# How might parish ministers

## (and other pastoral care givers)

# better support women who have experienced an early miscarriage?

Shaw James Paterson

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School of Critical Studies

College of Arts

University of Glasgow

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## Abstract

One quarter of pregnancies end in miscarriage, and eighty percent of these occur early during pregnancy. Yet, there is a lack of research in this area and particularly into the pastoral care offered or desired. This research project has, at its heart, the practical theological intention to identify how ministers (and other pastoral care givers) might offer better and more appropriate care and support to women after miscarriage.

Adopting an action research and feminist methodological approach, semi-structured interviews with twelve women were conducted. The women reported their experiences of early miscarriage and the absence of support received. Their narratives were presented in I-Poem form and, from their recommendations for future pastoral practice, four main themes emerged: that ministers should make contact, acknowledge the loss, listen, and respond appropriately. These findings were shared, by way of an educational intervention, with three groups of ministers to encourage reflection on their practice. These ministers' responses were also analysed and reflected upon in order to develop concrete recommendations for further pastoral, theological and ecclesial engagement with the challenges surrounding pregnancy loss.

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## Dedication

This thesis is dedicated to the fifteen women who volunteered to participate in this research study (three in the pilot and twelve in the main study). Without their contribution it would not have been possible to carry out this research. More importantly, their stories deserve to be heard by a wider audience. My hope and prayer is that by sharing their experiences it is the first step in improving practice among all those who offer pastoral care.

In addition, I would also like to offer this thesis as an apology to the countless number of individuals who have experienced miscarriage over the years, and whom I have been ill-equipped to support during my ministry.

## Acknowledgements

I have learned so much from numerous supervisors over this research journey. However, I owe a particular debt of gratitude to Professor Stephen Pattison and Professor Heather Walton for their patience as they guided me through so many stages of the process over the years. Their help has been invaluable and their encouragement immense. When life and work threatened to overwhelm, they were able to enthuse me to keep going and remind me that this research is valuable. Over the past two years, in particular, Heather has gone beyond the second mile in her guidance and pastoral care; for that I am extremely grateful! Thank you.

I would also like to acknowledge gratitude to my late parents. My Dad for discouraging me from following in his footsteps as a bricklayer, and instead to become the first in the family to attend university… and his constant encouragement to do a doctorate. My Mum, who in several different ways enabled me to embark on this journey and, who did not live to see the doctorate completed.

Finally, my research journey has not been completed alone. My wife Christine and our three children Euan, Ross and Kirstie (who have all completed undergraduate degrees during my studies) have travelled the road with me. Your support means so much!

## Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

*Signature:*

*Printed Name:* Shaw James Paterson

## Reflexive Prologue

As is now common and regarded as good practice within practical theological research (Bennett, Graham, Pattison and Walton 2018, 43), this thesis begins with a prologue which introduces the reader to the personal significance of this research topic, its place in my professional life and the hopes that drove my research. I present this as an honest and reflective account of my journey thus far. It gives context to my motivation for hearing the stories of others and learning from them in order to enable me to offer more appropriate pastoral support. Early miscarriage is not a rare occurrence, as I will evidence later, and yet, as a minister, I was not equipped to offer pastoral support to those affected. This thesis originates from my desire to improve my support to those who have experienced early miscarriage, and to share this knowledge as a means to encourage my colleagues in ministry to reflect on their own practice.

### Personal Significance

In order to give contextual background concerning my motivation for conducting research in this area, I first have to acknowledge that the many issues surrounding the topic of miscarriage are ones that have affected me personally for most of my life. My parents lived with huge financial constraints and, on becoming aware that an unplanned third child (me) was expected, they were very worried. In a sense I was a child that was not wanted, though my mother loved and cared for me just as much as her other children from the moment I was born. My mother would never have countenanced a medical abortion. However, she readily admitted that she took steps to induce a ‘miscarriage’. That was how she described it though, in reality, she clearly was attempting to induce a ‘spontaneous’ termination of her pregnancy. To complicate the picture, I was constantly reminded by an aunt that I ‘hadn’t been wanted’ and that my mother ‘tried to get rid’ of me. Unfortunately, I was too young, uncertain and confused to counter these abusive assaults by saying what I honestly knew to be true; that I was loved.

Matters came to a head when, as a young adult, I referred to myself as a ‘failed abortion’. The following day my mother explained to me in detail the ‘what,

how and why' of her experience. It is clear to me that my mother regretted not only her actions but even countenancing such actions. Knowing this, I have therefore always been concerned to contemplate how my mother would have felt had her actions been successful.

Moving forward several years, as a newly married man in my first year of training for the ministry, my mother-in-law confided to me that she had had a stillborn child, the third of her four pregnancies. Whatever her reasons for sharing this, it must have been a very significant moment when she talked through what she had experienced for, what she told me was, the *first and only time*. What she revealed to me was unknown to her three daughters as was the further revelation that her own twin had died in utero. Neither incident has been raised between us since. However, it gave me some understanding of why she appeared concerned when it was quite a number of years before our first child was born.

I have for more than thirty years lived with the dichotomy of a mother who, initially, did not want a third child and a mother-in-law who wanted a baby but did not have a successful outcome to her pregnancy. Neither would speak of their experiences apart from on very rare occasions (such as those described above). When confided in I felt deeply moved but totally inadequate and ill-equipped to respond.

As a postscript to this section, my research journey has involved a necessary and unexpected break. Following the sudden death of my mother I returned to pastoral duties very quickly (perhaps too quickly) but could not motivate myself to progress with my studies. It was only on resuming these that I began to fully own and realise the importance of being reflexive as a researcher. I now understand the painful ambivalence of my own story and how it cannot be separated from my research.

**My Professional Life**

In my quest to be an effective parish minister, I have also had to develop as a reflective practitioner. My pastoral experience has been a rich source of learning, but it has been necessary to engage in processes of critical reflection.[1,2] These have enabled me to challenge my attitudes and practice. Having been ordained for over twenty eight years I consider myself to be an experienced minister. However, this process has led me to acknowledge that there are certain areas of ministry for which I have not been prepared or equipped.

One particular sphere of ministry in which I repeatedly felt inadequate and unprepared was, 'How should I respond when informed that someone has had a miscarriage?' As stated, I have personal experiences that make this an area of both interest and concern to me. However, there are many professional issues to confront as well. Would it be best to visit immediately or give the grieving parents some time and space to recover? On visiting, what words of comfort might be shared? Should I offer to pray, or suggest some kind of memorial service? In most cases, there are no physical remains to be laid in a coffin and thus no need for a funeral service as a prelude to a burial or cremation. There are no official liturgical 'Orders of Service' to look to as a model for guidance. Reflecting on such questions, and seeking their answers, has been a strong personal motivation for carrying out this research.

**My Postgraduate Learning**

I have always found child bereavement to be the most difficult and demanding of situations and this led me to undertake Master's level research focusing on religious and spiritual care needs following a neonatal death. Through this process, I discovered that while a great deal has been written about the death of a new-born baby, relatively little research and/or reflection has been carried out around the effect of having a stillbirth or miscarriage. Zoe Mullan and

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[1] I have adapted Johns' Model of Reflection as a tool for reflecting on my practice as it provides guidance and structure (Johns 1995, 226-234). See Appendix 1

[2] "[G]ood practice in research ethics begins with a commitment to self-critical reflection and with a determination to pursue each research programme with integrity and honesty" (Hogan 2013, 4-5 as quoted in Bennett, Graham, Pattison and Walton 2018, 161).

Richard Horton argue that for parents, a stillbirth can be no less a tragedy than the death of a new-born baby (2011, 1292). I would argue that the same may be true for many people experiencing miscarriage. The various impacts of losing a child early within a pregnancy are very poorly researched beyond the medical context of seeking clinical understandings of the event. Not only are parents ill-prepared for what has happened, those to whom they would normally turn to for support also struggle to know what possible resources they can offer.

Having undergraduate and postgraduate science degrees I am deeply interested in scientific explorations of what happens and how things happen. However, my motivation behind this research was to look far beyond the science of miscarriage and focus on the people who experience it. The Doctor of Practical Theology Programme at the University of Glasgow provided me an opportunity to undertake research into early miscarriage that I might critically and academically reflect on my practice. I came to this project with a deep commitment to improve my understanding of what people experience, and how I might both better support them and also communicate my new understandings to others.

At the beginning of this research process, I was approached by a parishioner and asked (quite unexpectedly) about my research topic. The person shared the experience of an early miscarriage. The local doctor advised the parent to flush, what was described as the ‘products of conception’, and what they believed was their baby, down the toilet. A quarter of a century on and that event still haunts them. It was as if their baby had never existed. The term ‘products of conception’ may have been a valid medical term to use but was certainly not appropriate to the experience of the mother and father. I did not know how to respond to this disclosure which further strengthened my resolve to become better equipped as a pastoral practitioner through undertaking this research journey.

**I Am A Male Researcher**

It is now time to acknowledge the 'elephant in the room'. This research project entails a man researching into what is often viewed as an intensely sensitive and private aspect of a woman's world. I simply do not have and cannot share the bodily experiences of my research participants. Nor am I able to fully comprehend their emotional and spiritual significance.

In acknowledging this, I confess to having begun my research journey with no more than a passing acquaintance with feminist thought. Feminist theology was not taught when I studied Divinity at university. Nor did I have any understanding of how feminist thinking critiqued and challenged traditional research processes. I am glad that my research has introduced me to new and personally challenging areas, which have proved important in my developing reflective practice. The demographic composition of my congregations is such that the majority of my pastoral encounters are with women. I believe that, with continual reflection on the challenges of feminist thinking, I am now a better equipped minister as I seek to offer them appropriate pastoral care.

