ask questions at any time. The purpose of the research and qualifications of the interviewer were outlined. The style of the interview was given with the assurance that the content of the interview would only be read in its entirety by the researcher, that the tape would be erased after

² Barbara Anderson, "A Formative Assessment of a Thanatology Curriculum" NATCON #9 (Ottawa: Employment & Immigration Canada), p. 228.

transcription, and that the names of the subjects would not be used at any time. Follow-up support was offered to any one who felt that she had experienced such distress as would require further support. Each individual was given permission to withdraw from the study or refuse to answer any questions as well as notified of the appropriate channel through which to register any complaints about the study or the investigator.

Although each of the twenty women who were interviewed signed a consent form, none desired any further support or registered a complaint with the University of Windsor. It seems that the anticipated risks to the subjects did not materialize. In fact, at the conclusion of the interview, many expressed their gratitude for the time spent in review of their experience of miscarriage.

The type of research done was qualitative, in which "the ultimate aim is to study situations from the participants' point of view."³ In line with grounded theory, the research design is in constant modification and development throughout the project.⁴ In this research sample, a gatekeeper was used to gain access to volunteers for the study: a local obstetrician agreed to refer patients to the study. After a personal visit during which the research proposal, the consent form, and the outline of the

³ Robert C. Burgess, In the Field: An Introduction to Field Research (London: Allen & Unwin, 1984), p. 3.

⁴ Burgess, p.5.

topics for the interview were presented, he agreed to make referrals. After the interviews of the women who volunteered through his practice, I wrote a letter of confirmation about the completion of the interviews and about the sharing of the information gained that he would receive after the completion of the thesis. This gatekeeper assisted me by facilitating the exchange of information about the volunteers through his secretary.

Each week I would phone his secretary to get the names and phone numbers of women who agreed to participate. After one month with no referrals, six names were received from a nursing professor at the University of Windsor so that the interviewing could begin. At that time I also made a follow-up visit to the doctor's office with a notice asking for volunteers (see Appendix #5) which I wanted permission to put up in his waiting room. His nurse received permission to put these notices up in each of his examining rooms. The doctor said that the notice would help to remind him of this research. From these notices an additional eleven women volunteered. A final three women volunteers were received through a Bereavement Resources Volunteer, Canadian Mental Health Association, who had worked with women who had experienced a miscarriage. This judgment sample⁵ of twenty women volunteered to be interviewed about their experiences.

⁵ Judgment sampling occurs when informants are selected for study according to previous experience which "endows them with special knowledge." (Burgess, p. 55.) The special knowledge that was needed for this research was the experience of a miscarriage.

Some women researchers agree with Robert Burgess that qualitative research is very important for the study of women's lives.⁶ Further they affirm the inability of researchers to remain totally 'objective' about their research. One expression of this type of research is found in Carol Christ's article "Towards a Paradigm Shift in the Academy and in Religious Studies",⁷ in which she proposes an ethos of eros and empathy as a model of scholarship. In this ethos, the scholar remains "firmly rooted in her or his own body, life experience, history, values, judgments and interests."⁸ She further discusses three moments of scholarship which are part of this method. The first is to name the desire that motivated the research which might include a desire "to understand, to connect, to preserve or to change the world". The second moment of scholarship occurs when we keep in mind the limits of our ability to be objective, while we simultaneously remember that we can be far more than simply subjective in the drive to get as close to the intrinsic meaning of the material being studied and to a communally viewpoint or truth. The third moment occurs

⁶ Helen Roberts, "Women and Their Doctors: Power and Powerlessness in the Research Process", Doing Feminist Research, ed. Helen Roberts (London: Routledge, 1988), pp. 7-29; Ann Oakley, "Interviewing women: A Contradiction in Terms", Doing Feminist Research, ed. Helen Roberts (London: Routledge, 1988), pp. 30-61; Carol Gilligan, "Renapping Development: The Power of Divergent Data", The Impact of Feminist Research in the Academy, ed. Christie Parnham (Bloomington & Indianapolis: Indiana University Press, 1987), pp. 77-94.

⁷ Carol Christ, "Towards a Paradigm Shift in the Academy and in Religious Studies", The Impact of Feminist Research in the Academy, ed. Christie Parnham (Bloomington & Indianapolis: Indiana University Press, 1987), pp. 53-74.

⁸ Christ, "Towards a Paradigm Shift", pp. 58-59.

at the judgment phase of the research when the scholar incorporates the insights gained from the research into an expanded perspective.⁹ Christ thinks that this model of scholarship enables scholars to see and feel the world differently through an expanded vision. This theory of scholarship shows similarities to qualitative research based on grounded theory.

The interviews with the women followed a set of themes or topics around which a conversation could develop. A necessary characteristic of this type of research is that the interviewer be perceived as a friend/confidant who is very well prepared. Part of the process of becoming this friend is to be able to use personal experience to create this atmosphere with the volunteer.¹⁰

Each of the volunteers was contacted by telephone and informed of my name and the purpose of the research. They were asked if they had any questions at that time which were answered. An appointment for an interview was scheduled in each volunteer's home at their convenience. Eighteen were interviewed at home while two chose to be interviewed in their place of employment. At the appointed time I would arrive with the consent form which they read, questioned and then signed. While they were reading this form I set up the tape recorder. Several expressed concern that they would not

⁹ These three moments are described in Christ's "Towards a Paradigm Shift", p. 60.

¹⁰ Burgess, pp. 103 & 105.

be able to be relaxed with the machine between us on the table, usually the kitchen. But all of these women very quickly relaxed as they launched into their response to the first question.

Burgess talks about the use of personal experience as being appropriate for establishment of a friendly, confidant relationship between interviewer and volunteer. Ann Oakley would agree that this is the only way that interviews can be conducted with women. Her experience in the research of motherhood showed her that the interviewer could not remain silent or evasive in response to questions on the type of topic that was being researched.¹¹ She found that women simply asked more questions about the interviewer and the research than men did. To evade or not answer honestly would be unethical. This creates an interaction between the interviewer and the volunteer. Anderson maintains that this is part of grounded theory research and is the only logical method for thanatology research.¹²

Regina Flesch, in "A Guide to Interviewing the Bereaved",¹³ described a very structured style of interview in which the interviewer was to be un-involved in the manner in which Oakley and Burgess say is present in qualitative research. Although the topics covered were similar to those

¹¹ Oakley, "Interviewing Women", pp. 30-47.

¹² Anderson, pp. 227-229.

¹³ Regina Flesch, "A Guide to Interviewing the Bereaved: Parts I and II", Journal of Thanatology, Vol. 3, 1975, 93-106 and 143-159.

covered in my interview, this format did not allow for the free flow of conversation. Negatively, her research was conducted with an outside observer who was a clergyman who did not identify himself as such. I would question the ethics of her research method, particularly in this unidentified observer role.

The sample of twenty women was composed of white, married, Christian women who had had a miscarriage in the previous four years.¹⁴ The following tables show the basic data about the sample of women.

Basic Data

Total Number of Women Interviewed	20
Total Number of Miscarriages	31
Women With Multiple Miscarriages	6
Planned Pregnancies	17
Primipara	5
Infertility Complications	5
Average gestational age of fetus	10.9 weeks

Age of Subjects

	At Interview	At First Miscarriage
20-25 years	2	3
26-29 years	8	10
30-35 years	6	3
36-39 years	1	4
40-45 years	3	0

¹⁴ Although my advertisement was for women who had experienced a miscarriage in the previous three years, two of the volunteers ended up being over the three year period. Another woman, who had seen the sign in the doctor's office, stopped me in a store and volunteered as well. At that point I had already had my twenty necessary volunteers. She had not given her name earlier because it had been three and a half years since her last miscarriage, and thus she felt that she did not meet the criteria. I assured her that if the final volunteer changed her mind I would call her to do the interview.

Time Lapse Interview/Latest Miscarriage

	Number	Average
0 - 6 mos.	9	2.2 mos.
7 - 12 mos.	2	8.5 mos.
13 - 24 mos.	6	18.2 mos.
25 - 36 mos.	1	33.0 mos.
36 - 47 mos.	2	43.5 mos.

One tape-recorded interview lasting, on the average, 2 hours and 10 minutes, was held. Each woman signed the consent form and I personally transcribed the tapes and then erased the original tape. Each woman received a thank-you note for her participation along with an assurance, to those who requested it, that the findings would be forthcoming at the completion of the work. Two women, who were interviewed very recently after their latest miscarriage, were telephoned in a few weeks to see how they were coping and if they wanted or needed further support either from myself or from someone else. Both expressed that they had been helped by the opportunity to talk during the interview but that they felt that they were coping adequately at the moment.

At the beginning of the interviewing process which took place from early May 1989 until early August 1989, the Interview Topics (see Appendix #6) was followed for the first few interviews. By the end of the first three interviews a card was developed with the topics on it which

were covered in the subsequent interviews with the women.¹⁵

After transcribing the tapes of the interviews, I made notes in the margins about topics that seemed to be growing out of the information shared by the women. The themes that they described were as follows:

<u>TOPIC</u>	<u>TIMES USED</u>
<u>Psychological</u>	
Future Fantasies	19
Self-Image	15
Names	12
Perceived Guilt	8
Failure	7
Reaching Out	7
Minimization of Grief	6
Envy	6
Shame	6
Fear	5
<u>Social</u>	
Societal Attitude	12
Scripting	9
Klutzy Comments	5
<u>Medical</u>	
Medical Information	16
Caring Model	15
Hospital Experience	12
Suggestions for Medical Change	6
<u>Pastoral</u>	
Spiritual Crisis	16
Pastoral Visit	13
Attitude to Pastor	11
Going Back to Church	7
Current Picture	6
Ritual	3
Spiritual Change	2
<u>Personal Perceptions</u>	
Attitude to Baby	16
Attitude to Pregnancy	13
Significance of Talking	13

¹⁵ The topics on the card were: What? Plans? Self - before/after? Self-image? As woman? Treatment? Being Pregnant? Spiritual? Life-event? Change? What happened to fetus?

Woman Self-Knowledge	12
Visual Confirmation	9
Significance of Event	6
Mementoes	4

Four of the topic themes were easy to identify: psychological, social, medical, and pastoral. There were other topics that the women discussed that did not fit easily into any of these four themes. I have grouped these topics under the theme Personal Perceptions. Some of these topics fit into several categories indirectly while others are unique. I will attempt to show how these topics show particular importance.

PSYCHOLOGICAL TOPICS

Nineteen of the twenty women had some future fantasies about the coming baby. The only woman who had not made any plans at all had only known for two days that she was pregnant and her grandmother's funeral occurred during that time. The future fantasies and plans made by these women confirm Larry Peppers and Ronald Knapp's work on the early bonding that is done by women. These plans took the form of planning re-arrangements of sleeping quarters within the house [3], purchasing infant clothing [1], purchasing decorative items for the nursery [7], gathering infant clothes and equipment [5], purchasing maternity clothes [4], re-arranging long-term plans [3], purchasing larger vehicles [2], hiring a nanny [1], and choosing a name [12]. It was

interesting that such a high proportion of them had discussed and chosen names for the coming baby.

Feelings of failure, guilt, and shame were wrapped up with how the women felt about themselves. When these topics were grouped with the self-image topic eighteen out of twenty had had some negative attitude towards themselves. About their self-image they said:

I think I felt better knowing that nothing had died in the process except me a little bit in the process.

Your body has lost something.

I felt that a part of me was taken away.

I feel that I am not a whole mother because I can't have another child.

I still feel like a woman, I guess. I don't know.

I'm not a complete woman because I can't do this! I felt really rotten. I felt really rotten about myself.

Damage to selfhood was expressed in feelings of failure:

You feel like such a failure after you miscarry.

More of a failure. A woman is supposed to have babies.

Like a failure because anything I ever wanted I got. I went for it. I've always succeeded in whatever I've tried to do. Every time I've had a miscarriage I failed.

This damage was also expressed in feelings of shame:

I couldn't tell anybody for awhile that I had miscarried.

The night that it happened, I just didn't want everybody to know about it. [tears]

Many of the women felt that they were at fault for their

miscarriage in some way. At least they perceived that they were guilty:

There must be a reason why. I must have done something to do this.

The guilt - it centers around yourself - at least it did for me - I shouldn't have been lifting those heavy boxes. That ultimately, it was my fault. Ultimately, it was my fault.

Maybe I was praying too hard for what I want and not what He wants. I thought He would answer. [tears] Maybe my miscarriage was my answer. But I didn't think that I was asking for something special. I just wanted a child for Jenna and a child for Tim and I to love. Now I feel bad that I did something wrong. Did I do something wrong? Was I praying for the wrong thing?

Because of these feelings of failure, shame, and guilt, the damage to the woman's self-image was seen in a minimization of her grief:

I think that I would find a stillbirth a lot more devastating than a miscarriage.

It would have been worse for me if I was five months along. I would be really devastated.

It is maybe not a crib-death.

Much of this minimization of grief seemed to be connected to a need to compare the woman's grief with that of others and to reach out to others in a similar situation.

Much of this reaching out to others was done in order to identify and confirm their own feelings and reactions. Sometimes this was done overtly and sometimes it was a silent comparison.

One girl had had one too. We miscarried at work basically and we work together as well. She came up to me one evening and she was sincerely

interested in what had happened and how I felt. Of course, I was also equally interested in how she was doing and I could say that was about the only person who really cared or really understood.

If I wasn't a nurse I think that the first one [miscarriage] would have hit me more because I watched my sister-in-law and then I watch other people and see how they react then I think Gee, maybe I should have reacted more.

There was this lady that she spend an hour with me. Just a stranger. She was miscarrying herself! I saw her three weeks later in the doctor's office. She was more concerned about me than most of the staff people there. She sat and talked with us for quite awhile in fact. She talked about what was happening to her and I told her what was happening to me. It makes you feel better.

Most of these women volunteered this information without having been asked about this topic in the first half of the interview.

Two other emotions expressed by some of the women were fear and envy. Fear was expressed in the first half of the interview while envy was usually expressed later in the interview. The fear was generated from a fear of losing the baby and from not knowing what was going to happen. One woman said:

I didn't know what was going to happen! I was - I was absolutely petrified because it is the fear of the unknown. I was petrified more than frightened. I really was!

Generally other emotions such as anger and pain were expressed in the same ways that have been described by authors who discuss the emotional reactions of grief experienced by women who have experienced a miscarriage.

SOCIAL TOPICS

The women experienced personal emotions which interacted with attitudes they either felt were directly or indirectly expressed by the social setting in which they live. Sixteen of the women made some comment about societal attitudes towards the event of miscarriage.

I felt that they don't think this was my baby that just died. A lot of the family said: It's better that it happened now than afterwards ... after it was born or eight months or nine months down the road. I wanted to say: How do you know it is better at three months than at six months? How do you know? A baby is a baby.

I don't know, I felt that nobody really felt that this baby was anything!

I felt that they found it just insignificant.

From what I can see miscarriage is looked upon as a very minor thing! I have had it said to me, so I know.

No one has said anything. There wasn't even an I'm sorry to hear. There wasn't even that. Maybe they don't know what to say. Maybe they don't know anything about it.

These women shared that there was a difference in the way that they felt towards the miscarriage and the way that the people around them view the event.

Nine of the women expressed that they were not aware of what was expected of them in this life-event. At the time when they were reaching out psychologically to reflect on the feelings that they were having they were looking for some social scripting that would assist them in processing their miscarriage into their lives.

I didn't know what the proper thing to do or if we should have something special. I didn't know what to do. I should have said some things - a special blessing.

I don't know but they don't want to talk about it and I can't understand that - I just can't, even now. I was by myself and nobody comes around and I just felt like rolling up and I couldn't sleep, rolling up and literally: Just leave me alone! I guess I needed somebody to be there. Leave me alone but come talk to me. Somebody help me! I don't know where I am ... I know where I am and I know what's happened but I don't know what to do about it.

... I remember a few days after miscarriage Charlie's aunt called and said that she was sorry and everything and then she said: Oh, you'll be better in two days. Two days came and I wasn't better.

... I don't know how to feel. I didn't know how to behave. But it's like death. People were telling me that I should be feeling better after a day or so. Is that the way that I'm supposed to feel? I know how I am feeling!

I didn't know where to go and I didn't know what to do.

I just wanted to get on with my life! I didn't know if I really wanted to but society kind of makes you get on with your life! You are just not allowed to sit home and grieve. Not allowed.

I get the feeling that people see the whole pregnancy as a tragedy. Whereas I see the fact that it ended as a tragedy. But everything that went before that was a miracle! It was absolutely wonderful! But everybody sees it as one thing. The fact that I was pregnant was as much of a tragedy as the fact that I had a miscarriage - to them.

This final comment expresses the divergent attitude towards the event of miscarriage and pregnancy that the women perceived between others and themselves. This attitude is a product of the medicalization of motherhood rather than coming from the women.

The verbal responses of others also reflected the societal attitude of the unimportance of a miscarriage. These 'Klutzy Comments' caused more pain instead of being the helping comments that the speakers thought they were making. Some examples of these were:

It's probably good because it was nature's way of taking its course because there was probably something wrong.

It is really nothing. [not a baby]

It's better than having a baby that isn't formed properly.

You're young, you can have more.

It was meant to be.

The reactions of the women were:

It made me feel like hitting or something. It made me feel worse. Because I felt that they found it just insignificant.

It made me feel lousy. Deep down I knew that that was probably right but I didn't want to hear that from someone.

Although the women recognized that there was much truth in these statements, they would have preferred some acknowledgment of their pain as well as acknowledgment of their loss.

The women generally felt that there was a social expectation that the event was a non-event and thus there was no social script for them to follow in order to interpret the event and respond to it. They also expressed the problem of trying to integrate the event into their lives in a setting in which the event itself was not

acknowledged as very significant. The unspoken messages they received did not assist them in determining how they could or should integrate this event into their life-pattern.

MEDICAL TOPICS

Almost from the earliest stages of the interview the women talked a great deal about the medical treatment and information that they had received during the course and following their miscarriage.

Of the fifteen who talked about the medical information received, six felt that they had received the information in a positive manner that they understood.

Before I went for the D&C the doctor had a list of causes.

Every time they would do something the doctor would explain the whole thing.

Nine others felt that the information was not clear, or painted a negative picture that they could not relate to, or did not receive any information at all.

They never really said for sure. I never really was really told anything.

The doctor didn't even call it a baby! If it had made it, it would have been a monster. That's what he said. ... As women we need more information, not group therapy.

The doctor came in and he said: Well, the ball-game is over. That was not helpful. ... I didn't really like the way that was put.

The doctor just told me: If that baby wants to abort itself, it will whether you stand on your head with your legs closed. It will abort itself if it wants to.

Blighted ovum - the doctor explained it all. There was no baby there. There really never was a pregnancy. The sack was empty. I think that [term] covers a lot of other things though ... blighted ovum, I think that it is a term that is used for a lot of different things ... an all-inclusive term for lots of things [laugh].

He told me that it was a blighted ovum ... It might have been an abnormal egg that had been fertilized so that it seemed like a normal pregnancy blah, blah, blah.

The manner of person disseminating the information was consoling when a caring model was used.

Fifteen of the women spoke of experiencing the caring model described by Nel Noddings or having a need for such a method of caring.

This one nurse was very good really. She held my hand and kind of spoke to me. She took the time to talk. She kind of understood where I was coming from.

I thought that she was going to cry with me. I felt so lucky. She gave me a hug and I hugged her. It was special. It meant a lot. [nurse's reaction]

One nurse said that she had had the same thing happen to her. I felt that there was a bond. She knew what I was going through. She might not be able to talk about it but I could see looking in her eyes that she had been through what I was going through.

The doctor came in and he told me what happened. He put his hand on my knee. He never made light of it. He told me that he was very sorry. He didn't make any excuses. He looked at me. He seemed to care. He was very quiet but I could tell that he cared.

My aunt phoned me up and she is about 68 and somebody that you get the idea that she doesn't know about such things and she used the actual word. I found that actually comforting that she would say the actual words about it and it was

really neat. She used the words.

[ultra-sound technician shared a similar experience] She shared with me. I was really impressed by that. They didn't have to go into their own lives with me. It just made me realize that people care. It made me feel that life goes on and that maybe I would begin to feel like a human being again soon too.

It can be seen from the women's experience that the one-caring who appeared to take the cared-for into themselves was perceived as being caring. This affirms Nodding's model as being the appropriate one for these women.

Unfortunately, the hospital experiences of many of the women did not match the ideal of the caring model of support expressed by the women. There was also evidence of suffering, as described by Eric Cassel. Several women spoke of suffering caused by a lack of dignity and basic privacy. This was usually expressed by women who had been either outpatients or been in the emergency departments of the hospitals in which they had had D&Cs.

I just lay there constantly bleeding. Not being able to do anything. I had no clothes on. They put a blanket on me. They put the big blue pad underneath me to soak it [the blood] up.

They make you wait there with no undergarments on, no pad or nothing and you are bleeding all over the place.

They took my gown off me and I was going to be totally naked and I didn't know that and then they put them stirrups on me and I had no idea what I was going to be put through and I didn't like that at all.

They put me in a room. They took my clothes away. I was lying on a table. The blood was coming down my legs ... I felt that I had no dignity.

There seems to be a violation here of the basic need for dignity and control. During a menstrual cycle these women would all have used sanitary protection and would have preferred to have had something similar to that in these waiting situations. Some had to wait many hours before being taken to the operating room.

When asked if they had any suggestions for medical change six of the women made specific suggestions.

When I [a nurse] go into a room. I sit down - I don't stay very long. I pop in several times during the day until they get to know my face a little bit before I go in and get into something heavy. Maybe the nurse should double up with another patient so that the nurse has more time to spend with the person.

The nurses kind of made sure that they knew if I had one [a child] or not and then they asked me her name and how old -- that was nice!

If the medical people wouldn't gloss over the pregnancy history. How many pregnancies have you had? Four and you have one living child? But then there is nothing about asking about the identity of those. Opening up the possibility that somebody else is interested. Or did you have any difficulties. Something like that.

I think at the hospital they might have a class that you could go to for pregnancy loss.

If they could come up with some sort of code that they could put outside the room so that we wouldn't be asked awkward questions would be helpful. You just handle that type of thing. The staff feels horrible when they blunder.

It would be a good idea to have the VON or someone to come and see me afterwards.

Each of these suggestions is valid and show that the women perceived that the event of miscarriage as a significant one

which should be acknowledged.

Once again the theme of 'significance' came out of the women's discussion of the medical topics centering around their miscarriages. Positive responses and experiences seemed to come from those who showed that they understood that the event was significant while negative responses and experiences grew out of a diminishing of that significance.

PASTORAL TOPICS

As I was interviewing the women about their experiences they did not seem to be discussing the spiritual or pastoral aspects as much as they discussed the other aspects. Consequently, it was with some surprise that, when I examined the transcripts, I found much information about their spiritual experiences.

Sixteen of the women had some kind of a spiritual crisis around the events of their miscarriages. Their comments were:

Why are you doing this? That was the only thing that went through my mind. Why Me? Why are you doing this to me? Am I supposed to be learning something from this?

The first thing that I thought was: Why is God doing this to Me? I don't deserve this. I've never done anything bad to anybody. ... About having faith in God. Sure I was angry with him for awhile. At the time I was angry with him. I really was!

I think for someone who is a Christian it is comforting to know where that child is. That helped. It stood out in my mind. It helped to know that the Lord had my child. But I also

question why he took it. [tears]

[prayer] I just couldn't. I couldn't understand it. He's perfect. But I didn't understand. I still don't understand. I don't. I never will.

We had prayed about it [another pregnancy] and that was one thing that I couldn't understand: Lord, we prayed about it and now I have all this back pain and we went through all these steps to get this.

I've become a little angry, religiously. I feel guilty for feeling resentment because I don't feel that it is fair to feel resentment because I don't think that God is a punishing God -- but yet, I can't help but feel punished! [tears]

Why would God let me get pregnant? [tears] Why give me all that hope and all that happiness that I had and that I felt and then take it away? I would just rather not have been pregnant at all! I don't think that it is fair! Then I thought: Well, He must be punishing me. I must have done something bad. I deserve it. Why make me go through all that?

Much of this crisis involved a search for the meaning of the event which was perceived as evil but somehow stemmed from the source of creation. Most of the women found it difficult to verbalize their spiritual dimension. For instance:

Lately I haven't gone for awhile and I don't really know why. I don't know. I don't really say to myself. I'm not really religious enough. I don't say to myself: why is this happening to me? Going negative on the church. But this third time I did think it. I did think it this time. [one week before] I just thought - my mother is very religious and I don't talk to my mother about this and religion because - it is not that - she would do it in a loving way - [very long pause and tears] - there is a purpose in everything and I know that she would do it in a loving way and I don't want to get into it. I don't want to say now. I don't want to sit there and listen to a sermon because I never know what it is going to be. I think maybe because they will talk about something that I'll associate with or something

and I'll start thinking: Yeah, that's true and why is this happening.

It was a phenomenon that I noticed early in the interviews. The women who did not seem to be highly distressed talking about the miscarriage and did not show any emotion would cry when discussing the spiritual aspect of this event. At this point in the interview, there was most often likely to be an expression of deep sadness.

Thirteen of the women discussed some aspect of a pastoral visit that they actually had or wished that they had had. The visits from the hospital chaplaincy teams were viewed as nice and not very involved. "I don't think that she knew my situation. But she asked how I was feeling. It went fine. She was very nice. She didn't say anything threatening." Four had visits from their own pastors while in hospital.

The minister was up the first time when I was in hospital overnight. It was short and it wasn't drawn out. I don't think I felt like talking and he knew that and he was there and that was nice. I haven't seen him since the second one. ... Now that I think of it, it is kind of funny that they don't call and see how you are.

The pastor was very good. he came to see me in the hospital. His wife works at the hospital and she came to see me too. He came and we said a little prayer together. They sent me something too. Was it flowers? Maybe it was just a card. Yes, they sent me a sympathy card. I think they really realized it was a loss.

The thing I really remember is the assistant coming in to see me. I had a good cry. I don't think he said talk about it but he said to me: The baby was in heaven and I would see it when I got there. [tears] That helped! That really

helped! Because I found that most people, because it was nine weeks, don't look upon it as a baby. But I do! I think of it as a baby! Most people don't but that has stayed in my mind when he said that to me [tears]. The other minister, I don't remember him saying too much to me.