In Chapter 2, I discuss feminist research in greater detail. Here, in this prologue, whilst not seeking to minimise the problematic nature of male researchers interrogating women's experience, it is important to emphasise that many women do seek pastoral care from male ministers in relation to issues surrounding pregnancy loss. In my own experience as a parish minister, it has almost always been a woman who has raised their experience of miscarriage with me rather than vice versa. Indeed, when my own congregation became aware that I was to undertake this study, I was inundated by offers from women to contribute to this research project. In conducting a study motivated by the need to provide more adequate pastoral responses to early miscarriage, it has been vital to engage with the reported experience of women, despite the many ethical and political issues this process raises.

My research findings will be of pastoral significance to carers of both genders and the male and female partners they seek to support. Furthermore, as this is such a neglected area of care an intervention is justified by need. As stated,

when searching the literature there was very little evidence of research into how better to support people who have experienced an early miscarriage *by either men or women*. I particularly noted the lack of work on how support might be offered within faith communities. Therefore, despite the clear ambivalence of my own position, I am motivated by my concern to make a positive pastoral intervention in this field. Investigation into the pastoral needs of women who have experienced early miscarriage is essential and it is long overdue.

**Summary**

Writing this reflexive prologue has been extremely difficult. Including it in this thesis even more so! I confess that my academic history has played a significant role in my hesitance to include personal experience (as opposed to biographical information) within this thesis. I was tempted like so many others, as Elaine Graham describes it, who follow convention and "leave themselves off the page" (2017, 9). However, I recognise the great importance of reflexivity within my research journey. Not only does this ground and enrich my research it has also compelled me to confront some emotionally difficult and very sensitive matters.

# Introduction

This introduction presents the research question which lies at the heart of this project. I will also indicate my rationale for conducting this research, highlight how the thesis is structured and locate its place within practical theology.

**Research Question, Purpose and Intended Outcome**

Early miscarriage is the most common adverse outcome of a pregnancy.[3] Yet, little research and/or reflection has been conducted around the support needs of those who have experienced an early miscarriage and, therefore, it is an underdeveloped field in the area of pastoral care and practical theology. This research study explores the experiences of women who have suffered early pregnancy loss and their self-reported support needs. It does so to ascertain how ministers (and others who offer pastoral care) might be able to offer appropriate pastoral care to those who have suffered miscarriage early in pregnancy.

To fulfil its aims, this project uses a variety of qualitative research methods and is located within the methodological frames of 'action research' and 'feminist research'.[4] The purpose of this study is:

1) To interview women who have experienced early miscarriage of a much-wanted baby to ascertain what support they received and what support they think might have been helpful.
2) To present the findings in a form accessible to pastoral support workers, ministers and other concerned people.
3) To design and critically reflect upon training sessions for those called upon to offer support following early miscarriage.

By carrying out this study it is hoped that:

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[3] Early miscarriage will be defined within the literature Review Chapter as there is no internationally accepted definition. For this study, women who have miscarried before reaching twenty weeks gestation will be deemed as having an early miscarriage.

[4] See Chapter 2.

1. The gap in published literature concerning pastoral support after early miscarriage will begin to be addressed.
2. Awareness will be raised within the Church (and beyond) concerning the effects of miscarriage.
3. Those who are called upon to offer pastoral support might be better equipped to do so.

**Rationale**

Modern cultural expectations are that children will outlive their parents. Therefore, when a child dies it is a shattering and (in most cases) an unexpected event. Furthermore, it is the common perception that conception will lead to a successful pregnancy resulting in a healthy child. Therefore, when all does not go to plan parents are left trying to come to terms with something they may not have seriously considered. Ian Ainsworth-Smith and Peter Speck comment that: "The experience of losing a child early on in its life has been described by one parent as 'death before life' and it is against all the normal established order" (1988, 44). The experience of those who lose a child through miscarriage, where a new life in the womb never had the chance to be born, can very much be equated with death before life.

Within the Church, there is no clearly accepted understanding of when life begins and this controversial topic is not the subject of my research.[5] The purpose of this study was to look at the support needs of individuals who, having conceived a child, saw themselves as parents (even if others did not) and whose expectations of welcoming this new life had come to a premature (and involuntary) end. Mark Cobb, writing about spiritual care at the end of life, describes death as, "a sign of failure in a predominantly curative system" (2001, 48). He states that death imposes a loss through absence, punctuates familiar continuity with irreversible change, incites severe emotions and presents an unwanted demand to say farewell. Cobb accurately names these major traumas from his experience in palliative care perspective where patients have lived

[5] This will be discussed further within the literature search chapter.

their lives, even if death is unexpected and premature. With miscarriage those involved, as has already been mentioned, are facing death before life.

Every year in the United States nearly one million women experience pregnancy loss (Ventura, Abma, Mosher, & Henshaw 2009, 1). This statistic is replicated in the United Kingdom where (according to the Miscarriage Association) there are around a quarter of a million miscarriages annually.[6] In fact, one in four pregnancies end in such a loss and, of these, 80% are early miscarriages. This fact alone should be motivation for those involved in pastoral care to address the need for support following an event experienced by such a large section of society.

Other research has shown that 39% of women who experienced early pregnancy loss met the criteria for probable moderate-to-severe Post-Traumatic Stress Disorder (Farren et al 2016, 6).[7] [8] Furthermore, this same research suggests that, "exposure to EPL [early pregnancy loss] on a daily basis may lead clinicians to normalise the experience and overlook the possible profound psychological sequelae" (2016, 8). This finding confirms my own anecdotal experience that proper support is essential as is the need for better education and training. This study seeks to identify what support would be valued by those who have experienced an early pregnancy loss, and how those involved in pastoral care can be better equipped.

Clearly, it would be more than foolhardy to try to imagine what support is needed and required by grieving parents without listening to them, trying to understand them, and researching what would fulfil their needs. Otherwise the support that is offered could become an act of malevolence when benevolence was our intended outcome. In conducting this research, I have sought to listen to

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[6] https://www.miscarriageassociation.org.uk/media-queries/background-information/ accessed May 2019.

[7] A survey of 164 women who miscarried before 20 weeks and who attended a London teaching hospital early pregnancy unit who were asked to complete a self-report questionnaire. Farren et al (2016) found that 39% of participants 3 months after suffering an early pregnancy loss met the criteria for probable moderate-to-severe PTSD. Furthermore, 20% met the criteria for moderate-to-severe anxiety compared with 10% in their control population.

[8] Post-Traumatic Stress Disorder = PTSD.

the lived experiences of those who have gone through early pregnancy loss in order to identify areas of religious and/or spiritual support that could be offered. The first stages of my study focussed on asking individuals about their experiences of early miscarriage, with the aim of hearing their testimonies in order to gain some understanding of their experience as they feel it and live it (Sherman and Webb 1988, 7, as quoted in Ely 1991, 5). I sought to listen, engage with and reflect upon the experiences of women who have experienced early miscarriage, to investigate the support that was there for them, and to hear their perspectives concerning the support they would have valued at the time and since.

This would have been a valuable learning experience on its own. However, the title of this thesis: "How might parish ministers (and other pastoral care givers) better support women who have experienced an early miscarriage?" indicates that I need not only learn how to be a more effective parish minister but develop awareness raising and educational resources, which might better equip all those involved in pastoral care. I acknowledge that my research was focused on ordained ministers. However, I believe that it is applicable to all those involved in pastoral care and, indeed, to the whole people of God.

My own experience as a parish minister is that it was almost always the mother who spoke to me about her miscarriage. Why were so many women willing to speak with me – either from the perspective of a researcher or as a pastor? This, to me, was anecdotal evidence which was backed up by the lack of literature on the topic, indicating that there was a significant lack of support and understanding of those who had experienced early miscarriage. Linda Layne, who experienced five unexplained miscarriages in five years and who, from a feminist standpoint, calls for a reappraisal of the woman's health movement issues this challenge: "It is time to face up to the reality of pregnancy loss" (2003, 1889). This is reinforced by the findings of Rosalind Crawley, Samantha Lomax and Susan Ayres who claim that their research shows that time between stillbirth and perceived professional support is associated with better mental health outcomes. Crawley, Lomax and Ayres also claim that their research, "for the first time shows the importance of opportunities to share memories of the

baby" (2013, 2). It is important to share memories and talk about their baby and, where appropriate, support to allow this must be encouraged. I would argue that this is no less true with regards to early miscarriage and this research seeks to identify what support ministers, priests, pastoral care-givers could (and should) offer.[9]

**Relationship to Practical Theology**

This section aims to present how this research is situated within the discipline of practical theology as a serious attempt to develop faithful action in the light of critical reflection upon practice.

Elaine Graham, Heather Walton and Frances Ward in writing about theological reflection note that:

> Over the past twenty years the history and identity of pastoral and practical theology have been the subject of intense revision. Broadly, this period has seen an epistemological shift from a discipline that regarded itself as supplying practical training for the ordained ministry… to one that understood theology as a critical reflection on faithful practice… (2005, 2)

This revision of practical theology has paralleled my own understanding as I have reflected on my practice as an ordained minister.

Practical theology has also been described as: "an open-ended, contingent, unfinished grasp or analysis of faith in action. It focuses on the tangible, the local, the concrete, and the embodied" (Miller-McLemore 2014, 14).[10] This

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[9] A UK based study of 162 mothers of stillborn babies who completed online questionnaires of how memories were made and shared, satisfaction with memory making and sharing, professional and social support, and symptoms of depression, anxiety and PTSD.

[10] Bonnie J Miller-McLemore argues for the need to take great care in distinguishing between pastoral theology and practical theology. She writes: "Whereas practical theology is integrative, concerned with broader issues of ministry, discipleship, and formation, pastoral theology is person – and pathos – centred and focussed on the activity of care." She situates pastoral theology as a subdiscipline within practical theology, and warns that the blurring between the two also pushes to the periphery the other subdisciplines of practical theology, such as religious education and preaching (2014, 6).

focus upon faith in action is an invitation to consider a different approach to knowledge. Gillian Bolton summarised the core values of practical theology when she stated: "Much of our knowing is in our doing" (2005, 23). By doing, we will be learning, but only if our doing is accompanied by theological reflection. Affirming this insight, Stephen Pattison states in the introduction to his book *The Challenge of Practical Theology* that: "Many of the essays are likely to be of particular interest to those who work within Christianity with concerns about the relationship of theology to practice" (2007, 91). Pattison understands Practical Theology to be more than a meeting of belief, tradition and practice with contemporary experiences, questions and actions. He says that the meeting must lead people to dialogue which is enriching, intelligently critical, and practically transforming in order to make transformative change happen.

Practical theology is thus deeply committed to the notion of understanding leading to and from action, or praxis and aspires to be transformative in both theory and practice (Pattison 2000, 11). Practice is both the origin and the end of theological reflection (Graham, Walton and Ward 2005, 170). Denise Ackermann and Riet Bons-Storm affirm this in their definition of practical theology as, "the theological discipline which is essentially involved with living, communicating and practising the life of faith" (1998, 1). Peter Buttitta put it well when he wrote:

> God is faithfully present to the circumstances of our lives. Amid the diverse collection of thoughts, urges, beliefs, emotions and memories which make up our interior life, God acts to deepen our awareness and inform our decisions in the direction of the good, the just, the holy. (1995, 112)

As pastoral carers our job is to 'do' and 'reflect' and 'learn'; then put it all into practice so that we are doing, reflecting and learning; this should be a never-ending cycle.[11]

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[11] Praxis based theological reflection was schematized into the 'pastoral cycle' of action and reflection. Its origins come from the Roman Catholic usage of 'pastoral' to mean that which pertains to the life of the Church, its ministry, sacraments and social witness (Graham, Walton and Ward 2005, 171).

Buttita's words remind us that reflection informs practice and is one of the ways we experience God's activity and presence shaping our lives. Our practices contain values, beliefs, theologies which are part of our inner being and are only brought to our attention when we reflect on them (Swinton and Mowat 2006, 20). Indeed, many of our practices may well be learned activities passed down from teacher to pupil, who in turn becomes a teacher. Yet, our practices should not be solely the result of handed-down traditions. What we do and how we do it needs to be examined and critically evaluated on a continual basis. Though this should not be done merely to justify practical theology as a valid discipline, but to ensure we act in a manner that aligns itself to the practice of Jesus and reflects, "a God who is involved" (Forrester 2000, 8).

From a practical theology point of view then, our reflection must be done in the light of the scriptures, together with the traditions of faith, to ensure that what we 'do' under the banner of belief is relevant and appropriate. Reflection must be a means to an end (rather than an end in itself) and, in my own case, it should be an aid to developing meaningful professional practice (Perry 2000, 137). Indeed, for any reflection to make a real difference to practice, it is important that the outcome includes a commitment to take action (Atkins and Murphy 1995, 33).

I am a full-time parish minister who is called upon to offer support to my parishioners. I have already spoken about my lack of practical training and preparation for important aspects of my future ministry. As I became involved with those I sought to minister to, the words of the author Lyman Abbott, struck a chord: "Christianity is not a philosophy that Jesus came to teach. Christianity is a life that Jesus came to impart" (as quoted in Angell 1963, 15). Jesus spoke mostly in parables and used the language and the symbols of the common listener to offer care and comfort to those with whom he came into contact. The only way ministers can offer appropriate support is by continuously listening to what is being said and entering into the experience with those being ministered to. As has already been elucidated, my motivation for undertaking this research has been to learn, review my practice and become a better minister.

In other words, I must gain the confidence to follow Jesus in his ministry and fully engage with the people I encounter day by day. As a parish minister, I must come down from the pulpit to the pew, from preaching to practising. Don Browning says that in order to be a pastoral theologian, one must, "think hard about … issues theoretically and to develop action strategies for addressing them" (1983, 47). This is what my research is fundamentally concerned with; inter-relating with people's lived experiences, reflecting on them and using such thinking to shape any theories for appropriate strategies to bring God's transforming love into all the situations of human life; including those which are currently not sufficiently understood or acknowledged within our current practice, and certainly ones in which deep suffering and pain are experienced.

When Jesus visited Mary and Martha following the death of Lazarus he felt the grief of those around him: "When Jesus saw her weeping, and the Jews who came with her also weeping, he was greatly disturbed in spirit and deeply moved" (John 11: 33).[12] Not only did Jesus feel the effect of the loss on others, he felt it within himself because, "Jesus began to weep" (John 11: 35, NRSV). In other words, Jesus became involved. I seek to share his healing compassion which will also entail recognising grief, sorrow and loss – and sharing in them.

This is a rather different understanding of healing than those models that are dominant in our culture. In modern times healing has become very much the domain of the medical profession.[13] Browning describes our situation well when he says:

> In modern societies the spiritual, psychological and physical dimensions of life have become broken apart. Our church,

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[12] Taken from the New Revised Standard Version which is used throughout the Thesis.

[13] Modern medicine has begun to recognise that physical healing is only part of health (The World Health Organisation, [WHO] 1990). Much has been learned from the discipline of palliative care which has taken many years to earn its place among mainstream medicine. The WHO website includes within its definition of palliative care that it:

- affirms life and regards dying as a normal process;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help the family cope during the patient's illness and in their own bereavement

> synagogues, our psychological professions, and our medical professions and hospitals are all relatively autonomous or institutions (1983, 12).

Practical theology, then, is a critical discipline which seeks to end these divisions and offer new insights through this process to other caring disciplines as we seek holistic healing together, both physical and spiritual.

In summarising this section, I am reminded of the woman with the haemorrhage pushing through the crowd to touch the hem of Jesus' cloak (Mark 5: 24b-29). The focus we place on the story tends to be on her physical healing, rather than on what she had experienced in hiding her pain and her ostracism from her community. I cannot help but think that this is analogous to the situation of some parents who have lost a child during pregnancy. I keep this image in mind as I situate this work within a practical theological framework of critical thinking, reflection and commitment to action.

**Structure**

In line with the understanding of practical theology outlined above my thesis is structured as a movement from faithful reflection to action. Within the Literature Review in Chapter 1, I review research which shows that early miscarriage is not a rare or unusual occurrence. Thereafter, I explore research on pregnancy loss – and note that in terms of early pregnancy loss, very little has been published. This being the case, I have drawn on published material which focusses on stillbirth and neonatal death. Whilst clearly not ideal, some useful insights are contained within this body of literature.

The second chapter presents an introduction to the methodological approach I have chosen and an assessment of its suitability for my research question. It also details the methods used in carrying out the research. I argue for the appropriateness of semi-structured interviews and justify my sample size of twelve for the main study. Within this chapter, I include a section entitled 'Telling the Story' which describes the interviews as the means for my interviewees to tell their story. As a prelude to the main study, I carried out a pilot exercise which involved interviewing three women who had experienced

early miscarriage. Despite noting the small sample size, the pilot gave me an opportunity to rehearse my methods while at the same time highlighting the need for research into this under-investigated area of pastoral care. The main study consisted of further semi-structured interviews with a further twelve women. The transcripts I made from these interviews were then used to create 'I-Poems'. These are presented in Chapter 3 under the title 'Hearing the Story' as they are a powerful means to enable others to hear the recalled experiences of the women in the main study.

Whilst acknowledging that the creation of the I-Poems is, in itself, a form of analysis, Chapter 4 offers a broader analysis of the data generated in the interviews. This analysis utilised the I-Poems and other methods of data coding of the interviews to generate themes which were grouped together to identify the support that the participants would have valued, and which serve as a recommendation for future pastoral care practice. This chapter also details accounts of sessions held in three ministers' fraternals, at which the I-Poems and the recommendations of the interviewees were presented as part of an educational intervention to enable the women's stories to be shared. Having heard and shared these stories, the fraternals functioned as focus groups whose participants were invited to consider if they would review their practice in the light of what they had heard. As a further means of enabling the women's stories to be heard, the educational intervention was trialled with groups within my own Presbytery as a means of disseminating my findings.

Chapter 5 consists of a reflective response to my research journey. Presented in three sections, it explores texts of lament in scripture as a resource for support, offers an outline of my theological understanding of early miscarriage, and reflects on how my research has brought about a change in my own ministerial practice.

The final chapter is headed: The Story Continues … This chapter notes that the story for those who have experienced early miscarriage does not end, and therefore our search to improve how we support must continue. In suggesting that further research is required, I note the limitations of this study before

offering five recommendations for my own denomination as a means for bringing about institutional change.[14] I also identify the need for a societal change in how miscarriage is spoken about, both in medical contexts and elsewhere. This is followed by a summary of what this thesis has achieved and a conclusion.

A flow chart detailing the research journey and how it is presented in this thesis is provided below for ease of reference (See Figure 1).

[14] My recommendations are rooted in my own context as a parish minister in the Church of Scotland. However, I offer these ecumenically to aid other denominations address how they might support those who have experienced early miscarriage.