Some expressed concern about an expected visit that did not materialize.

He knew I was pregnant. He didn't say anything. He is usually very caring and very interested in everything that happens. Nothing was said. It's funny. I guess I was a little surprised and a little hurt.

The priest knew about it because I had just miscarried the week before I had her [toddler] baptised. I told him that I had lost the baby but he never made a point of coming out to visit me or talk to me at all.

I was really mad at the younger priest because he didn't call me. They knew that I was pregnant.

Only one woman talked about the expectation she had about pastoral care within the hospital setting.

Nobody came to me in the hospital. I really expected somebody to, . I thought that there would be somebody that comes to try to talk to you-like a pastor! I don't know, I felt that nobody really felt that this baby was anything. I was just expecting it. Somebody who had had some kind of experience with something like this. Like a special person that comes in and just to know that the hospital really cares. Like they really reach out and care! I don't know why I was expecting that I just expected it. They should have something for miscarriages. You just don't go in there to have a D&C. It is much more than that.

It is interesting to note that the women who did receive a positive visit still spoke in terms of having some kind of spiritual crisis. The main difference was that these women had much less bitterness and anger towards the church as

revealed by the tone of their conversation. Another very significant difference was that the women who had had a positive pastoral visit from their pastoral person did not have the same negative attitudes towards the pastor that were expressed by some others.

This attitude towards the pastoral person involved in their lives was expressed in several ways. Usually it was in response to a question about the pastoral person response, whether they would feel free to talk to their pastor, or if they thought the pastor would ask them to share their story.

But I didn't tell him! See, I told my cashiers but I didn't tell my priest! Because we say hello when we go into church. we are not really on the friendly type basis.

I don't find it easy to talk -- to go up to a priest. I feel that women understand more than a man as far as losing a baby. [would your priest have asked you to share your story?] Oh, No! [laugh] I don't think so! [laugh] Definitely not.

I couldn't talk to him very well because he was about to retire and he had grandchildren older than my daughter.

Everything is God's Will or This is God's Plan. Nothing in 'you must be feeling this' or 'tell me'. None of that! I don't see any vulnerability in him. He does not pray for those who have died. He prays for the service and life that they had but not for the soul. He doesn't give me any hope for him being supportive.

I didn't go to him because I never even -- I never thought of going to the priest. That was never in my mind. Honestly [chuckle]

I have trouble with these priests. I think that they should get married. I think that they should experience what they are trying to deal with. I don't think that they can really understand. I think that it is his lack of experience.

For over half of the women there was not a positive feeling of support for them from their pastors. They also did not feel free to ask for any support. The three women who did receive a positive pastoral visit from their clergyperson did not have any adverse feelings about returning to church.

Returning to church after the miscarriage was not an easy thing for any of the women to do. Some had not returned after their most recent miscarriage but some had and they talked about that experience.

Lately I haven't gone for awhile and I don't really know why. I don't know.

At first it is the worst! I knew that I wanted to go but I would not go! because I couldn't face the people in that church and I couldn't face the priest.

It is a chore for me to get to church. Once I'm there I'm fine. I have to fight crying through the service once I'm there. I cannot pay attention to what I am saying or what is being said. I can't pay attention to singing the songs. When I pay attention I start crying. I think because the feeling. My religion is at a feeling level.

I've stagnated. My religious development has stagnated.

It seems that there is a certain level of unfinished business involved with returning to church and an unsatisfactory interaction with the clergy.

Although only one clergyperson discussed the present state of the miscarried baby, five of the women had a vision of their infant in heaven. "I see my baby as the tiny bundle wrapped in a white receiving blanket and lying in God's

lap." Even though some of the women pictured their baby in heaven only one of these talked about ritual.

Three of the women spoke in terms of some kind of ritual in connection with their miscarriage.

I think that that is kind of personal. I said extra prayers and talked to my grandmother and told her to watch for it type of thing. It gave me peace of mind. I think of it as a private matter that I dealt with on my own and I don't think that anybody could help me with that.

When somebody dies there is an actual body. There is a funeral. This is just in the background and it isn't entirely real. It is very real to me. A friend of mine had a miscarriage and she had a private mass said afterwards. The priest that did it never once said 'the baby'. They were praying for life in general and never mentioned the baby that they had lost and she found that really disconcerting. He is a great believer in the Pro-Life movement but when it came down to actual specifics, he didn't mention it. Maybe I'll think of something else to commemorate this child. I haven't done anything. I just couldn't think of anything that would be appropriate for me. A parade would have been nice. Something private is good because again it just is private. I don't think I would be comfortable with something public.

I didn't know how to say good-bye [tears]. The baby had died. [tears] When we were in the room by ourselves we said good-bye. [tears] On Sunday when we went to mass we kind of took care of that ourselves also. We took care of it. We did everything that we thought we had to.

These women expressed a need to ritualize their loss. Each considered that she had had a child that died and that somehow she had to mark this event as a passage in their life. However, for these women, there was no script of acceptable rituals available. At the same time none of them asked what could have been done.

Few of the women talked about their spiritual experiences in connection with their miscarriages. However, two women did talk about this:

I'm a Christian and I found that as soon as I gave it over completely to the Lord - I named it Leslie. It was something I had to go through, that process, in order to rid of all that guilt because I felt guilty. There really was a reason that the Lord did this to me. I don't know the reason but I believe that this child has a soul before it even has a body. According to the Word the Lord knows before you even conceive. I put that child to rest and I can feel at peace about it.

I have been under anaesthetic a couple of times and I have never, ever dreamed under anaesthetic except for this D&C. There was this amazingly comforting dream all full of good feelings and warmth and stuff to the point that when I woke up in the Recovery Room I had no clue to where I was. It wasn't til I saw the sign 'recovery room' that I knew where I was. For the next couple of days every time I went to sleep I would have these warm and wonderful dreams - very, very comforting. I talked to my husband about it one day and he said: obviously, God is just trying to tell you that everything is OK and God still loves you. I thought that that was a really neat idea. God couldn't give me my baby back but he could still let me know that he is still there and that he is still thinking of me. ... It kind of strengthened my faith that I had been coming to for some time. He is not testing us ... It is not God's fault. This is what was given and the rest is up to us. God is there loving us and He doesn't do this to me. ... It is like God and I are a team now and I don't have to believe in this big Father-figure that is going to pester me.

For both of these young women, in their late twenties, the experience of miscarriage was something that they had prayed about and thought about and thus had integrated into their lives, at least at a spiritual level.

The women that were interviewed showed that the event of miscarriage does indeed create a spiritual crisis for many women. Penelope Washbourn is correct in saying that pregnancy and loss can cause a crisis at the spiritual level.

PERSONAL PERCEPTION TOPICS

There were topics that the women spoke of which did not fit easily into the other categories. As I examined these topics I realized that they were topics which came from the personal experience of miscarriage and could be called personal perceptions. The most significant concerns pertaining to miscarriage mentioned by the women were in this group of topics.

As could be seen in an earlier chapter, the society in which we live does not view miscarriage as a significant event. There are no rituals. The social script that is present for those who are involved in this experience is one of silence. The women's personal perceptions of the event show how much in conflict they are with this silent social script.

Although the future fantasies and the choosing of names were signs of bonding with the coming child, the language used by the women after the miscarriage indicates the significance they felt for this pregnancy. Sixteen of the women referred to the lost pregnancy as baby.

I have such hard times remembering birthdays - but September the 6th - I can't even remember half the time, my son's birthday, the one that's alive and I know September the 6th. I went to the hospital. I don't think I'll ever forget. A baby is a baby.

It is not just a blob. To me I don't think that anybody really feels that it is just a blob even if they say it is because it is a part of tissue. There is there - there is definitely a baby there.

I felt that I had lost a baby! I don't care that I wasn't very far along. It didn't make any difference.

To the women the length of gestation did not make a difference to their attachment to the baby even after the miscarriage. Obviously, this attitude towards their babies was in conflict with societal attitudes towards the event of miscarriage.

After interviewing four women, I realized that they considered this event much more significant than I thought they would. After that the women were asked if they thought this was a major or minor event in their lives. Only one of the women felt that it was in-between since she considered the death of her father more major than her two miscarriages. The importance of the baby to the women was also reflected in their perception of the significance of the event of miscarriage in the framework of their lives. One woman put their opinions very well.

I consider it a major event in my life. I didn't want it to happen and it did. I got over it and everything. It was major. I handled it with time quite well. But it was major. Yes, I think so. I don't care what anybody else thinks.

Miscarriage was a major event in the lives of these woman and they claimed it was such, even in the face of societal opinion.

In the course of the interview I asked the women how they felt about their pregnancy. Fourteen of the women had very positive memories of their pregnancy, but they needed to be asked about this. Not one volunteered this information in the initial general question about the miscarriage. They seemed to separate the pregnancy from the event of the miscarriage. One woman put it very well:

I get the feeling that people see the whole pregnancy as a tragedy whereas I see the fact that it ended as a tragedy. But everything that went before that was a miracle! It was absolutely wonderful! But everybody sees it as one thing - the fact that I was pregnant was as much of a tragedy as the fact that I had a miscarriage.

Being able to name and remember some very positive aspect of this event gave the women a sense of wholeness. One woman observed that she was not able to talk about her wonderful feelings about being pregnant because "I have nothing to show for it" and people would think that she was "batty". It seems that the baby and pregnancy were very significant but there was no vehicle for naming this significance.

Naming of experiences is very important, particularly when those experiences are significant. For an experience to be truly 'owned' by an individual the feelings and events have to be verbalized in order to be fully faced and resolved so that the experience can become part of the total

life experiences. The second question that I asked of the women in the interview was: Has anyone else asked to share this story with them? Three-quarters of the women had no one ask to hear their stories. The others had shared their story with sisters, and close friends. Several had not shared the whole story with their husbands.¹⁶ The women spoke of the importance of talking.

Well, it just gives me a sense of peace. If somebody is willing to listen. It is like a comfort to be able to talk about it. It's like a chapter - the more I can sort of relate the story maybe I can come to terms with it better.

I had to talk about it [with the family] I had to tell them to make it real. I just had to make it real. There was this person there that I had lost and since nobody had ever seen him and I was the only one that was really aware of his existence, I just really, really, needed to talk about it.

As you talk it out, I feel better about it. I feel better about myself.

You don't have anything to go on. You are going on story-telling.

Telling one's own personal story is an important way of making that story real, particularly the feelings. Because of societal pressure and attitude these women felt that they could not or should not talk about their experience of miscarriage. Yet they recognized the importance of naming the experience in order to give it reality and validity. Women need to be invited to share their stories if they

¹⁶ This is not an unusual reaction between bereaved parents. Each partner tries to protect the other from the powerful feelings that they have. There is a conspiracy of silence which is sometimes felt to be helpful but is usually a cause of distress.

wish.

Twelve of the women spoke of knowledge that they felt they had about their own bodies and their own experience of pregnancy that came in conflict with those around them. Eleven of them expressed some knowledge of the inevitability of the miscarriage or the actuality of their pregnancy which was denied by others around them.

I thought at the time that I had passed something because I was on the bedpan in the hospital and I had passed it. I asked the nurse if that was the baby and the nurse sort of said: No, it was just some tissue or something. Like I was really confused about that but I did pass something. I felt inside that it was the baby. I don't know why she didn't just tell me.

They never believed that I was pregnant which was really upsetting to me at the time of the miscarriage. I had a pregnancy test at my family doctor. It was negative. But I had all the symptoms of pregnancy and I felt fairly certain that I was. I went to London and it was confirmed. Then when I went into the hospital it was not my regular doctor but his associate. He kept saying to me: Are you sure? It made me really angry. All I kept saying to him was: I saw the ultrasound. I saw the heart beating. He tried to get in touch with London to find out if I was really pregnant! And that really annoyed me! That really upset me.

The lack of worth and value given to the women's knowledge of themselves actually caused suffering. It is evidence of the disconnection from the body prevalent in dualistic thinking. If the woman knows that her essential self is fully connected to her 'lived-body' experiences, then she will automatically be able to have confidence in her knowledge of her body-self. This approach should replace the

dualistic approach that permeates our western civilization.

This last example showed that the woman had visual confirmation about her baby. Nine of the women spoke of some kind of visual contact with their baby.

I knew then for sure that it was gone. It was real. I imagine if I didn't see it it would be harder for me to believe. Maybe it didn't happen.

I went to the bathroom and everything came out. I was kind of shocked. I was amazed. I just sat there and looked at it. I had seen fetuses in jars and I was sort of - it was like it wasn't mine - I was looking at a sample that I had seen. It was like - you could see the enlarged head, the little curved body, the hands and the feet. It was very small.

I actually saw it. The doctor had a little pan there and he asked me if I wanted to see it. I can't remember, maybe I asked to see it. I guess I wanted that final look or something, not that I didn't trust him. I just wanted to know that it had actually happened.

These women spoke of visual confirmation of the miscarriage and pregnancy as being important to their perception of the event as being real. It did happen.

The women had kept the little things that they had purchased for the baby while they were still pregnant. Four of the women spoke of having mementos relating directly to the baby. They had ultrasound pictures, little symbolic pictures of feet, and pregnancy diaries. One spoke of her perception of the importance of these things.