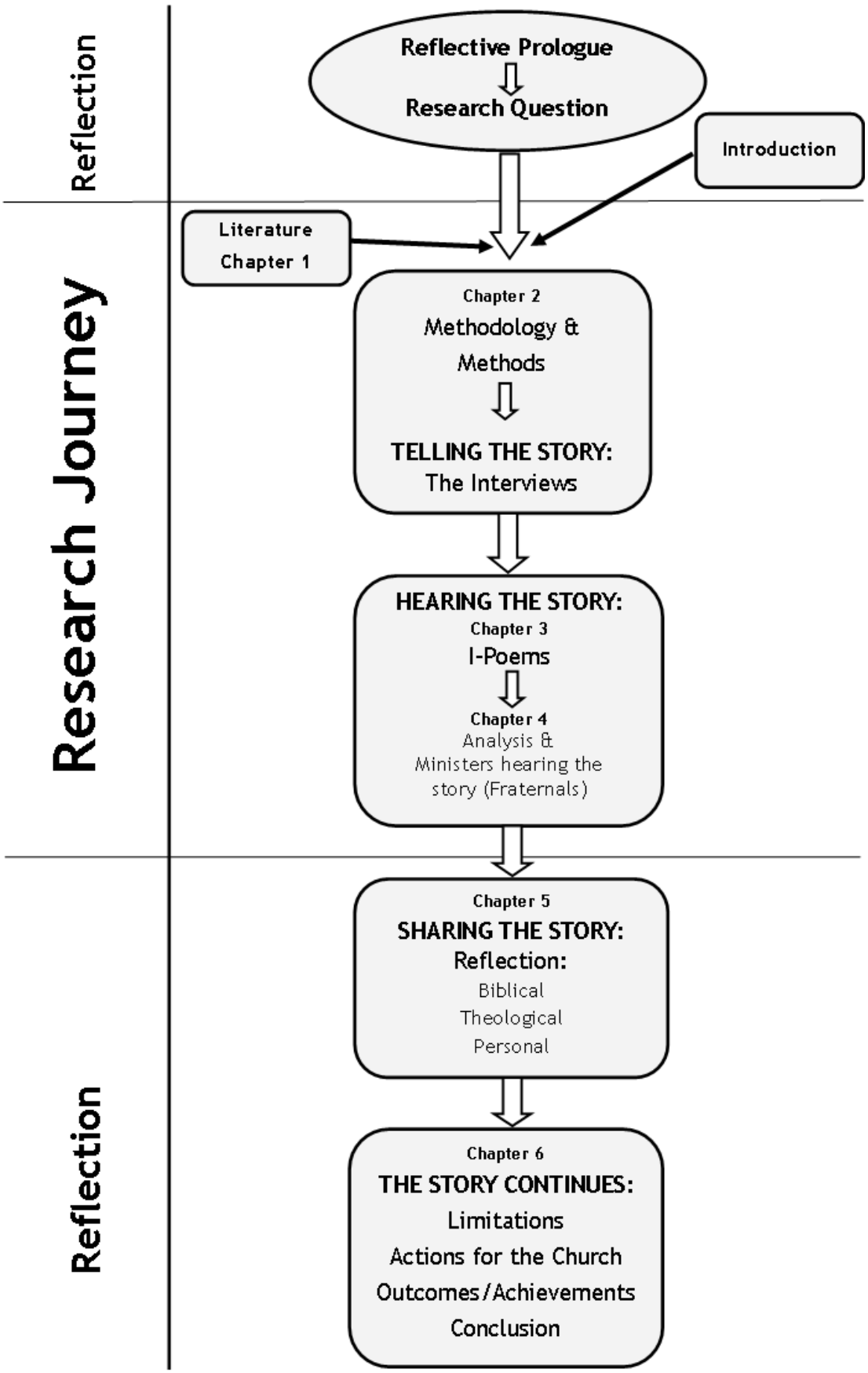


*Figure 1 – Research Flow Chart*

As will be discussed within the literature review, most of the research into early miscarriage has been conducted within the medical realm. What we need to do now is to move beyond a medical experience and create a space where women [and men] can feel surrounded by love, and where it is safe and acceptable to grieve for all that is lost and all that could have been (Morrissey 2007, 1415). This research project seeks to do just that – or at least to take the first step.

This introduction has highlighted my research question, the rationale for conducting this research project and its place within practical theology as a faithful response to reflection on practice. The structure of the thesis has also been outlined.

# Chapter 1 - Literature Review

In seeking to frame my research question, this chapter represents a review of published literature in order to: a) understand the category of early miscarriage better; b) examine what support is provided following miscarriage; c) ask what support might helpfully be offered; d) discuss issues in offering spiritual support, including who should offer support and in what way.

Reviewing the literature relating to my research topic was a challenge in itself because there has been surprisingly little research undertaken into support following early miscarriage. As noted in the Introduction, in the absence of relevant published material, I have drawn on research into late miscarriage, neonatal death and stillbirth hoping that they might offer insight into the support that could and (perhaps) should be offered. These studies serve as a starting point in a cognate area to my own research thesis and, whilst not immediately transferable, do explore issues relevant to my own concerns.

Miscarriage is often a traumatic event which is rarely spoken about. The perception of most is that conception will lead to a successful pregnancy resulting in a healthy child. Yet, as detailed, one in four pregnancies end in miscarriage. It is estimated that up to eighty percent of these occur before 20 weeks gestation (Stratton and Lloyd 2008, 5), and so miscarriage early in pregnancy cannot be viewed as a rare event (Simmons, Singh, Maconochie, Doyle and Green 2006, 1934). All bereavements are significant to those who have suffered the loss.

## 1.1 Exploring Miscarriage and Early Miscarriage

The medical profession continues to debate the appropriate use of the term miscarriage in speaking of early pregnancy loss. Much has been written in the literature about miscarriage and stillbirth, and yet there is no universally accepted view of the point a foetus is recognised as ‘a baby’. As this is a topic fraught with cultural and religious ambiguity this lack of definition is certain to endure. However, medical practice requires some attempts to categorise and define terms – not least to offer appropriate health care. In Australia,

miscarriage is the term applied to the birth of a baby before 20 weeks gestation (Moloney 2011, 167). Twenty weeks is also currently used to define miscarriage in some American states, but they state that the foetus must also be less than 25cm long and 250 grams in weight (Moulder 1990, 59). In the United Kingdom (UK) the term miscarriage is used to refer to pregnancy loss prior to 24 weeks (NICE guidelines NG/126 2019). The World Health Organisation (WHO) recommends that miscarriage be defined as delivery before 28 weeks gestation with no sign of life (Mullan and Horton 2011, 1291).

In the midst of this complex situation, there is also a great deal of debate within the medical world as to the definitions of early and late miscarriage. For example, Christine Moulder describes late miscarriage in the U.K. as being after 16 weeks gestation (1990, 47), whereas the NICE guidelines (NG/126 2019) recommend that early pregnancy loss be deemed to have occurred within the first 12 weeks of pregnancy. However, the international community does not share a consensus regarding any precise date. For the purposes of this study, 20 weeks gestation was chosen as marking early miscarriage. Before this point the end of a pregnancy is internationally understood *within medical contexts* as a loss of a foetus rather than the loss of a baby.

Regardless of definitions, the loss of a pregnancy is still a loss. Parents focus on the developing baby they are waiting to welcome rather than the terminology of the medical world. In addition, miscarriage can often be perceived as the loss of the future which was expected to follow the birth (Gerber-Epstein, Leichtentritt and Benyanini 2009, 1). Every experience of miscarriage is unique and each parent will have their own individual parameters of loss. It is the duty therefore of the professional (and all who offer care) to endeavour to understand something of this unique situation (Mander 2006, 17). It is time to move beyond previous assumptions within healthcare, ecclesial contexts and popular cultures that pregnancy loss is not a significant bereavement (Kelly 2007, 23).

In the UK's Annual Chief Medical Officers Report of 2012, one of the key messages for future policy was: "Pregnancy is the very start of child development and a time when women are more motivated to make healthy

choices. Most women are in contact with services and hence there is the potential to intervene and make a difference" (Davies 2012, Chapter 5, Page 10). Intervention and making a difference is highlighted, but the report's focus is in relation to the future health of the child (and the mother). Indeed, the last key message of the chapter on 'Life Stage: Pre-conception and Pregnancy' is that policy makers should ensure that care for the mothers is holistic. There is an underlying assumption that this is following a successful birth, as it does not make any reference to care following miscarriage.

The lack of attention to this question may be partly because the nature of miscarriage remains ambivalent. Indeed, the *Oxford Handbook of Clinical Specialities*, one of the most commonly used reference books for junior doctors, states under the sub-title 'After a Miscarriage':

> Miscarriage *may be* [my emphasis] a bereavement. Give the parents space to grieve, to ask why it happened and if it will recur. Offer follow-up. Fetal products should be incinerated but if the mother requests alternative disposal (to bury herself) respect her wishes. Give in an opaque container (Collier, Longmore & Amarakone 2013, 260).

In the light of my ministerial experience, this struck me being rather insensitive and inappropriate advice for current doctors in training. It is apparent that the medical profession is equivocal as to whether miscarriage is a bereavement or not. Yet, many parents regard it as such. Indeed, Ewan Kelly, a healthcare chaplain, practical theologian and former hospital doctor, echoes a common sentiment expressed by parents when he writes of personal experience: "He became our baby from the moment we knew he was there" (Kelly 2007, 11).[15] Cognisance needs to be taken of this view when communicating with parents.

[15] Kelly conducted in-depth qualitative interviews with 31 bereaved parents whose babies had died in utero from 16 weeks of gestation to term and referenced his own loss.

### 1.1.1 Support Following A Miscarriage

This section examines the need for support following miscarriage and seeks to highlight the need for support for grieving parents. As stated, losing a pregnancy is a deeply personal experience which affects everyone differently (NICE guidelines NG/126 2019). There is often a profound sense of loss and many women report that they grieve as they would for a close friend or relative (Royal College of Obstetricians and Gynaecologists, 2006). Ingrid Lok and Richard Neugebauer reported that, "studies show that early pregnancy loss can produce a grief reaction as substantial as that to loss of any loved one" (2007, 231). Such a loss also contributes to disenfranchised grief, since the lack of societal recognition and support does not correspond to the intensity of the emotional response to the physical and emotional loss (Lang, Fleiszer, Duhamel, Sword, Gilbert and Corsini-Munt 2011, 183; Mulvihill & Walsh 2014, 2290). This indicates that parents who are grieving through pregnancy loss are not offered the level of support given to others.

A miscarriage is a personal, private and intimate event (Gerber-Epstein, Leichtentritt and Benyamini 2009, 91), and it brings about an internal search to find meaning in the loss of a new creation of life. This search can be both intense and protracted (Royal College of Obstetricians and Gynaecologists, 2006). William Worden in his book *Grief Counselling and Grief Therapy* warns that we must avoid assumptions, especially in relation to the meaning of any pregnancy and its loss (2009, 131-33). Anne Smith and Sherry Borgers comment that the general view within society is that perinatal death, as a significant loss, is not on a par with other types of losses to death (1989, 211). The significance of miscarriage is often minimised by well-intentioned family, friends and the community, which leaves grieving parents with an unmet need for support (Gold, Boggs, Mugisha and Pollondina 2012, 67-8). Kimberly and Philip Monroe, recounting their own experience of miscarriage, write: "Grief. No funeral. No burial, No flowers. No cards. Yet there is a death: the death of hopes of the wonder of a child emerging from your love" (2005, 53). Such a view is supported by Rosemary Mander who warns that,

> we must be wary of regarding perinatal loss as the loss of a baby and nothing more … we must take account of the wide range of personal and relational implications and accept that, additionally, there will be some which are not known to anyone but the grieving parents and, perhaps, not even to them. (2006, 208)

Mander highlights a core issue by identifying that the grieving parents are the ones whose views and experiences should be central. This, I advocate, is where research is required to be carried out to enable carers insight into the necessity of support and of the form it might take.

In researching women's experiences following stillbirth (where the gestational age of the baby was greater or equal to 23 weeks), Gravensteen, Helgadóttir, Jacobsen, Rådestad, Sandset and Ekeberg (2013, 2) noted that while the great majority of the 379 women in their study saw and held their baby and were satisfied with the support from healthcare professionals, one in three presented with a clinically significant level of post-traumatic stress symptoms 5-18 years after stillbirth. In other words, while their baby had died, their experience, their trauma, lived on. Jessica Farren, Maria Jalmbrant, Lieveke Ameye, Karen Joash, Nicola Mitchell-Jones, Sophie Tapp, Dirk Timmerman and Tom Bourne (2016, 7) claim that similar findings in relation to PTSD have also been found following early pregnancy loss (as was noted in the Introduction).[16] What these studies imply, therefore, is that loss at any stage during pregnancy can cause long term stress. In fact, the intensity of loss experienced may not be directly correlated with the gestation period of the infant.

Reflecting on the developments in the general understanding of and research into loss and death in childbearing, Mander notes that the, "disregard of miscarriage has been made worse by our limited knowledge of the emotional processes of early pregnancy, which may include the assumption that shorter gestation carries less emotional investment" (2006, 42). This claim is supported

[16] 39% of women who experienced early pregnancy loss met the criteria for probable moderate-to-severe PTSD (Farren, Jalmbrant, Ameye, Joash, Mitchell-Jones, Tapp, Timmerman and Bourne 2016, 7).

by the findings of a large-scale study which found that the stage the pregnancy had reached is not a predictor of the length or depth of the parents' grief. Importantly, no significant differences were discovered between the grief responses of women losing their babies through miscarriage, stillbirth or neonatal death (Peppers and Knapp 1980, 157).[17] In describing best practice, Professor of Psychiatry and Director, Women's Mental Health Program at the University of Toronto, Gail Erlick Robinson asserts that the effect of unwanted pregnancy loss is not associated with the length of gestation but with the meaning of the pregnancy for the individual woman (2014, 176).

Natalène Séjourné, Stacey Callahan, and Henri Chabrol (2009, 403) confirm that miscarriage can be a very difficult experience and that support is both necessary and desired by many women who have experienced early pregnancy loss. However, this support appears to be lacking. In a Scottish audit, it was found that 38% of women reported that there had been no follow-up procedure following their miscarriage (Scottish Audit of the Management of Early Pregnancy Loss 2003, 9).[18] This is a sizeable figure on its own but may, in reality, be an understatement of the true picture as my own experience suggests that many women who have a miscarriage in early pregnancy are not referred to hospital and, therefore, would not have been included in this audit. A similar audit of those who only accessed General Practitioner services would provide a more comprehensive account of the support available. Even then, a complete picture would be difficult to obtain as some women who miscarry never make contact with medical services.

The conclusions of the Scottish Audit are consistent with Moulder's finding that, "Women were more likely to be followed up if they had miscarried late in pregnancy or had miscarried before" (1990, 87). Paulina Van and Afaf Meleis (2002, 37) confirm this and report that society provides more support for

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[17] Peppers and Knapp studied 100 mothers and fathers who lost a child through miscarriage, at birth or in the first 28 days of life.

[18] Assessed via Scottish Programme for Clinical Effectiveness in Reproductive Health. The audit included a survey of women who had accessed obstetric & gynaecological (hospital) services over a four month period. 649 responses were received from 1750 questionnaires issued.

women who experience a late pregnancy loss, such as stillbirth, than for women who experience early pregnancy loss. This would imply that there is a medical understanding that severity of the loss is dependent on gestational age, in contrast to the research findings noted above. It remains unclear whether women's normal social support networks (such as family, friends, colleagues) perceive miscarriage as being less significant than stillbirth and, therefore, provide varying degrees of support based on gestational age at the time of loss, although this is likely to be the case (Plagge & Antick 2009, 126). Importantly, the support offered may be based on others' perception of the significance of the loss.

This section of my literature review has indicated that miscarriage can be a significant, life-changing event, even if it is not generally regarded as such by the wider population. As such it must be acknowledged that appropriate support should be provided. The nature of this support will be discussed in the next section.

### 1.1.2 What Support Might Helpfully Be Offered?

As already indicated, I have critically explored literature that focuses on support following neonatal death, stillbirth and miscarriage. These experiences have different features from early miscarriage and I would not wish to elide them. However, given the lack of research in this area, examining the provision of support (or otherwise) in these situations will offer an insight into what responses might be appropriate to early miscarriage.

The loss of a child is the most difficult loss that a person can experience in their life and it is argued that the associated grief, "is particularly severe, long-lasting, and complicated" (Lang, Goulet, Aita, Lamarre, Giguère and Perreault, 2001, 498). This is supported by Deborah Rich (2000, 261) who goes on to argue that bereaved mothers and fathers have unique needs. Knowing the best way to support someone who has lost their baby and to get it right – every time – is not easy.

It must be noted that while this thesis does not examine the ethics of abortion, early miscarriage can be described as natural or spontaneous abortion. For example, in an online article about miscarriage, medical doctor Jacqueline Payne describes miscarriage as up to 24 weeks gestation and uses the synonym 'spontaneous abortion' (2016, para 1).[19] The word abortion adds confusion into an already complex and emotional debate because many people regard this word as implying a woman's choice in the termination of a pregnancy. The focus of this research is to identify appropriate support for those who wished to proceed to full-term with their pregnancy yet have lost their baby early in the process. It is important to say that it is not my intention to enter into the ethics of 'choice' which, in itself, merits study to identify what support can and should be offered to women who choose to terminate pregnancy.

#### 1.1.2.1 Recognising The Baby As A 'Real Person'

According to The Miscarriage Association (2016) some hospitals still refer to and treat the remains of an early miscarriage as clinical waste. This causes additional upset for those grieving parents who perceive their miscarriage as the loss of their baby and would wish it identified as such.

Much of the literature examined highlights the expressed desire of grieving parents to have their longed-for baby recognised as a 'real person'. Judith Lumley asserts that it has long been known that by eight to twelve weeks gestation, some mothers perceive their babies to have become a real person to whom they relate (1979, 1067 & 1069).[20] Lumley also noted that this perception increased with gestational age (1979, 1068). This was confirmed in a study of perinatal loss which was integral to the founding of SANDS (Stillbirth and Neonatal Death Charity), that found: "over 60 per cent of [Lumley's] sample of eighty parents, who experienced neonatal loss, considered that having their baby recognised as a 'real person' was their major concern" (Lewis 1978, 2479). Lumley also adds that giving the body a name and using that name may

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[19] See patient.info/doctor/miscarriage-pro. Accessed 30th May 2019

[20] In an Australian study of thirty pregnant women conducted between 8-12 weeks gestation, Lumley noted that 30% already believed that the foetus was a real person (Lumley 1979 1067).

facilitate this recognition. This finding is echoed by Diane McGreal, Barry Evans and Graham Burrows (1997, 3) who claimed that one of the problems associated with miscarriage is the failure to recognise that the subsequent grief has arisen from the death of a person.

However, this is not a universally accepted view. Nel Noddings, in her book *Women and Evil,* 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). (1989, 152)

Again, there is simply not enough research to make definitive statements on this issue, but it seems sensible to assume that there will be different responses to early pregnancy loss depending on the very different circumstances in which women find themselves. As Nodding suggests, for some women's loss may be expressed in terms of hoped for potential futures rather than loss of a baby.

Nevertheless, that many people view early miscarriage as loss of a real person, was brought into focus by the report into the Edinburgh Mortonhall Crematorium 'baby ashes' scandal. This centred round the disposal of miscarried baby remains following a large media-focussed outcry of bereaved parents. The report by Dame Elish Angiolini, the former Lord Advocate of Scotland, condemns the "casual reliance on received wisdom" (2014, 538) that there would be no ashes following the cremation of babies who died in utero or stillbirth. This approach was followed not just by Mortonhall staff but by funeral directors, professional bodies, the NHS and the Scottish Government. Angiolini states that there was "overwhelming evidence" (2014, 536) that bones from foetuses as young as 17 weeks do survive cremation.[21] This means that some parents do not receive the

[21] While seventeen weeks is comparatively late for early miscarriage, it falls within my working definition for this research project. Notwithstanding, cremation of foetuses who died earlier

ashes of their miscarried baby; instead they must speculate as to whether their baby's ashes were interred at the crematorium, were "Hoovered up" with dust from the cremator and buried in an "undignified" strip of ground next to a skip at the site, or were mixed up with other ashes and put in the urns of adult strangers (2014, 543-49). This casual approach to miscarried baby remains provides evidence that they are treated differently, and not with the same dignified approach as other remains. The public reaction to the grieving parents involved in the Mortonhall enquiry, and the acknowledgment that such practice is widespread, led the Scottish Government to establish an Infant Cremation Commission, which was chaired by Lord Bonomy (reported in May 2014) which recommended changes to the law to prevent a similar scandal happening again.