I have kept them [ultra-sound pictures] ... I had a pregnancy diary - I kept them all in there and I kept the rose which I dried pressed. Let's put it this way. If ever there was a fire in this house I would go for it! [laugh] I would go for my pregnancy diary for Spencer too. Those were

my pregnancies so - my life.

The significance of the pregnancies and the miscarriages of these women was of prime importance to them as a woman. Nevertheless, they experienced difficulty in integrating the event into their lives afterwards.

The integration of the event of miscarriage into the lives of the women was a major aspect that I examined when I took yet another look at the entire set of transcripts. I made a subjective evaluation on the integration of the miscarriage into the woman's life by the way that she was able to describe some positive outcomes and by the way that she was able to feel at peace with the event. Then I examined the personal perception topics to see if there was any connection between the two. I finally wanted to see if there was a connection between this and those who described some kind of spiritual crisis in their life.

INTEGRATION OF MISCARRIAGE INTO LIFE PATTERN

I found that six of the women had integrated the event of miscarriage into their lives to some extent. Since making this type of judgment is very subjective, I selected those women who showed any form of integration. This meant that some integrated quite well while others had only partially integrated the event into their life-pattern. The length of time since the latest miscarriage seemed to be significant here. The three women who were farthest away from their

miscarriage were in this group (46, 40 and 33 months). Two others had had their last miscarriage 17 months previously, and one woman was only one month removed. This last woman was unique in many ways since she had no pastoral support or emotional support at all during her two day stay in hospital. However, her strong Pentecostal faith and personal prayer led her to name the child, even though she had been told that she had had a blighted ovum which meant that there was not really a baby there anyway. I realize that this event was not totally integrated into her life but there was a sense of peace about how it related to her life that was not present in the other women interviewed at the same time after their miscarriages.

These six women had two important ideas in common which were topics in the personal perception section. Each woman had a strong sense of who this baby was.

A baby is a baby.

There was this person that I had lost. ... He was a person.

It is not just a blob ... there is definitely a baby there.

This baby, this whatever it was, he (dr) didn't even call it a baby! I wanted this baby. We would have had four kids by now.

No one ever died on me before. This was like a death. This was the first time I had had any kind of a loss.

Two of the women had been told that they had had a blighted ovum and that there had not really been a baby there.

However, they did not perceive their child in this way.

Five of the women also showed a strong sense of their own knowledge about themselves.

I'm not sure how I knew but I knew that I was going to lose the baby.

I thought at the time that I had passed something I felt inside that it was the baby.

The other two had been very sure that they were pregnant. even though others around them did not trust their knowledge of themselves. From these two common personal perceptions, it might be inferred that when the woman has a strong sense of who she is and what she has lost, she is better able to integrate the event of miscarriage into her life. Time to reflect on the whole experience is an important contributing factor as well.

One other factor that appears to be important in this integration is the significance of talking about the event. Four of the women felt that talking was very necessary.

I love to talk about it. Anybody who asks, I'll tell them. It feels good. [17 mos.]

I needed to talk. ... There was this person there that I had lost and since nobody had ever seen him and I was the only one that was really aware of his existence, I just really, really needed to talk about it. [17 mos.]

I felt: why am I even bothering to talk? But I needed to talk. It was good for me. [33 mos.]

As you talk it out. I feel better about it. I feel better about myself. [1 mo.]

The other two women, after 40 and 46 months, described themselves as very private people who did not talk about

themselves and their lives outside of their immediate home. It seems that talking about the event was very helpful for those women who were not so far away from their crisis event as these latter two women. Because this sample is quite small, only a tentative conclusion can be made. Talking and integrating seem to be interconnected. Naming the event seems to be important. The other eight women in the sample who discussed the importance of talking spoke in terms of wanting to talk but not having someone really interested to listen. Although they recognized the importance of talking, they felt that not many people were really ready to listen to their story.

Of all the women only one had received a positive pastoral visit. This woman had been visited by both her pastor and his wife, who had experienced infant loss themselves, and they sent her a sympathy card. The other women did not receive a pastoral visit.

The most significant concern of the women interviewed was that the miscarriage was a unrecognized major event in their lives. Few had been asked by anyone to share their story of the miscarriage. They felt that they had lost a baby for whom, in many cases, a name was already selected. They wanted recognition of this event and many felt a need to tell their story. Very few had integrated the miscarriage(s) into their life pattern. Those few who had displayed three common things: time, a need to talk, and a

sense of themselves.

Because of the need to 'name' their experience through the telling of the story of that experience, it is important for pastoral persons to be aware of the theology of storytelling. Another form of theology which would fit well into the concerns of these women would be the 'lived-body' approach which is evident in much of the theological thought of Penelope Washbourn and Rosemary Radford Ruether.

The questions that are raised by this examination of the information are: Is time the most important factor in integration? If talking is perceived to be so important, how can care-givers facilitate this? If women recognize the actuality of the event and its significance to them, then how can care-givers validate this for women?

The topics that the women discussed point to areas in which pastoral people may be able to react to assist the woman in integrating her miscarriage into her life-pattern. It is important to determine the significance that the pregnancy and the miscarriage have in her life. The personal perspective topics and the above issues of integration are important to keep in mind when working with the woman. There needs to be an examination by the pastoral person of both their theological approach to women and their bodies as well as their particular approach to pastoral theology. All of these factors will determine the type of care they give to women who experience a miscarriage.

CHAPTER FOUR
IMPLICATIONS FOR PASTORAL CARE

From the information shared by the women participants, it became evident that a miscarriage was a major, significant event in their lives. I learned that time was probably the biggest factor in the integration of the experience of a miscarriage into the fabric of the woman's whole life in our present societal setting. They felt that talking about the miscarriage was important as well. Looking only at the role of a clergyperson as a pastoral caregiver, I will attempt to give some suggestions about pastoral care for women who have experienced a miscarriage.

The implications for pastoral care will be discussed under the categories: pastoral care theory, clergy biases, grief and spirituality, pastoral role in bereavement, pastoral role after miscarriage, rituals for miscarriage, and further suggestions for pastoral care.

From the psycho-social aspect of the effects of bereavement upon bereaved parents, it is important for caregivers to have information about the dynamics of bereavement in general and particularly about the unique dynamics of grief in perinatal bereavement. The social script of behavioral expectations prevalent in our society must be understood as well, in order to evaluate the situation of the woman and her family at the time of a miscarriage.

From the theological aspect, it is important for clergypersons to understand the position to which the body has been relegated in Western philosophy and theology. The implications for women and for their reproductive functions are relevant to an understanding of the background of the clergyperson as well as the woman's expectations of the clergyperson.

PASTORAL CARE THEORY

Pastoral Care is sometimes seen as crisis intervention given at times of distress. However, it is an essential aspect of the ongoing care of someone after the immediate crisis has past.¹

Although pastoral counseling is much like mental health counseling, the incorporation of religious principles into it makes it pastoral rather than secular in nature. Wayne Oates, in Pastoral Counseling, describes some of the distinct characteristics of pastoral counselling. There is a God-in-relation-to-persons consciousness in this type of counseling, in which God is a reality and faith in God is talked about. The pastoral counselor brings special information into the situation based on both biblical and theological literature as well as her or his experience with others. The pastoral person represents the community

¹ Swanee Hunt, "Pastoral Care and Miscarriage: A Ministry Long Neglected", Pastoral Psychology, 32 (4), Summer 1984, p. 274.

resources of the church, as well as a prophetic and ethical dimension into the pastoral care setting. Finally, Oates says that the pastoral person has the power to bless or to withhold blessing on the cared-for individual.² These are the dimensions that make pastoral care pastoral rather than secular. Another way of putting this would be to say that "pastoral counselors are listeners to and interpreters of story."³

Ellen Leonard, in "Experience as a Source for Theology", discusses the importance of having our experience interpreted for us so that we can make sense of it and so that it can become shared experience.⁴ She notes that although experience has been integrated into theology, it has not included the experience of women, particularly the experience of being a female body with reproductive functions. She advocates that there be an identification of how exclusively masculine experience and thought have influenced theology and how aspects of women's experience can provide resources for a fuller understanding of human experience.⁵ When this is done, there will be a fuller view of sin and salvation which will be more relational, communitarian and pluralistic.⁶ It seems to me that the

² Wayne Oates, Pastoral Counseling, (Philadelphia: Westminster Press, 1974), pp. 11-23.

³ Charles V. Gerkin, The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode, (Nashville: Abingdon Press, 1988).

⁴ Ellen Leonard, "Experience as a Source For Theology", The Sources of Theology, ed. John P. Boyle, George Kilcourse, (New York: The Catholic Theological Society of America, 1988), p. 45.

⁵ Leonard, pp. 47-48.

⁶ Leonard, p. 5.

exclusion of women's experience of human reproduction, both its successes and its failures, has left women bereft of a base for spiritual assistance at the time of crisis of a miscarriage. It has also left the pastoral person without a theological base upon which to develop some means of care for women. Perhaps the place to begin to develop this base would be to acknowledge the experience and to tell its 'story', and thus the woman's interpretation of it.

When a person's experience is named, the story can be used for theological reflection. Story theologians suggest that "the stories of ordinary people in ordinary places doing ordinary things can be a source of divine revelation."⁷ Story or narrative theology involves the process of taking a raw human experience and making it a lived human experience. An uninterpreted experience starts to become a lived experience when there is recognition of its significance in relation to the whole self. This recognition comes through reflection upon the experience by the 'naming' of the experience and by the telling of it. When the story is named, the individual can make some choices about the significance of the story of the experience. These choices are made against the wider background of the religious stories with which people live.⁸

The pastor represents transcendent stories as well as a

⁷ Douglas Bland, "Storytelling as Grief Ministry", *The Christian Ministry*, 13 (5), 1982, p. 32.

⁸ Tad Guzie, *The Book of Sacramental Basics*, (New York: Paulist Press, 1981), pp. 8-15.

critique of the predominant cultural myths and stories.⁹ Somehow, then, the pastoral person must change the existing view and story about miscarriage into one which portrays the gospel of love to the outsiders, the downtrodden, and the forgotten members of society.

Several authors discuss the importance of story-telling and grief recovery. Carolyn Bohler, in "The Use of Storytelling in the Practice of Pastoral Counseling", gives some guidelines for the counselor. The personal guidelines that she offers are to never impose your own meaning on another's story, never impose storytelling as a technique, and never impose your own stories on others. Being careful to avoid these impositions, the counselor then can remember "that stories need to be heard, and heard well, period", that sometimes they need to be given a new twist, and sometimes they need to be interrupted or prohibited if there is to be progress in the counseling.¹⁰ Bohler notes that the counselor must be aware of his or her own biases when listening to another's story, and that silence can be very powerful. Sometimes it gives permission or a space in which a story can be told.

Perhaps if we valued our help-seekers more, rather than our own expertise, we would in fact espouse a theology in which God hears more than God speaks. As a mama, hearing her crying baby

⁹ Mark Jensen, "Some implications of Narrative Theology for Ministry to Cancer Patients" The Journal of Pastoral Care, Vol 38 (3), 1984, p. 223.

¹⁰ Carolyn Bohler, "The Use of Storytelling in the Practice of Pastoral Counseling" Journal of Pastoral Care Vol 41 (1) 1987, p. 64.

and nursing it back to peace, Divine Creativity holds us, hears us, and nourishes us to growth.¹¹

Bohler says that the goal to hear stories well is to "enable the seeker to reintegrate her or his past events with a new feeling tone, as she or he gains a fresh perspective about the self, relationships and the future."¹²

In giving the story a new twist, the counselor attempts to get the teller to re-tell the story from another player's point of view. The counselor might ask the woman: How do you think your husband would tell me the events? The interruption or prohibiting of some stories is sometimes necessary. However, in the case of miscarriage, the personal biases of the counselor and the societal prohibitions against naming the experience could override this third guideline. Sometimes the story has never had the opportunity to be given words or value. Consequently, the counselor must offer the opportunity for this to occur. This is particularly true in the case of miscarriage, since the women in this study reported that almost no others invited the telling of their story.

The function of prayer in counseling is discussed by Bohler as well.

Prayer which expects us to be co-workers with God, rather than wholly dependent upon God, pushes us to transcend our own ways of looking. If I am functioning at my greatest potential, as the counselor, I hear the seekers longing for

¹¹ Bohler, p. 67.

¹² Bohler, p. 67.

meaning and openness to God's guidance, not only for what to do, but also as how to refeel his or her past events to achieve healing.¹³

In order to be able to offer prayer of this type the counselor must truly hear the story as told by the one recounting the experience.

Carolyn K. Dennis discusses 'personal legends' as important to pastoral care. These legends embody a statement about the significance of the individual.¹⁴ She notes that these legends are often-repeated set-pieces during which no dialogue is invited and little eye-contact is used. They usually occur during a 'life review'. These legends are not offered for judgment, suppression, nor dissection, but simply for illustration of the significance of the person. We all know of older adults who tell these 'personal legends' ad nauseam. The event of pregnancy loss might never become a woman's personal legend if she is never asked to name the story in the first place. If it does become a personal legend, what form does it take? This could be a subject for further research with older adults.

John Topolewski reflects on this in his article "The Angel of Death: Narrative and its Role in Grief".¹⁵ When griever's respond to the request, Tell me what happened, they begin to create a narrative which gives structure to their

¹³ Bohler, p. 69.

¹⁴ Carolyn K. Dennis, "The Recognition of and Empathic Response to 'Personal Legends'", Pastoral Psychology, 32 (3), Spring 1984, p. 262.

¹⁵ John Topolewski, "The Angel of Death: Narrative and its Role in Grief", Quarterly Review, Winter 1985, pp. 21-26.

experience, articulation to their emotions, and a solution to their affliction. The story we tell becomes, in time, a paradigm of the grief with which we have laboured.¹⁶ This retrogressive tale takes months and sometimes years to develop. Perhaps it is at the point of completion that the tale becomes a personal legend. The solution or issue which shows the way out of the affliction contains the significance of who the individual is. Topolewski notes the importance of this tale.

It is a story that may bring a tightness to our throats, a thickening of our speech, and tears to our eyes. Yet, there is a grace in such a tale and such grace comes with the realization that in pain, we can find a cure.¹⁷

This particular tale would be a tale of risk, struggle and victory as the woman tells of attempting a pregnancy, the adjustment to the loss, and the integration of the experience into her life-story.

The importance of telling the personal story of pregnancy loss is poignantly recounted by A. James Cox who interviewed his aunt and uncle who had almost fifty years before had three pregnancy losses. He notes that although his aunt Grace was seventy years old, she was not the least bit tired after over three hours of interview whereas he was exhausted. "Aunt Grace looked as refreshed at the conclusion

¹⁶ Topolewski, p. 23.

¹⁷ Topolewski, p. 23.

of the interview as she did when we first began."¹⁸ This couple had not received any family or societal support for their bereavement. This telling of the full story for the first time had meaning and purpose which was refreshing for Aunt Grace.

Charles V. Gerkin talks about this dimension of unspoken story about individual experiences. He notes in The Living Human Document: Revisioning Pastoral Counseling in a Hermeneutical Mode that story about an experience always includes two-sided language. There is the language of the deep forces which shape our lives as well as the language of our meaningful interpretation of those experiences and forces. Spiritual suffering occurs at the point of connection between the occurrence of the event and the language of the meaning of the event.¹⁹ If this process is blocked then the suffering becomes a crisis. This confirms the research that talking about the miscarriage or telling the story of this experience is very important to the integration of the event into the life-pattern of the woman.

CLERGY BIASES

From the material presented earlier in this work, it can be seen that the centuries of theology which clergy

¹⁸ A. James Cox, "Aunt Grace Can't Have Babies", Journal of Religion and Health, 25 (1), 1986, p. 83.

¹⁹ Charles V. Gerkin, The Living Human Document: Re-Visioning Pastoral Counseling in a Hermeneutical Mode (Nashville: Abingdon Press, 198), pp. 52-53.

study during their seminary years is biased against human bodies²⁰ and particularly against the bodies of women. There is no recognition of the power of the woman to reproduce the human species. The end result is given value but the process is not. When there is no end result the process is not seen as having value at all. If women's reproductive power were given value then there might be some understanding of the risk of failure, as well as the risk to health and safety, both physical and emotional.

An interesting study was conducted by Kenneth Doka and Michael Jendreski about clergy attitudes towards bereavement.²¹ They discovered that many clergy were unfamiliar with the nature and the symptomatology of grief. Most particularly, clergy underestimate the duration of grief. They are more likely to accept the affective symptoms of grief than the behavioural, physical, and cognitive symptoms of grief. My personal discussions with several priests over the years confirm Doka's and Jendreski's findings.

These authors warn that this lack of knowledge may lead to an avoidance of pastoral care of the bereaved. In turn

²⁰ A recent example of this can be found in Terrill L. Gibson, in "The Body as Theology In Pastoral Psychology", Journal of Religion and Health, 20, 1981, pp. 288-98, says that the church is embarrassed by the body. He goes on to discuss the body as being the physical evidence, through physiological reactions to stress, of our sin. "The body expresses the dilemmas of our uprooted souls." (291) Although he attempts to say that the body is part of our existence, he still feels that the inner world is the more important.

²¹ Kenneth Doka, Michael Jendreski, "Spiritual Support for the Suffering: Clergy Attitudes Toward Bereavement" Loss, Grief and Care, Vol 1 (1-2) Fall-Winter 1986-87, 155-160.

this avoidance may lead to negative implications, since the lack of empathy increases psychological pain. The failure to validate the grief adds an additional burden to the bereaved. The failure to recognize the grief of the bereaved may increase the social pain. "Pain can also be increased when clergy are unaware or insensitive to the social context of the death."²² When the event of a miscarriage is not even viewed as a death, the event is not going to be seen as a time of bereavement and therefore no response will be forthcoming from the traditional care-givers.

John Vogelsang speaks of this traditional role of the clergy at the time of a death. He says that clergy are the most obvious and important caregivers at such a time. They also have immediate access to the bereaved because they are accepted by society as appropriate care-givers.²³ Although he says that people welcome the clergy because they feel that the clergy will be sensitive to their faith issues at times of bereavement, he does not talk about the long-term aspects of bereavement but only the crisis time.

For Richard Bruehl, the greatest gap in the pastoral care of bereaved people occurs when there is no follow-up after the crisis of the death is over.²⁴ I think that this gap is caused by a lack of information about the nature of

²² Doka & Jendreski, p. 157.

²³ John D. Vogelsang, "A Psychological and Faith Approach to Grief Counseling", The Journal of Pastoral Care, 37 (1), 1983, p. 24.

²⁴ Richard Bruehl, "Mourning, Family Dynamics, and Pastoral Care", Death and Ministry, ed. J. D. Bane et al. (New York: Seabury Press, 1981), p. 99.

grief and bereavement. The clergy's bias comes from a lack of knowledge about the process.

Clergy bias against long-term bereavement follow-up may come from a more personal bias as well. It hurts to be with grieving people in a caring model that takes in some of the other's pain. There may be too many people for the pastor to visit. He or she may not have a team of lay people who do this follow-up visiting and contact within the parish. There may be other reasons. This topic might be an excellent area for further research.

There is another bias that has developed over the years through the institutionalization of the church. Even if the pastor has not absorbed these biases, the people may have. In his article "Problems Which Confront the Minister", Edward Dobihal addresses two particular problems in which the institution of the church dehumanizes individuals. The church tends to ritualize the ministry in that the clergy tend to feel that their primary emphasis should be the funeral rite, whereas the bereaved feel that the primary emphasis should be afterwards. The church also seems to give the message that faith is "demonstrated by a calmness and ability of the individual to bear their own burdens".²⁵ In this case the bias of the church can sometimes make returning to church difficult for the bereaved since they

²⁵ Edward P. Dobihal, "Problems Which Confront the Minister", Death and Ministry, eds. J. D. Bane et al. (New York: Seabury Press, 1981), pp. 138-139.

may fear that they will break down and become emotional. Both of these biases were evidenced by the comments made by the women when they discussed their attitudes towards the clergy and their return to church services.

GRIEF AND SPIRITUALITY

Any crisis in life is a time for re-evaluation of the meaning of life and the ultimate force or forces that control life. Grief is a particular crisis time in life that everyone must, at some time, face and live through. It is a multiple process. For many young people, the event of a miscarriage is the first time that grief has entered their lives so intimately.

Margaret Murphy, in "Grief Process and Becoming One's Own Person", discusses the relationship between grief and the spiritual dimension of the self.

Slowly, gradually, a kind of peace will come. Given the fact that most losses that we suffer in this life prove to be irreversible, it makes sense logically, as well as spiritually, to come to terms with them and to look for good in even the most crushing of them. Faith helps us to find that elusive good.²⁶

She speaks of several qualities of character that will help to determine the outcome of such a crisis. These are the capacity for receptiveness of new things, the need for social activity and privacy, and the ability to roll with

²⁶ Margaret Murphy, "Grief Process and Becoming One's Own Person" Studies in Formative Spirituality, Vol 6 (3) 1985, p. 383.

the punches. The fourth quality of character that Murphy talks about is

An awareness of one's abilities and talents, an awareness of one's own value is essential to recovery from a serious loss. This is an area which women have difficulty. Biologically and culturally women are bound to roles which stress their care for and service to others at the expense of their own development.²⁷

Basically it means that individuals have to learn to love themselves before they can become fully realized human beings. Women have had to struggle to overcome the role, based on their female body, that society has assigned to them. This is to successfully reproduce and nurture human beings. How much more difficult it must be to regain some feeling of self-worth when your body has betrayed you in the main role that you have been given.

PASTORAL ROLE IN BEREAVEMENT

Roles have been given to pastors as well. The literature discusses the various types of activities and functions that a pastor should carry out when assisting a bereaved person. Topolewski says that a pastor must suspend critical judgement and respond basically with acceptance and absorption so that the stories may be heard in entirety.²⁸ This approach requires a certain openness to what may be perceived as unusual or non-typical behaviour and thoughts.

²⁷ Murphy, p. 384.

²⁸ Topolewski, p. 26.

Pastors should be very aware that anger and guilt are primary emotional reactions to a loss to death. Thus it is important to realize that forgiveness of self and the loved one who has died may be important for integration. Grief is a form of suffering. Since it is such an inevitable event in the lives of humans, it needs somehow to be constructive, not destructive. Richard Driscoll and Lloyd Edwards discuss the responsibility of the pastor in the case of suffering.

pastoral counseling ... has some responsibility ... to see that suffering which is inevitable be channeled into personal growth and commitment to others, rather than into self-involvement or alienation from community.²⁹

Christian suffering, from their point of view, is not something that Christians should calmly accept as their lot in life. They need to search for meaning in its midst.

This search for meaning has to be done by the bereaved with the pastor helping the process. Jacob Goldberg suggests that the pastor needs to go into the 'valley of the shadow' with the bereaved before they can climb back to a more wholesome way of coping and a better, more hopeful feeling. One way of reinforcing this more hopeful level of mourning would be to notice, affirm, and encourage every sign of positive coping in the bereaved.³⁰

In her article "Sudden Death: Pastoral Presence with

²⁹ Richard Driscoll, Lloyd Edwards, "The Misconception of Christian Suffering", Pastoral Psychology, 32 (1), Fall 1983, p. 46.

³⁰ Jacob Goldberg, "Issue in Pastoral Bereavement Counseling", Journal of Pastoral Counseling, 15 (2), 1980, pp. 14-15.

the Bereaved", Irene Moriarty discusses the role of the pastor in the event of a sudden death. Much of what she describes as an appropriate role is important in other deaths as well. She emphasizes very nicely the importance of being still. Sitting with the family gives human presence which is important in a crisis. The pastor has to relinquish the need to do or say something. The main goal of the pastor is to elicit the story from the bereaved. Moriarty rightly puts the emphasis on the responsibility that the pastor has to initiate and maintain contact with the bereaved. She suggests a minimum schedule of contact would include a visit one to two weeks after the death, and another six to eight weeks after the death followed by personal or phone contacts at important birthdays, holidays and anniversaries.³¹ Since most bereaved anticipate being rejected, this response will increase their faith in the goodness of human beings.

Moriarty notes that the pastor can also

model an ongoing awareness of the presence of bereaved people in the congregation by addressing the alienation, pain and anger of grief during regular Sunday services.³²

While becoming in tune with the suffering and pain of the grieving people in his or her congregation, the pastor must be very careful not to become a cynical burnt-out pastor. The role of the pastor is to offer presence, provide

³¹ Irene Moriarty, "Sudden Death: Pastoral Presence with the Bereaved", Journal of Pastoral Counseling, 15 (2), 1980, pp. 42-46.

³² Moriarty, p. 48.

information, and to facilitate closure for the bereaved. It requires sensitivity and a knowledge of grief and bereavement.

Patrick Farmer offers some points of reference for the role of the pastor in bereavement counseling. Primarily it is necessary for the pastor to use basic listening and counseling skills. It is important to pay attention to the words that people use since they are full of symbolism and imagery. Non-verbal communication and silences are important as well. It is all right for clergy to model the normalcy of bereavement. Sometimes it is helpful to use linking objects to stimulate memory. It is important to recognize and respect the bereaved's defenses, and to bolster the support systems already available to them. Clergy should be prepared to make referrals when more deep-rooted problems arise.³³

Two models for bereavement pastoral care which will be examined are those given by John Vogelsang and Bill Platt. Vogelsang outlines the needs of the bereaved based on the four phases of Parkes and Bowlby. Subdivided under four headings are sixteen progressions of needs of the bereaved. Although Vogelsang says that this model is to be used over an extended period of time, he states that some people will complete their grief within a few months.³⁴ He is also reinforcing the misconception about the length of time grief

³³ Patrick Farmer, "Bereavement Counseling", Journal of Pastoral Counseling, 15 (2), 1980, pp. 32-33.

³⁴ Vogelsang, p. 27.

lasts. It seems to me that although Vogelsang has set out the needs of the bereaved, a pastor would have difficulty finding some specific ways of giving care since these are not given.

In contrast, Bill Platt offers some practical guidelines for pastoral people to follow when doing grief counseling. He offers eleven words that remind a person of the things that need to be done for the bereaved. He says that the pastor needs to 'care' or hurt with the bereaved, 'learn' about grief, 'attend' or honour the griever by his or her presence, 'control' in which it is all right to shed a tear but control of self must be kept, 'listen' even when it hurts to do so, 'accept' the grief because it validates the experience, 'wait', 'share' the genuine self through thoughts and feelings, 'reinforce' progress, 'innovate' using many tools available to the counselor, and 'refer' if necessary.³⁵ All of the needs of the bereaved are covered in the eleven words used by Platt, but he calls the pastor to a deeper set of commitments to the bereaved. There is more responsibility placed on the pastor in Platt's article.