Public concern and legal interventions in this area contribute to raising the issues of 'rights' in relation to pregnancy loss. In 1992 the not for profit organisation SHARE, Pregnancy and Infant Loss Support Inc, published a number of bullet points identifying the 'rights' of a dead baby (SHARE 1992, no page).[22] The rights include:

- To be recognised as a person who was born and died
- To be named
- To be seen, touched, and held by the family
- To have life-ending acknowledged
- To be put to rest with dignity

When these rights are respected, research indicates that grieving parents are comforted that their dead baby is being acknowledged. As Cathi Lammert affirms: "When caregivers acknowledge that losing a baby may be one of the hardest things that they will ever have to face, parents feel that they are given

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than seventeen weeks also take place, and the 'baby ashes' scandal has highlighted bad practice and raised concerns for grieving parents as to how their baby was treated.

[22] The Rights of Parents When a Baby Dies and Rights of the Baby were developed by the Perinatal Bereavement Team at Women's College in Toronto, Canada. With permission, the National Office of SHARE: Pregnancy and Infant Loss Support, Inc. revised and expanded these documents.

permission to grieve, even though many people will discount their loss" (2000, 225). For those who interpret early pregnancy loss as the loss of a real person these rights have indicative significance.

SHARE should be commended for the insights it offers. However, with early miscarriage, there may be no body to see, touch or hold and to be put to rest with dignity. Therefore, only three of the bullet points mentioned above apply. I paraphrase these as: To be recognised, named, and to have life-ending acknowledged. These could be adopted as a starting reference for best practice following early miscarriage.

The need for support is exemplified in a South African study of twenty-five mothers who had experienced a perinatal loss (stillbirth) and received crisis intervention from social work agencies. It reported that mothers expressed the wish that people would acknowledge their loss, be considerate and sensitive, be sympathetic listeners and offer emotional support (Human, Green, Groenewald, Goldstein, Kinney and Odendaal 2014, 14).

Acknowledging that much can be done to encourage hospitals, councils, funeral directors and all associated professionals to improve their practice, it must be recognised that many women miscarry outwith the clinical environment and may not know it is happening. Where there are no medical complications, it is often the case that no health professionals become involved. Indeed, it is likely that many will pass the remains of a pregnancy into the toilet and then, automatically flush the toilet. This brings into focus one of the significant differences between early miscarriage and neonatal death or stillbirth, which is that there is often no body over which to grieve. Indeed, some women may not even be aware of their loss until sometime after event has taken place.

#### 1.1.2.2 Grief and Ritual

This is not a thesis on either grief or ritual, but these are significant topics that must be addressed when trying to identify what might be accepted as appropriate support following miscarriage. This section seeks to introduce the effects of grief following neonatal and perinatal loss, and the role that ritual has

in its mitigation. By inference, this is relevant to this thesis when seeking to be aware of the support needs following early pregnancy loss.

Key influences within the literature on grief and bereavement include the work of Sigmund Freud (1913), John Bowlby (1979) and Beverley Raphael (1984) who agree that the aim of grief is to achieve resolution and recovery – to 'let go' and 'move on'. The main criticism of this model of grief is that it can become prescriptive rather than descriptive, requiring people to pass through prescribed markers on their grief process. In contrast, new approaches focus attention away from the individual, towards one which locates grief within social and cultural contexts. William Worden (2009) suggests that grieving should be considered as an active process that involves engagement with four tasks:

- to accept the reality of the loss (39);
- to process the pain of grief (43);
- to adjust to a world without the deceased (including both internal, external and spiritual adjustments) (46);
- to find an enduring connection with the deceased in the midst of embarking on a new life (50).

Tony Walter argues that the process of grief involves the renegotiation of identity for the bereaved person and that there is no prescribed way of grieving (1996, 7-8). However, while agreeing that grieving can take many forms, Walter's view is problematic when considering loss through miscarriage and it is extremely difficult to negotiate identity for a loss through miscarriage.

The death of a baby is an embodied loss that incites deep psychological wounds and can be isolating for many parents. Parents process their grief experiences within a sometimes oppressive social context that either sees their expressions of loss as a normal response to an abnormal tragedy or as pathology (Cacciatore & Thieleman 2018, 200). A number of adverse psychosocial outcomes have been noted in bereaved parents, including anxious, depressive, and trauma

responses.[23] This is highlighted by Erica van der Sijpt's Romanian study of bereaved mothers which reported that, "unbaptized babies are not entitled to a full funeral service or a proper burial place … At best, they can be buried … at the margins of the cemetery and without a usual tombstone" (2017, 6). Unbaptized babies and all those who die during or prior to birth are considered to exist, "in a 'dark world' rather than in heaven" (2017, 6). The results of Van der Sijpt's study cannot be applied universally, they are rooted in the practices of a particular country. However, it gives insight into the significance of cultural pressures on bereaved parents. Van der Sijpt adds that the women in her study described being told not to mourn, resulting in a lack of public space in which they could discuss their losses. Furthermore, she noted an indifference (and avoidance) by their families and communities reflecting the cultural norms around perinatal death. This societal attitude is also evident from an on-line cross-sectional survey (again from Romania) of 237 parents who experienced miscarriage. The results showed significantly high levels of distress with one bereaved mother noting that miscarriages and abortion are treated with the same cultural shaming and language in her country, and that women who miscarry are treated as sinners (Thieleman & Cacciatore 2018, 200-03). Evident in the narratives of the bereaved parents in Thieleman and Cacciatore's study, is the experience of disenfranchised grief which occurs when individuals, "incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" (Doka 1989, 103). This is applicable to miscarriage also, implying an increased likelihood of disenfranchised grief.

Cultural context plays a huge role in how pregnancy loss is constructed and dealt with. It must be noted that Romanian views on the status of unbaptised babies

[23] For example, in a Norwegian study, 34% to 52% showed significant trauma responses, of parents bereaved by young suicides, sudden infant death syndrome (SIDS), and child accidents, over a year after the death of a child (Dyregrov, Nordanger, & Dyregrov 2003, 156). In Sweden, depression and anxiety were more common in parents whose children had died of cancer 4 to 6 years prior than in matched controls (Kreicbergs, Valdimarsdottir, Onelov, Henter, & Steineck, 2004, 1431). In a study based in the United States 37% of parents showed significant anxious symptoms, 58% showed significant depressive symptoms, and 42% showed significant trauma responses over 4 years after a child's death (Cacciatore, Lacasse, Lietz, & McPherson 2013-2014, 198). In another U.S.-based study of bereaved individuals (primarily parents) seeking grief counselling showed significant distress for all measures of anxious, depressive, and trauma responses (Thieleman, Cacciatore, & Hill 2014, 260). In Finland, a sample of parents attending a peer-support weekend intervention showed mean scores were above the clinical cut off for three trauma response clusters (Aho, Malmisuo, & Kaunonen 2017, 329).

are likely to have been shaped by Orthodox theology and, therefore, cannot be simply equated with the practice in other places. For example, and in contrast to the Romanian study, the work of Jan Bleyen (reported by Komaromy, Earle, Lloyd & Foley 2007, 4) has charted historical changes in Belgian practice following the death of a baby before, during or shortly after birth. In particular, there is a move away from removing the bodies of dead babies in favour of an approach which encourages mothers and/or fathers to hold, cuddle and dress their babies. Emphasising the importance of practice in the construction of identity, Bleyen argues that without the opportunity to meet their baby, parents could not be given the opportunity to form or construct an identity for that child. There are no similar studies in relation to early miscarriage. Furthermore, as has been discussed above, research is required to examine the traditions and theological context and how these have determined the practice adopted within different countries.

Commenting on the new SANDS Guidelines in the British Journal of Midwifery, Judith Schott and Alix Henley (2007, 157) explore the evidence-base for current practice in supporting grieving parents. Their conclusions can be summarised as follows:

- There is no conclusive evidence to show that parents should hold and see their baby and no evidence which justifies telling parents that they will benefit from this, but neither is there sufficient evidence to show that this is harmful.
- Parents should not be expected to behave in a ‘certain way’ but should be given choices to enable and empower them.
- It is important to reflect on how your own values may affect your response to parents who have different values, ideas and wishes.

Good practice following neonatal death is informative; however, further study is required to examine its applicability towards those who have lost a longed-for baby early in pregnancy.

Within the UK, when a baby dies before 24 weeks of pregnancy there is no legal requirement that there should be a burial or cremation (The Miscarriage Association, 2016). However, many hospitals have developed sensitive approaches and encourage parents to consider what they would like, which may involve ritual. It should be recognised that parents may be so traumatised by the miscarriage that they simply accede to the particular hospital's policy, and that what actually happened to their baby would have a lasting effect on them, whether or not there was any associated ritual.

Some authors feel that rituals play an important role in enabling individuals to cope with grief (Irion, 1991; Rando, 1985). For example, Therese Rando (1993, 12) emphasizes how rituals such as funerals can be used therapeutically for the bereaved. Funerals provide an important step in facilitating the grieving process and can make death more of a reality (Irion 1991, 170).