When we consider the work of Doka and Jendreski about the clergy attitudes towards bereavement, we must applaud the work of Vogelsang and Platt since they both recognize the need for some kind of model or plan for clergy. William C. Moore offers a very detailed strategy for clergy to

³⁵ Bill Platt, "Grief Counseling", Pastoral Psychology, 36 (3), Spring 1988, pp. 134-144.

follow when there is a death in the congregation. He outlines the steps from phoning immediately to the involvement of the parish secretary in sending letters, putting notices in the bulletin, and contacting the appropriate lay person to make the on-going follow-up visits. Moore does make another suggestion about the role of the pastor when one of the congregation has a family member die who is not a member of the congregation. He notes that it is good for the pastor to visit the funeral home during the wake if it is a local funeral. Although the pastor will have no official role, she or he is still the friend of the bereaved person and so makes a call just like their friends.³⁶ It was good to see that someone has addressed this issue since often the bereaved are disappointed that their pastor did not extend sympathy in such a direct manner.

It can be seen that the pastor's role is important and necessary during a bereavement. Each of these writers acknowledges that importance and all to some extent note the commitment that it takes to carry out the appropriate pastoral care.

PASTORAL ROLE IN BEREAVEMENT AFTER MISCARRIAGE

Considering how important the pastoral role in bereavement seems to be, as proposed by the literature

³⁶ William C. Moore, "The Pastor's Role in Death", Christianity Today, #6 March 18, 1983, p. 39.

considered, there was little actual and appropriate care given to the women interviewed in this study. There is also very little in the literature about the role of clergy in perinatal bereavement. Janet S. Peterman's article on miscarriage and stillbirth and Swance Hunt's article on miscarriage are the ones that will be discussed here. In some of the books there are little sections for clergy.³⁷ These two articles are the ones that speak specifically to pastoral people.

Peterman's article covers both miscarriage and stillbirth. She suggests that part of the pastoral care that can be offered is to increase the awareness of the normal grief that follows such an event by using this type of case as an example of grief for a sermon example. She also notes that

the church should provide a rite for use at the time of stillbirth or miscarriage. The rite should be published where it is seen and discussed. When parents and pastors know that an appropriate rite is available, it will seem a natural choice and a comfort in the time of loss.³⁸

These changes would cover the double need of the clergy being educated about grief and particularly perinatal grief, but also the need for a change and acceptance of the

³⁷ Borg and Lasker have a section but it deals almost specifically with other forms of perinatal loss than miscarriage. Sherokee Ilse and Linda Hammer Burns in Miscarriage: A Shattered Dream, (Maple Plain, MN: Wintergreen Press, 1985) give an outline of the type of options that are available to parents who experience a miscarriage but nothing specific to clergy is offered in this material.

³⁸ Peterman, p. 752.

significance of miscarriage by the wider community.

Peterman also suggests that the community of faith needs to affirm that this event was not what God intends life to be for people, and to proclaim that God in Christ reaches out to comfort and heal. The rite that is created for this type of event should be short but still contain words of comfort, a biblical lesson, and some prayers as a basic format, with the option to move to a full funeral with a Eucharist if desired. The parents need to be given the choice of a private or a public setting for the actual ritual.³⁹ This article seems to be a call for some change without giving any specific details about this change.

Swanee Hunt, however, does go into more detail and she deals just with the event of a miscarriage. Right from the beginning she acknowledges that the pastor may not be able to relate to this particular type of loss since the "life and death were experienced internally."⁴⁰ After acknowledging this possible bias, she offers some specific interventions that the pastor might be able to facilitate. If the pastor is present at the hospital he can encourage physical or visual contact, and especially naming. If a name has not been chosen or the sex of the child is not possible to determine, a neutral name might be suggested. Some type of ritual should be offered to the mother as well. In

³⁹ Peterman, p. 752.

⁴⁰ Hunt, p. 273.

addition, the pastor must be willing to meet the woman where she is and not where he would like her to be. The pastor needs to explore the meaning of the event with the woman. A very important aspect of the pastoral care for the woman will be to find ways to help her express negative feelings by giving permission. The final suggestion that Hunt makes is that the pastor can become a catalyst for ongoing support by suggesting a self-help group, a support network within the church, and by having books and pamphlets available for the woman to read.⁴¹ Each of these suggestions is specific and helpful.

It is interesting to note that Hunt refers to the minister as masculine only in her article. This seems to be a deliberate move on her part. She gives the last portion of her article over to the purpose of the minister's presence.

He is there to experience the woman. In her presence, he sees the strength of endurance. In her grief, he measures the love she felt for her child. As he is open to her story, he may enter into a sacred place where life is nurtured at its most vulnerable stages. He is there to appreciate in a new way the meaning of motherhood, the sacrifices it requires, and the inner strength that it demands.⁴²

This is the caring model that Nel Noddings advocates. It is only through this type of caring that the minister will be able to see the other in such a way. Although Hunt refers to the minister as male, I think that unless a female pastor

⁴¹ Hunt, p. 273-274.

⁴² Hunt, p. 276.

has experienced a pregnancy loss herself, she could be in exactly the same position as the male minister.

Hunt notes that there is a risk in going to the place where the grieving woman is. But at the same time there is something very valuable to be gained. This gain should outweigh any reluctance to enter and learn from her story.

In that moment with the woman, he can identify the force of love that has not died with the child. It is present in the depth of the loss, as the cause of the mourning. It is there in the ongoing living of the woman through the time of sorrow. It is there in the presence of community and in the unspoken bond between two who share the deep moments of grief. God's spirit is there opening the woman to the minister's words of faith and opening the minister to the woman's lesson of love and endurance. Ministry is not a one-sided happening. Where the spirit of God is active, everyone is touched with faith, hope, and love.⁴³

RITUAL FOR MISCARRIAGE

Several authors make suggestions that might be appropriate for incorporation into a ritual for a miscarriage. In general there are items that should be a part of any funeral ritual. There should be a painful confrontation with the reality of the death, a drawing together of the support system around the griever, and permission for the griever to say good-bye and to be touched by the healing presence of God.⁴⁴ The ritual must also have meaning for all involved and should include more

⁴³ Bunt, p. 276.

⁴⁴ Moriarty, p. 45.

than just two people. It is always good to use existing rites but the pastor should be open to creating new ones if that is appropriate.⁴⁵ In the light of Dobihal's criticism of the expectation of the institution of the church to expect a calm acceptance of the pain of grief from Christians, Sheila Carney suggests that it is very appropriate to have biblical expressions of anger in the funeral ritual for Christians. She advocates the use of the cursing psalms in the funeral ritual. Although there is a threat in this, since it will bring us face to face with the anger and violence within, it is probably the best reason for using them at the time of death. The cursing psalms are psalms of lament. She lists Psalms 5, 7, 9, 10, 13, 16, 21, 23, 28, 31, 35, 36, 40, 41, 44, 52, 55, 58, 59, 63, 68, 69, 70, 71, 73, 83, 94, 104, 109, 137, 139, and 140 in this category.⁴⁶ These invocations should be used to engage the community in the mourning. This mourning will break down barriers between people and create a solidarity through shared emotion.⁴⁷ It seems to me that the use of the cursing or lament psalms has a valuable place in our rituals. For instance, Psalm 139 has been used in the Anglican Funeral Liturgy from the beginnings of Anglican worship. However, verses 19-24

⁴⁵ Kenneth R. Mitchell, "Ritual in Pastoral Care", The Journal of Pastoral Care, 43 (1), Spring 1989, p. 77.

⁴⁶ Sheila Carney, "God Damn God: A Reflection on Expressing Anger in Prayer" Biblical Theology Bulletin Vol 13 Oct 1983, p. 116.

⁴⁷ Carney, p. 120.

- 19] O that thou wouldst slay the wicked, O God,
and that men of blood would depart from me.
- 20] men who maliciously defy thee,
who lift themselves up against thee for evil!
- 21] do I not hate them that hate thee, O Lord?
And do I not loathe them that rise up against
thee?
- 22] I hate them with perfect hatred;
I count them my enemies.
- 23] Search me, O God and know my heart!
Try me and know my thoughts!
- 24] And see if there be any wicked way in me,
and lead me in the way everlasting! [RSV]

no longer appear in present liturgies. It is unfortunate that the vengeful verses when they could be so useful in these circumstances. These psalms usually include finding strength in God, which is supportive.

Robert Klein, in "Chaplain's Ministry When a Baby Dies", includes some recommendations for readings to be included in a ritual for pregnancy loss. The psalms that he includes in his list are 23, 42, and 139. He also recommends the readings John 11: 35 and Romans 8:39 for permission to grieve and for the support of God's love.⁴⁸ For a miscarriage he suggests a special blessing be offered which would be short, with some familiar but brief scripture. The idea of a special blessing would have met the needs of the of the one woman who found the lack of ritual distressing in her experience of miscarriage.

The Pregnancy and Infant Loss Center of Minnesota has produced several pieces of information which includes a

⁴⁸ Bert Klein, "Chaplain's Ministry When a Baby Dies", Pregnancy Loss: Medical Therapeutics and Practical Considerations, ed. James R. Woods (Baltimore: Williams & Wilkins, 1987), p. 135.

short book called Planning a Precious Good-Bye. The authors suggest that the plans and hopes for the child be included in the ritual. Lighting candles is appropriate and if the family so wishes they suggest distributing flowers to the people in attendance as a keepsake of the event. The scripture passages that are recommended in this pamphlet are Ecclesiastes 3: 1-8, Isaiah 25:8, Isaiah 40:31, Matthew 5:1-12, Mark 10:14, Psalm 23: 1-6, and Revelations 21:4.⁴⁹

Using Psalms of lament there is this suggestion:

Lord God, today we can say with your psalmist, "My god, my God, why have you abandoned me? I have cried desperately for help, but still it does not come." May we also remember your promise that you do not willingly harm us. We ask you to be compassionate towards us in this time of grief over the child they expected, who now is not to be. As you knew the suffering and death of your own son, so now join us and hear their sorrow and pain, that they may in the days to come be comforted and receive your peace.⁵⁰

This acknowledges the anger at God and also reminds the bereaved of the strength that faith can offer during their time of distress.

The authors also recommend that the parents be given the opportunity to take an active part in the ritual. Susan Erling offers "A Reading For A Miscarried Baby":

Today we come together in sorrow over the death of _____ and _____'s baby. Their child, created in love and eagerly wished for, has died - never to be nestled securely in their arms in this lifetime. To these parents, the pain and the

⁴⁹ Sherokee Ilse, Susan Erling, Planning a Precious Good-Bye, (Wayzata: The Pregnancy and Infant Loss Center of Minnesota, 1985).

⁵⁰ Ilse & Erling, p. 14.

disappointment is great and their loss will be carried heavily in their hearts for all their days. In the weeks and months ahead, they will miss their child terribly and will be in need of love, compassion, time and understanding from all of us.

Each life comes into this world with a mission. Sometimes the mission or purpose is clear; sometimes it is vague and shrouded in misunderstandings. In time, we will see what this baby's mission was on earth. Could it have been just to add a little flicker of love that otherwise may never have been lit? Was it to soften our hearts so that we may in turn comfort others? Could it have been to bring us closer to our God and to each other?

This child's life was short, yet the death has left a huge void in all of our hearts and lives. Let us remember today and for always the tiny baby who will never see childhood or adulthood, but will remain our tiny baby forever.³¹

The first section brings home the reality of the death of the child. It would be nice to include some of the hopes and plans that the individual couple had for this child and, if named, to use the child's name. The second section calls forth the spiritual search for meaning that is being done at this time. It also gives the bereaved a positive direction to search in without writing the script for them. The third section acknowledges the significance that the child had in their lives and the fact that this will never be forgotten. It is a reality that flies in the face of the social script that has been written for such bereaved persons.

Rosemary Radford Reuther includes a Rite of Healing From a Miscarriage or a Stillbirth in her book Women-Church:

³¹ Ilse & Erling, p.14.

Theology and Practice.

Community Prayer: O great Mother and Father, power of all life and new life, we are sorrowful this day. Our sister (name) and brother (name) were anticipating the birth of a child into their lives. Already expectations, preparations, and plans had been formed around this new child. But this potential life that had begun to grow and develop has been snuffed out. We are left with empty arms and an empty heart where the thoughts of this coming child had been. We are saddened by the insufficiency of life, our inability to shape life to our wishes, and make a life that had begun to grow to fruition in a newborn child. We would like to rail against heaven, to be angry at the blind forces that end so quickly the fragile beginnings of our hopes. But we don't know who or what to be angry with. Should we be angry at you, the source of life, who have deprived us of this life? Or are you, too, subject to the insufficiency and limitations of life as you struggle to bring new beings to birth? Are you, god and Goddess of life and new life, also unable to control the forces of death that circumscribe your creative work? Do you too mourn and sign with us at this quick snuffing out of the spark of being that had begun in us? Can we weep and mourn together, humans and God/ess, for the little one who was and now is not and shall not be?

Yet we must go on, we and you. We must continue our struggle to support life, both the lives of those who are around us and depend on us, and our own lives. Failing in our hopes to nurture a new life, we turn to nurture the lives that already exist and need our help. Heal our sister (name) and brother (name) from their sorrow. We turn our energies to them and affirm and uphold them in their ongoing life, as they gather their lives together, center their energies on how they are going to continue to sustain both their own lives and the lives of those around them.

The woman (or the couple) now reflect on feelings about the miscarriage or stillbirth and hopes for taking up the threads of life. The group surrounds them, lays hands on them, and says,

Be healed of sorrow (names), be whole.

Then one of the women brings a flower pot with new soil in front of her and scatters seeds in it, saying:

Life is broken, life dies, but life is reborn, life continues. We do not look back to the past, but to the new futures that arise each day with the new rising of the sun, with the fresh dew on the grass and the sunshine of new possibilities of life that open up before us, even as we mourn the flickers of life that are not to be. The woman in the center takes a watering can and waters the seeds, and the flower pot is presented to her.⁵²

The first section includes well the plans and hopes of the couple for the child. It acknowledges the pain and feeling of empty arms. It also gives a more positive view of God. It is the view of a God that suffers with. The major concern that I have with the remainder of the ritual is that it does not acknowledge the length of time that grief can take after a miscarriage. It is almost too soon to be calling the bereaved to be healed and to move on. This would be good for those with unresolved grief but for newly grieving people, I would be concerned about continuing the social script not to grieve such a loss. The blessing of the community with the touch is very healing in itself.

At a recent conference on bereavement in Ottawa, May 1990, Diane E. Bridges, D.Min., presented a paper on "The Role of Clergy in Bereavement Follow-up". She concurs with the previous types of support for perinatal bereavement follow-up and discussed the necessity of ritualising well. In order to do that the pastor must be creative. She described using a ritual for a couple, in their home, for

⁵² Rosemary Radford Ruether, Women-Church: Theology and Practice of Feminist Liturgical Communities (San Francisco: Harper & Row, 1985), pp. 162-163.

seven miscarriages. They met in the couple's home. They went upstairs to the nursery. At the beginning of the ritual she had seven white carnations which she laid in the crib saying the name of each of the babies who had been miscarried. Then she went on with a ritual much like those described above. This ritual marked the beginning of the healing process for this particular couple.

One of the interesting points that came out of the research on ritual was the language used for God. Both Leonard and Hunt suggested using female imagery of God. If we follow Sallie McFague's metaphor for God as Mother, Lover and Friend we might become more in tune with the whole birthing imagery which could be of value for the mother who experiences a miscarriage. As Hunt says: "For God as Mother is the God who 'suffers with' in this situation".⁵³ The use of female imagery for God should fit into the framework of the individual woman, however. If she is very traditional in her thinking about God, bringing a new and perhaps threatening image into her consciousness might be more distressing for her. Thus each individual pastor must be very sensitive to the woman as well as being very comfortable with the imagery at a personal level. Bereaved people are very sensitive to phoniness and an honest approach is always best.

When I examined the transcripts of the women who had

⁵³ Hunt, p. 275.

had some integration, there had been some kind of ritualization. For the three who were quite a long time away from the event it was the ritualization of talking and naming the event. For the two at 18 months there was the visual contact as well as the talking that seemed important to them. For the third woman it was the conscious decision to name her baby. She did not however, think up this idea all by herself. She told me that she had heard about this on a Christian radio programme out of Detroit where a woman psychologist had made the suggestion to name the baby. She remembered this idea and decided that she would do so herself. If she had had contact with a pastoral person while in hospital, I would imagine that she would have welcomed some kind of ritual from that person.

It is important to remember to keep the ritual in tune with the tone and feelings of the woman and not the biases of the pastor doing the ritual. It needs, therefore, to be individual and creative. Flowers and balloons are not inappropriate symbols to use during this type of ritual. Remember the woman whose first response to the idea of a ritual said "a parade would be nice!"

It is important to provide a ritual which is creative, inclusive, and meaningful to the woman and her family. Just as important is the follow-up of the woman. The pastor needs to be very specific about this follow-up. It is my recommendation that the critical grief crisis times, six

weeks, six months, and the due date be put into the pastor's calendar as a reminder to contact the woman to see how she is doing.

FURTHER SUGGESTIONS FOR PASTORAL CARE

There are several things that a pastoral person can do to improve their care of mothers grieving a miscarriage. The pastor should become aware of his or her own biases about miscarriage and about women's bodies and their reproductive function. Are pregnancy and birthing an act of value, courage, and sacrifice or a 'natural' act for women? To this end there needs to be a shift towards a 'lived-body' view of human existence.

The pastor should improve his or her education about the phenomenology of grief and perinatal bereavement. To this end there should be some books on perinatal loss in the church library which can be loaned by the pastor to the woman to increase her information about a topic that she may perceive as being taboo. A short pamphlet on miscarriage might also be appropriate to give to the woman. (see Appendix #6 for such a pamphlet) The pastor may find that sending a sympathy card to the woman would be a physical affirmation of her loss.

Using Bill Flatt's guidelines for assisting the bereaved, they can then invite the woman to share her story about the miscarriage. To increase the congregation's

awareness of perinatal bereavement, in sermons, the pastor should use an example of a miscarriage as well as an example of widowhood to describe a normal grief situation.

Because the description of a miscarriage often has a lot of reference to blood, some women may be reluctant to talk fully about a miscarriage with a male pastor. From what the women in this study said, it can be noted that they preferred to talk with pastors who they knew on a friendly basis. Some women even expressed a distaste about speaking to a celibate priest about marriage/birthing topics at all, since they felt that these pastors would not know how to relate to their experiences. It seems that the culturally reinforced denial patterns about bereavement after miscarriage also interfere with the opening up of the topic at all.

The single most important thing that a pastor can do is to ask. If you don't ask, how will you ever find out how the woman is feeling? (see Appendix #7 for some suggestions for clergy to use) Just by asking about the event indicates that the pastor understands the significance of the event in her life. It seems that the lack of understanding of the significance of the miscarriage was one of the main points of distress for the women. To be able to offer some type of ritual for the woman and her family would be the next important validation of her loss of a 'baby'. Since so many of the women had discussed names, it would be appropriate to

ask what name they had chosen for this baby. The pastor should recommend using the selected name. If the couple prefer to save the name for another child then a neutral name, like Chris or Leslie, if the sex is not known, or the name of a flower which could then be used in the ritual. Naming the baby is the first important step in any kind of ritual.

To assist the integration of the miscarriage, the pastor can suggest that the woman make a memory book or memory box. This could include the ultra-sound pictures, the cards received, and written reflections about the feelings that the woman and the other members of the family had at the time. It might include a copy of the ritual that was done. A flower or flowers that were received at the time could be dried and included in the book for decoration. In an event in which there is nothing concrete, this would offer something specific to focus the feelings of grief on and thus assist in the integration of the death of the baby into the woman's life-pattern.

It seemed that many of the women asked the ultimate question, Why? Why Me? This needs a sensitive response. Perhaps the most honest one would be: That's a good question. I wish I had the answer to it. This validates the woman's spiritual searching for meaning behind the event as well as giving permission for further feeling and expression of these feelings. It also shows the vulnerability of the

pastor. It makes him or her more 'present' with the bereaved than 'separate'. It might be tempting to say that it is God's Will but might be more appropriate to discuss the failure of creation to be perfect and introduce female imagery of God. It would depend upon the individual pastor, of course.

From the study it seems evident that women did not receive or reach out for pastoral care in ways that were of assistance to them. They wanted to talk and tell their stories about their babies with a person who would understand what it was like to have a family and someone who they felt comfortable with or were on friendly terms with. Some expressed that they would prefer to talk to another woman.

It might be easy to suggest that a female clergyperson be the appropriate one to approach a woman after a miscarriage. However, if that suggestion were to be followed through, women's spiritual needs simply would continue to be ignored in these situations. Female clergy are around but in very small numbers. Somehow clergy must be educated about the importance of the spiritual crisis and psychological crisis that occur around a miscarriage, so that they will be able to invite the woman's story. It is in the telling of her story that some kind of reality, validity and meaning can be gained from her experience. The confirmation of the significance of the miscarriage should be ritualized so that

the experience can be integrated into the woman's life-pattern.

CONCLUSION

There were many questions that arose out of the research and the gaps in the literature about the topic of miscarriage and perinatal bereavement.

There needs further research about the attitudes towards women and their bodies in theology after the fourteenth century. This should cover both the Protestant and the Roman Catholic traditions.

It would be extremely interesting to do a study about the clergy attitudes towards perinatal bereavement. Both male and female clergy should be included in this study. Part of this study might be an examination of the type of pastoral bereavement work that is actually done by clergy people.

Another study that might prove interesting is an examination of the mature population about pregnancy loss experienced earlier. This might include the types of attitudes and social script that the women experienced and how all of it relates to integration into the life-pattern of the women.

From the material gathered in this study, there are many recommendations to be made in the psycho-social, theological, and pastoral areas so that women who experience a miscarriage can be better helped.

PSYCHO-SOCIAL RECOMMENDATIONS

There needs to be even further education of all caregivers about the dynamics of a miscarriage, for both medical and pastoral people. The various works cited would be helpful, particularly the work of Ronald Knapps and Larry Peppers. Changing the attitudes within our society is going to be a long process but it has begun with the recognition that a stillbirth is a significant loss and a similar recognition can be extended to miscarriage. This increased awareness gives validity to the woman's significant event of miscarriage.

The use of a 'Disposal of a Miscarried Baby' form would give the woman the information about the disposal, give the woman more autonomy over the outcome of the miscarriage, and provide a socially acceptable opportunity for the pastoral people to provide a ritual for those who feel a need for such a closure to the event.

A caring model such as the one suggested by Nel Noddings would be the best for these women in their state of vulnerability. This depth of reaching out and taking in the cared-for one's pain would give recognition of the significance of the event.

THEOLOGICAL RECOMMENDATIONS

Dualism is detrimental to women since they are seen, in the classic sense of dualism, as related primarily to their

bodies. when their bodies fail to perform the 'normal' function of reproduction, an acceptance of dualism creates an atmosphere, both socially and theologically, which can do haarm to the already threatened psychological and spiritual state of the woman who has a miscarriage. There needs to be an awareness within the theological and pastoral training of pastoral people about the effects of this classic theological and philosophical attitude. This knowledge would also assist pastors to begin to understand the roots of their biases towards a miscarriage. A deeper understanding of classic dualism and its effects upon later theology is needed to understand the attitudes that prevail towards human reproduction as well as the failure of that reproduction.

There should an analysis of the classical theological works of Augustine and Aquinas in relation to dualism and the attitudes they have fostered towards women's bodies. The work of Penelope Washbourn, Page DuBois, Prudence Allen, and Rosemary Radford Ruether would add much value to the curriculum of theological and pastoral institutions.

The ideal for the theological aspect of human life is to view the traditional dualism of body/spirit as detrimental and move to a 'lived-body' concept of the experience of human life.

An adoption of this view of life-existence would help to develop an increase in the dignity, worth, and power of

women to reproduce the human species. Although it is a possible, though not a necessarily inevitable event for women, it is just as 'natural' as death. However, our western Christian-based society does not consider death as 'natural' for anyone anymore. Although birthing is very much in the control of medicine in our society, it is still considered 'natural' for women. When these two events are interconnected in a miscarriage, our society and churches are embarrassed and do nothing.

One specific terminology that has grown out of the legacy of Aristotle's generative theory is the term 'blighted ovum'. The use of ovum rather than conceptus places the responsibility for the miscarriage on the woman. I would suggest that this can have a detrimental effect on some women. It places the blame for the miscarriage on the woman at a time when she may already have exaggerated guilt feelings. The use of the term 'blighted conceptus' might prevent additional guilt being assigned to the mother, both by herself and by others.

Even the term 'blighted conceptus' has negative connotations. Changing the 'ovum' to 'conceptus' still leaves the term 'blighted'. Perhaps some neutral term could be devised that would explain what happens when a conceptus does not develop such as 'undeveloped conceptus'. I would recommend that for those persons who use the term 'blighted ovum' a change to 'blighted conceptus' might be the more

comfortable move for them to make. For those persons who have not used a term because they dislike 'blighted ovum', a term like 'undeveloped conceptus' would be preferable when explaining this phenomenon to a woman who has miscarried.

Even when this term is used, it should be used with careful explanation. It was noted in Chapter Three two women who were told that they had had a blighted ovum felt very angry because they thought, at first, that they were not pregnant at all. The only women that did not refer to their miscarried fetus' as 'baby' were women who had been told that they had had a blighted ovum. These women showed little indication of integration of the event into their lives. Perhaps instead of saying that the fetus didn't develop, the person explaining the concept could use the word baby. This might give the woman the validity of the significance of the event. Even if the medical terminology used with the woman is like this, the pastoral person can use these terms to assist the integration of the event into the life of the woman.

RECOMMENDATIONS FROM THE PRIMARY RESEARCH WITH WOMEN

The research with the women confirmed many aspects of the psycho-social nature described about the event of miscarriage and the reactions to it. The additional topics that the women discussed that did not fit into the areas of

usual examination I have called personal perspectives. These topics were the attitude towards the baby, the attitude towards the pregnancy, the significance of talking, the woman's self-knowledge, visual confirmation, the significance of the event, and mementoes.