Drawing on the insights of literature focussing on child bereavement is useful. In writing about the role of ritual following the death of a child Terri Daniel says:

> Ritual gives words to the unspeakable and form to the formless. It brings the non-physical into physical form so we can see it, touch it, feel it and process it. Creating this link between Heaven and Earth helps us to see the connection clearly, and to establish a bond between the realms, which gives us great comfort. It brings the spirit of the dead person into the body of the grieving person, and closes the perceived gap between them (2014, 121).

As Daniel claims, rituals can help the bereaved to express something of the significance of the relationship which has ended. This is supported by the Harvard Child Bereavement Study (as reported by Worden 1996, 'part 1') which found that maintaining an ongoing relationship is a normal part of the bereavement. By internally representing the person lost, the meaning of the loss is re-interpreted in an ongoing way and the deceased is memorialised.[24]

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[24] J. William Worden conducted this study which consisted of a group of 125 bereaved children from 70 families over a two year period, beginning at the time of their parent's death.

Yet, in terms of miscarriage, this is very difficult to achieve since it is the hopes and dreams of the parents for their child's future lived experiences that are their focus, and these have no tangible form of memorialisation. Reflecting on his research amongst parents of babies who died in utero, Kelly (2007, 228) argues that rituals such as welcoming and funerals help to make the baby and his or her death real.

Kelly concluded that ritual in the case of in utero death was associated with reduced parental feelings of regret and unfinished business, as well as offering some sense of meaning and purpose (2007, 17), and that rituals helped to provide some orientation in parents' lives amidst the confusion following baby death. He goes on to add that for parents whose baby died in utero in the second trimester, ritual was felt to be the only formal way parents could publicly recognise the life of their baby (2007, 18).

In order to adequately support grieving parents, several other studies have also highlighted the role of ritual. These almost always focus on stillbirth and neonatal death. For example, in a neonatal setting, Lawrence Seidl (1989, 51) claims that many bereaved parents cling to the outward symbols of the Church's sacraments which may have been performed. However, there is no analysis of what the child receiving the sacraments may mean to the parents. As Gerald Coleman (1986, 46) comments, some parents may still have fears related to the fifth century Augustinian doctrine that infants who died unbaptised suffered the pains of hell.[25] This doctrine is now largely abandoned across the denominations but it still haunts the minds of some believing parents. However, baptism (and a funeral) may not be possible in relation to early miscarriage and so, while being aware of the role that traditional rituals

[25] "Unconscious infants dying without baptism are damned by virtue of their inherited guilt" Augustine (354-430) as quoted by Newman (1899). It is worth noting that Augustine's thought enjoyed a revival in the 16th century, During this period the popes (Paul III, Benedict XIV, Clement XIII) defended the right of Catholics to teach Augustine's stern view that infants dying with original sin alone are damned and punished with the perpetual torment of the fire of hell (International Theological Commission, 2007).

serve, thought should be given to alternative rituals that may be of support to those parents.

Following an early miscarriage, none of the normal rituals that surround bereavement may be deemed appropriate, and that in itself may leave grieving parents feeling unsupported. Diane McGreal, Barry Evans and Graham Burrows (1997, 164) identify that there is a lack of social ritual following miscarriage and stillbirth.[26] However, this is only partly true. The Book of Common Order of the Church of Scotland includes an 'Order' for the funeral of a still-born child (Church of Scotland Panel on Worship 1994, 319-25). Yet it contains no material specifically relating to miscarriages. The absence of suitable liturgical material may suggest, to some, that the Church does not view a miscarriage as a significant loss.

In this section, I have introduced the significance of grief and the role that ritual may have (for those who seek it) as a supportive approach for those coping with loss through miscarriage. It has shown that while there is a need, for some parents, to identify a miscarried baby as a real person the traditional ordinances of the Church do not provide comfort or support for those who have experienced early miscarriage.

#### 1.1.2.3 Offering Spiritual Support

As a parish minister, I not only conduct rituals associated with death and bereavement, I am also expected to offer spiritual care to my congregation and parish. In order to identify how better to support those who have experienced early miscarriage, it is important to understand what is meant by 'spiritual' in this context. In this section, I will identify what is meant by spiritual care and how it can be of support following early miscarriage.

Spirituality is difficult to define and it is as unique as each individual (Lammert 2000, 211). Many competing frameworks have been offered to engage with it. Kelly describes spiritual in the following way: "It is the element in us and

[26] The study by McGreal, Evans and Burrows involved fifty one adults who lost a baby as a result of miscarriage or stillbirth.

beyond us that makes each of us truly unique and gives us, at times, the ability to see beyond what is happening in the present moment" (2007, 81-82). He goes on to say that:

> Spiritual need is that aspect of an individual's personhood which seeks to make sense of, and find meaning in, the present moment. Any such exploration is done in the light of an individual's previous life and involves, potentially, consideration of any significant element of their unique life story (2007, 83).

Another helpful definition is offered by Joseph Driscoll (the Executive Director of the [United States] National Association of Catholic Chaplains) who believes that: "... spiritual care can be defined as discovering, reverencing and tending the spirit of another person" (1996, 14).

These views help us focus on caring for the needs of each individual. As spiritual caregivers we stand on holy ground, in the midst of a person's journey not knowing the beginning and the end. The spiritual caregiver can be equated to Philip in the Book of Acts (Chapter 8, verses 26-40), who was prompted by the Holy Spirit to join an Ethiopian eunuch as he travelled home from Jerusalem. This important official was reading from the prophet Isaiah but did not understand the message. Philip explained to him the Good News about Jesus and baptised him. Those who give spiritual care are called to travel with people along certain parts of their life's journey. They try to help them make sense of where they are and what is happening in and around their life. When it comes to loss, the spiritual carer has to remember that while the grief experience is universal, each person has his or her own personality, history and coping style (Lamb 1992, 52).

A useful set of Guidelines and Standards have been produced to develop the role of spiritual care within a health care setting. The Guidelines as set out in NHS HDL (2002) 76 affirm the distinct roles of spiritual and religious care and provide useful definitions:

> Religious Care – is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.
>
> Spiritual Care – is usually given in a one-to-one relationship, is completely person-centred and makes no assumptions about personal conviction or life orientation.
>
> Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.

These definitions provide a useful framework for everyone within the so-called caring professions and move spiritual care from being the preserve of the religious. This change in understanding was encouraged by NHS Scotland which produced the following definition:

> Spiritual care is that care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires. (NHS Education for Scotland 2009, 6)

However, from a theological perspective, there is no widely accepted definition of spirituality. Indeed, as Heather Walton points out:

> It often refers broadly to a person's sense of meaning in life, connectedness (to people, nature, and/or the divine) and the quest to reach beyond the self to something that transcends the immediate and personal – regardless of religious affiliation. (2015, 3-5)

The definitions above are helpful, but they merely serve as a starting point from which professionals should begin to consider what might be appropriate for the individuals who look to them for spiritual support.

Those who turn to me for support have a connection with the Church, even if tenuous. However, it cannot be assumed that they are seeking traditional forms of religious care rather than care that is focussed on a holistic understanding of their person and particular needs. Ministers, therefore, should be with people where they are and help them make sense of what they are experiencing in life.

In terms of this thesis, I set out to identify the support that would be valued by those who have experienced early miscarriage – whether that be religious or spiritual or both.

#### 1.1.2.4 Who Should Provide the Support?

Having considered the issue of spiritual support, I now turn my focus to who should offer the support that is called for. The historic answer to this question would have been ministers and/or priests. However, just as there has been a growth in understanding of the place of the laity as part of the priesthood of all believers, so there has been development of pastoral care outwith the world of the Church. Spiritual care is no longer the preserve of the clergy. In fact, the medical and nursing professions have increasingly been examining their spiritual care role. Cobb (2001, 74) argues that nurses as a profession are increasingly exploring all dimensions of care – including spiritual. In fact, the Nursing and Midwifery Council (NMC, 1992) now confirms that spiritual care is a responsibility of nursing. In all spheres it seems we are recognising that spiritual care is a corporate responsibility. This raises the question of who should provide spiritual care and more importantly, who do people turn to for such support.

The World Health Organisation's definition of health is holistic, including the spiritual element alongside physical, emotional, mental and social (WHO 1990),. The provision of spiritual care is, therefore, an integral part of the healthcare offered. However, in my Master's dissertation I concluded following interviews of midwives that they viewed spiritual care as being the domain of the hospital-based chaplain (Paterson 2004). Spiritual care was not (at that point) holistic. Furthermore, much of what the Church (or faith group) does happens in the community or parish setting rather than being confined to the hospital.

In the following subsections, I will look separately at the support which is offered by health care professionals, spiritual care professionals and family.

#### 1.1.2.4.1 Support from Health Care Professionals

The death of a child brings with it a complex set of emotions in which it might be thought that parents are not able to make decisions for themselves (Downer, 1996, 6). In the past, a very paternalistic attitude existed. The child would be taken away and buried in the hospital cemetery, often without the parents knowing where. Indeed, society very seldom spoke about the loss of a child. Nowadays, things are very different, and parents are encouraged to become fully involved by taking photographs and making funeral arrangements. However, it is tempting for staff to become beneficent and suggest what should be done next. This they would see as following the NMC Code of Conduct (1992), which states that nurses should: "Act always in such a way as to promote and safeguard the well-being and interests of patients/clients." According to NC Drew, P Salmon and L Webb (1989, 1084) midwives and obstetricians are aware of what women want in maternity care. In a study by Rosalind Bluff and Immy Holloway (1994, 163) who carried out unstructured interviews with eleven women who had miscarried, it was found that women trust midwives to make decisions about procedures, drugs and types of care, and it can, therefore, be assumed that the midwife will know what parents should do if their baby dies in utero.