These topics point towards measures that pastoral people can use to improve their care of these women. It is important to determine the woman's attitude towards the baby and her pregnancy. This helps to determine the extent of the dreams and plans that were made as well as help to separate the events of pregnancy and pregnancy loss. The whole pregnancy is not necessarily a tragedy because there was no baby to nurture. It seems that the women felt that talking about the events was very important to their feelings of well-being and to their readjustment. Thus it is necessary to invite this conversation.

During the conversation about the pregnancy and pregnancy loss, if the woman expresses definite self-knowledge, it needs to be affirmed not denied. It seems that a number of women had visual confirmation of either the pregnancy through ultra-sound or of the miscarried baby itself. The reality that this experience has for women needs also to be affirmed. The central need related to miscarriage is for everyone to confirm the significance of the event for the women. This confirmation re-enforces their own feelings about the pregnancy, the pregnancy loss, and themselves.

In order to assist the integration process for women the three aspects that the research revealed should be kept in mind. Time does not need to be the only factor. Pastoral people can recognize the significance of the event. Time in conversation with the women about the miscarriage is extremely valuable.

PASTORAL RECOMMENDATIONS

There are eight specific things that pastoral people can do to assist women who have miscarried. First of all the pastoral person needs to examine her or his personal bias towards pregnancy loss. This awareness will allow the pastor to move beyond the personal towards assisting the woman in care. Secondly, there needs to be greater education about bereavement, perinatal bereavement, and the implications of classical theological attitudes towards women and their bodies. Thirdly, the pastor should follow the guidelines of someone like Bill Flatt when working with bereaved people.

Having digested the information from the previous steps the pastor can then, fourthly, invite the woman to tell her story. This invitation will acknowledge the significance for her as well as increase the pastor's understanding about miscarriage. Fifthly, with this increased understanding, the pastor can help to change societal attitudes towards perinatal bereavement by using pregnancy loss as an example of bereavement, instead of widowhood, in sermons.

The most important thing that a pastoral person can do in the case of miscarriage is to provide some kind of ritual to the women who wish it. This sixth item involves naming the baby, including the parents in the ritual, using their names and the baby's name, talking about the hopes and dreams for the baby, using female imagery for God if appropriate, and being creative in the symbols used.

The seventh item is the development of specific pastoral strategy for follow-up of the woman. The eighth recommendation would involve the woman in a creative way. The pastoral person can encourage the keeping of the mementoes and possibly the creating of a memory book or box. This would add meaning to the event as well as facilitate closure and integration.

The ultimate goal for the pastoral person is to assist the woman in integrating the event of miscarriage into her life-pattern.

APPENDIX # 1

CONSENT FOR DISPOSAL OF A MISCARRIED BABY.

Date _____

I hereby authorize and request Name of the Medical Facility
 to dispose of the dead fetus born to _____
 on _____, 19___, in accordance with
 customary medical practice. All claims to the body are
 hereby relinquished.

Signed _____

Witness _____

If burial is preferred, please indicate the Funeral Home to
 be retained: _____

Signed _____

Witness _____

Note: When burial is preferred, and if charges are made by
 the retained Funeral Home, these charges will be the
 responsibility of the family.

Office Use Only:

Released To:

Date: _____

APPENDIX # 2

MASTERS THESIS: Bereavement After Miscarriage: Implications for Pastoral Care

Investigator: Catherine MacKendrick, Graduate Student,
Department of Religious Studies,
University of Windsor

Institution: University of Windsor, Department of Religious Studies

This consent form is only part of informed consent and is meant to give you the basic idea of what the research project is about and what your participation will involve. If you would like more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of the research is to explore women's view of the event of a miscarriage in order to determine if some women perceive miscarriage as a significant life-event and how that affects their view of themselves and their world. The findings may determine some proposals for changes in present pastoral care treatment of women who have experienced a miscarriage.

The investigator was first a volunteer, and then a staff member of the Bereavement Resources Program at the Canadian Mental Health Association for eight years. Since then the investigator has been doing bereavement consulting for various groups.

The procedure for research will be an interview through informal, non-directive questions using a tape recorder. Confidentiality of the subject will be maintained by erasing the tapes after they have been transcribed by the investigator. The names of the subjects will not be used.

There may be an inconvenience associated with participation as far as time is concerned. The interview may cause emotional stress either during the interview, or later, since the topic is of such a personal nature. The investigator will be available for any needed follow-up should this be desired by the participant. (966-5729)

Participation will entail a single time commitment of about one and a half to two hours in a location of convenience to the participant. In some cases it may be desirable to have a second meeting.

The participant may find that sharing information about the experience is beneficial. The results of this study may bring about more effective pastoral care of women who have experienced a miscarriage.

The thesis will be directed by Dr. Maureen Muldoon, bioethicist, Department of Religious Studies, University of Windsor. Completion and defense of the thesis is expected sometime in 1990. The results will be available to the participant upon request from the investigator.

You have the right to withdraw from the study at any time and/or to refrain from answering any questions.

Any complaints regarding any procedure used that you feel violates your welfare should be reported to the Office of Research Services (253-4232 X 3916) for referral to the Ethics Committee, University of Windsor.

My signature on this form indicates that I have understood to my satisfaction the information regarding my participation in the research project and that I agree to participate as a subject. In no way does this waive my legal rights nor release the investigator, Catherine MacKendrick, or the University of Windsor, from their legal and professional responsibilities.

Name of the Participant

Signature

Date

APPENIDX # 3

INTERVIEW TOPICS FOR UNSTRUCTURED INTERVIEW

TOPIC: Bereavement After Miscarriage: Implications for
Pastoral Care

How much are you involved in a religious tradition? (at random)

Narrative

Narrative about the experience

Tell what happened.

Sharing of narrative

How often do you share this?

Who do you share with?

What professionals have done this?

How has the clergy responded to you?

Has anyone else ever asked you to tell them your story?

Is it easier to talk to your partner? your mother? your women friends?

Bonding (Attachment to Baby)

How long had you been trying to get pregnant?

How far along in your pregnancy were you?

Did you do a home pregnancy test?

Did you have an ultrasound?

What types of plans had you made for this coming baby?

Self-Image

Previous self-image

Before your pregnancy, how did you feel about yourself?

What does it mean to you to be mother?

How did you feel about being pregnant?

Present self-image

After the miscarriage, how did you feel about yourself?

How do you think others feel about you as a woman now?

What does it mean to be a mother after this experience?

Treatment

Medical

What did the medical people say or do to you?

Pastoral

What did the clergy people say or do to you?

Change

If you could change any of the events surrounding this experience what would you like to see happen?

APPENDIX # 4

BEREAVEMENT AFTER MISCARRIAGE: IMPLICATIONS FOR PASTORAL CARE

INTRODUCTION

Miscarriage is the premature, involuntary termination of a pregnancy before twenty weeks of gestation. The medical term for this is an abortion which then is described by its type such as spontaneous abortion. It is estimated that between 15 and 25% of all pregnancies end in such a way. There are two types of miscarriage. An early miscarriage occurs in the first trimester of a pregnancy between conception and 13 weeks. A late miscarriage occurs in the first part of the second trimester between 14 and 19 weeks. 75% of miscarriages are early ones with 25% late miscarriages.

The purpose of interviewing women who have recently experienced a miscarriage is to obtain primary research material to substantiate a premise that women are given a "voice" which is authenticated for one of the most pivotal experiences of life. The theological outlook of the society in which they are raised and the religious group that they may belong to is one of the determining factors in the self-image of women. In Canada this has been the Judeo-Christian tradition. The view of woman and her body has been very negative in the past. With the present feminist theorists and the contemporary theological view of the God 'inside', the view is that there is a discrepancy between the theoretical and the pastoral implications of miscarriage and the actual experience of women. It is on the basis of possible needs which are not being met, that implications for change in pastoral care will be explored. The research with live human subjects will determine much of where the focus of the thesis will be.

The investigator has worked in the field of bereavement, specializing in perinatal bereavement, for nine years and is presently working towards a Master of Art. degree in Religious Studies.

RESEARCH METHOD

The research will be qualitative in nature using an unstructured interview style. Each interview will be between one and a half hours and two hours in length. Each interview will be recorded on a tape recorder and transcribed by the investigator. The tapes then will be erased in order to maintain anonymity.

The sample population will come from a group of women who have had a recent miscarriage. Ideally the sample will be composed of 50% early miscarriages and 50% late miscarriages. Studies have proven that the bonding level is different for these two groups since quickening, fetal movement, begins during the latter group. To get this precise breakdown may not be possible. The sample size will be 20.

The possible subjects will be asked if they are interested in participating by a local obstetrician. He will inform them that whether they participate or not will in no way affect their course of treatment with him. When the subject has agreed to participate, the investigator will contact them by telephone to set up a time for the interview. The interviewing will be carried out at a place comfortable to the subject, which will probably be their home. No monetary compensation will be given for participation in this study.

Customarily in unstructured interviews there are topics which will be covered but definitive questions are not possible in this style of qualitative research. A copy of the topics, with sample questions has been included with this material.

Risks and Benefits

The risk to the subject will be a possible emotional one. It is possible that they have never talked about this topic with anyone other than their doctor. If that is the case then there could be some emotional distress either during and/or after the interview. The risk to the investigator will be that of over-involvement.

The benefit to the subject will be that they will be given some validation of the experience simply by having it recognized as significant enough to research. The interview may also be therapeutic, not therapy, to them emotionally. The investigator will have a reading list available for the subjects should they wish to find more information for themselves and will encourage any further counselling through the doctor. The benefit to the doctor will be that the patient will be provided with listening time that he is not able to provide.

The tape recorded interviews will be transcribed by the investigator and then erased. No names will be used in the documentation of this research. This information has been included in the consent form.

The subjects will be informed of the research by the doctor.

At the time of the telephone call to set up the appointment for the interview, the subjects will be told of the nature of the research as well. Before each interview begins the consent form will be read, explained if necessary and signed. The information about the interviewer's background will be shared with the possible subjects. A copy of this consent form is included with this material.

The subjects will be competent to consent.

APPENDIX # 5

NEEDED - VOLUNTEERS

for

Research Project on MISCARRIAGE

Cathy MacKendrick, a graduate student in Religious Studies, at the University of Windsor, is investigating the care of women who have experienced a miscarriage in the last three years.

What did this experience mean to you? What type of care did you receive? What changes would you like to see occur for other women?

If you would be willing to assist in this project, please give your name and phone number to Allison, in this office, and Cathy will contact you with more information about the project.

APPENDIX # 6

A copy of a pamphlet developed by C.L. MacKendrick for the Bereavement Program, Canadian Mental Health Association, Windsor-Essex County Branch, Windsor, Ontario.

Miscarriage

What is it?

Miscarriage is the unplanned ending of a pregnancy before the 20th week of the pregnancy.

15 to 20% of all pregnancies end with a miscarriage.

EARLY miscarriage (75%) happens in the first trimester (12 weeks). There are many reasons for this. Most common are improper attachment to the uterine wall, or an imperfect fetus either for genetic reasons or more usually, by a chance mutation of cells at the time of conception.

LATE miscarriage (25%) happens during the 13th to 20th week of the pregnancy. Usually the fetus is normal but other problems cause the miscarriage. Some of these problems are: improper attachment of the placenta, uterine difficulties, or an incompetent cervix.

Why did it happen?

Several reasons have been mentioned already. Sometimes a mild virus, more serious disease, or infection can cause a miscarriage. Malnutrition of the mother and many environmental factors can add to the risk of miscarriage.

Many times there is no definite reason for a miscarriage.



Canadian Mental Health Association
Windsor-Essex County Branch
880 Ouellette Avenue, WINDSOR, Ontario
N9A 1C7

APPENDIX # 7

SUGGESTIONS FOR PASTORS CARING FOR WOMEN WHO HAVE
MISCARRIED

It is important to give parents choices when a pregnancy ends with the death of the expected baby. Not all of the suggestions below will be used by the woman but should be given to her anyway.

Call or visit as soon as you hear of the loss

Express your sympathy - perhaps even send a sympathy card

Invite the story of the loss. Encourage the mother to talk about the event. Ask about the hopes and the dreams - it helps to separate the pregnancy from the miscarriage. Ask if they had chosen a name for this baby. Suggest that they might name the baby. You might suggest a neutral name or the name of a flower.

Discuss the options available for a ritual, including the option of a burial. She may need to hear the reasons why this would be helpful since the social script that they may think that they have to follow may be to ignore this as a significant event. After you have discussed the options, give the mother some time to think about it. Call back later for the decisions that she and her family have made.

When members of the congregation hear about the event, they may need some concrete suggestions about things that they can do to help the family. Some suggestions - send a sympathy card, make a personal visit, prepare a meal, offer to sit any other children, be willing to listen, remember to keep contact with the mother over the next few months.

During the ritual include the parents, use names, express hopes and dreams and give hope.

Be sure to do follow-up care. Call and visit during the months ahead, particularly at anniversary times, such as the due date or the beginning of another pregnancy.

Encourage the mother to read about miscarriage and to talk about her loss with other women who have had a miscarriage.

Be there for the mother and her family, love them, allow them to grieve, and pray for their healing.

The idea for this was suggested by the "Sample Clergy Checklist" of The Pregnancy and Infant Loss Center of MN, 1415 E. Wayzata Blvd., #22, Wayzata, MN 55391.

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