In contrast, Steven Edwards in discussing nursing ethics suggests that it cannot be assumed that the professional's knowledge enables them to decide what is best for a patient, since this inevitably leads to the imposition of their own values (1996, 7). Neonatal nurses caring for an infant have a legal responsibility to ensure that parents have been given adequate information in a sensitive way that they can readily comprehend (Emery 2000, 90). Indeed, it is claimed that parental autonomy is largely being fulfilled in neonatal units (Yeo 1998, 17-18). Anita Lundqvist and Tore Nilstun (1998, 247) conducted a survey to determine the experience, behaviour and attitudes of nurses towards parents who refuse

or are reluctant to see, touch or hold their dying or dead baby.[27] Eighty three percent of respondents were of the opinion that conflict between beneficence and autonomy was difficult but not impossible to solve (1998, 246-250). This has provided insights. However, these were limited because it did not consider or compare the experiences of the parents, nor did it identify specific solutions to support conflict resolution. Regardless of the legal imperative of parental autonomy, there is a strong moral case that it should also apply in miscarriage situations and that parents should be given sufficient information to enable them to make informed decisions with regards to their baby's remains.

The UK's National Institute for Health Care Excellence (NICE) guideline entitled *'Ectopic pregnancy and miscarriage: diagnosis and initial management'* (2012) states that a woman and (with agreement) her partner should be given information of: "Where to access support and counselling services, including leaflets, web addresses and helpline numbers for support organisations." However, the website of the Miscarriage Association claims that:

> The recent NICE guidance on the diagnosis and management of early pregnancy loss stresses the need for health professionals to be trained in providing supportive and sensitive care, breaking bad news and giving clear information. At the same time, however, limited training budgets and staff cover can make this difficult to implement, so it's important to be aware of opportunities for training and advice. (NICE 2012)

From this, it would appear that health professionals are not likely to be equipped to deal with the support challenges of early miscarriage.

Within a clinical setting, the hospital chaplain would be seen as the health care professional best equipped to offer spiritual support to grieving parents. Seidl (1989, 50) claims that the chaplain is called because: 1) they represent the

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[27] 144 questionnaire responses from nurses working in Swedish neonatal wards to assess the nurses' experience, behaviour and attitudes towards parents who refuse or are reluctant to see, touch or hold their dying or dead baby.

spiritual and may help the parents find purpose and meaning in their tragedy, 2) they are trained to listen and help parents talk through their experience, and 3) they can foster healing relationships among friends and families and with God.

Referring to hospital settings, John Swinton urges chaplains to be healers and care for a person's spirituality, "that dimension of humaneness which is unquantifiable, mysterious, individual and unique" (2003, 223).[28] The way to do this, he claims, is to practice a narrative based chaplaincy where chaplains listen to, bear and share stories. Stories, he says, reveal the way people construct their universe. Chaplains themselves embody, act out and re-tell faith narratives. They "cross over into strange lands" and "listen to stories of illness, sickness and suffering, happiness, brokenness, life and death" (Swinton 2003, 224). I applaud the thinking of Swinton. However, community based health care chaplaincy is almost non-existent in the Scottish context, which leaves a void in the provision of care outwith the hospital setting.

#### 1.1.2.4.2 Support From Parish Based Spiritual Care Professionals

The raison d'etre for conducting this research has been to equip myself, and hopefully others, for those occasions that we are called upon as professionals to offer support. Apart from acknowledging the dead baby as a real person when this corresponds to the parents' understanding, and conducting rituals where appropriate, further thought is required as to what support can be offered.

The literature makes mention of strategies and support mechanisms, yet it contains little information about the spiritual care needed, and offered, following miscarriage within the community setting. Daniel Nuzum, Sarah Meaney and Keelin O'Donoghue (2017, 1081) carried out a study in Ireland of 17 parents (twelve mothers and five fathers) who had experienced stillbirth and found that none of them had received any follow-up pastoral care from the hospital. One study was identified from Sweden which stated that pastoral support from local parish churches following a death immediately before or

[28] John Swinton originally trained as a nurse, is now a Church of Scotland minister and Professor in Practical Theology.

after birth, was almost non-existent (Wretmark, 1993, 272).[29] Indeed, Cathi Lammert claims that: "Faith communities do not always provide support for parents who have had an early pregnancy loss and may be insensitive to their grief" (2000, 227). More research is clearly needed to identify why this should be the case. However, since individuals have to self-refer themselves (or have someone do it on their behalf) to their local church, it would only be those with some kind of contact (however tenuous) that would receive support from their local parish minister or priest.

Lack of adequate support was also identified by Ingrid Rowlands and Christina Lee (2010, 285) who concluded (from a study carried out in Australia) that hospital-based interventions should be combined with community-based interventions in order to build adequate support mechanisms. This is certainly an area that warrants further investigation particularly since it has been hypothesized that religious participation assists in coping with the stress of early motherhood (Mann, McKeown, Bacon, Vesselinov and Bush 2008, 745), and might thus also prove welcome in supporting parents following miscarriage.

Religious professionals have a role to play. However, according to Alice Lovell. who conducted a literature search of over 200 articles on miscarriage, stillbirth and perinatal death, they are slow to change their practice. I quote:

> Functionaries with experience ranging from two to twenty five years, spoke at length about what they 'would do', but most had hardly ever conducted funerals (or other rituals) for early neonatal deaths, fewer for stillbirths and, with one exception, none for miscarriages (2002, 47).

Despite this apparent apathy towards funerals and/or rituals, Kelly advocates that clergy should offer their services, but must let go of the ownership of ritual content (and therefore of hundreds of years of Church power and

[29] Consisting of semi-structured telephone interviews with 79 parents who had experienced perinatal loss.

tradition) by offering control back to parents, should they want it (2007, 19).[30] "Over the last millennium patterns of mortality have changed and have determined who grieves and how" (Parkes 2010, 1). Therefore, the church needs to continually address its rites and rituals. Kelly argues in favour of co-constructing rituals which would empower the bereaved parents to "regain control in a situation where hitherto they felt powerless" (2007, 19). By addressing changes of mortality patterns, the church would be in a position to educate the functionaries to which Lovell refers, so that they are equipped to empower bereaved parents.

The brevity of this section serves to highlight the lack of research into the area of pastoral support, both spiritual and religious, following early miscarriage and should serve as a catalyst for future investigations.

#### 1.1.2.4.3 Support from Partners and Family

If grieving parents are left unsupported by the health care and parish based spiritual care professions, do they support each other? This section highlights the absence of published literature concerning the support offered by partners and family following early miscarriage.

Drawing on the parallels with perinatal loss, one study involving twenty two mothers and nine fathers, which investigated the ways family and friends supported parents, concluded:

> Family and friends need to understand the importance of being with parents and allowing parents, in particular mothers, to talk about the loss … because parents feel that friends and family are minimizing the loss of their baby when they avoid talking about the baby. (Kavanaugh, Trier and Korzec 2004, 90)

[30] In reference to the role of chaplains in the immediacy of the labour ward or in the emptiness of bereaved parent's homes (Kelly, 2007 19).

In fact, it has been found that rather than supporting the mother, the needs of family members may predominate over those of the grieving mothers, thereby making it difficult for them to offer the support needed (Rajan 1994, 100).[31]

As has already been noted, many believe that an early miscarriage is not a real loss. This was highlighted in Larry Peppers and Ronald Knapp's study, that the nature and intensity of grief is strongly affected by the inappropriate reactions of friends, relatives and caregivers (1980, 157). They concluded that a loss in pregnancy, whenever it happens, should be mourned as a loss in its own right.

It should be noted that while the studies highlighted in this section offer valuable insights, the data was collected from the perception of parents, highlighting that the views of other family members and friends is an under-researched area. Partners and family are also grieving and trying to cope with the loss and this, perhaps, might be a factor in the perceived lack of support.[32] Findings from University College London and the Miscarriage Association (2014), who carried out in depth interviews of 160 partners of miscarriage sufferers, showed that a significant number of the partners of women who miscarry did not communicate about their own feelings of loss and pain. In fact:

- 46% of them didn't share all of how they were feeling with their wife or girlfriend for fear of saying the wrong thing or causing her further distress.

- 22% didn't talk about any feelings of loss and pain with their partner.

These findings present evidence that those who might be expected to offer the greatest support were not able to, or prepared to, do so.

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[31] In a study of 509 mothers following miscarriage, stillbirth and neonatal death.

[32] It was reported that partners would value (amongst other things) the offer of support while they were caring for their wife or girlfriend. In response to the experiences of partners the research has been turned into materials to support the Partners Too campaign which utilises films of their stories read by actors, cartoons and information leaflets which is offered by the Miscarriage Association for the male or female partners of someone who has had a miscarriage, ectopic or molar pregnancy.

## 1.2 Chapter Summary

There is a desperate need to move beyond medical discourses and begin to appreciate what it means to live through a miscarriage (Morrissey 2007, 1415). Joshua Mann, Robert McKeown, Janice Bacon, Roumen Vesselinov and Freda Bush (2008, 753) have highlighted that, to the contemporary medical world, religion has a significant role to play in health. Their work was published in the *Journal of Women's Health* and reinforces the WHO (1990) view that health is a holistic concept, and that this includes the spiritual dimension.[33] From the pastoral perspective Browning advocates developing action strategies for addressing holistic care. (1983, 47). This fits well with the action research approach to this study (see Methods Section).

I have already mentioned the contribution of Kimberly (and Philip) Monroe. Kimberly is a stay at home mother of two and she describes her feelings and emotions in a world where everyone else is carrying on as normal and she was struggling to cope with miscarriage: "The church we attend has three hundred children. They announce new births. People hold their kids during worship. I cried every Sunday in church for about a year" (Monroe and Monroe 2005, 52). She would not have been the only one to have felt like that in such a large congregation. Such feelings may well be compounded every time the Sacrament of Baptism (a ritual) is celebrated. There is an added complication with early pregnancy loss which can be compounded within the Christian context from the often repeated Apostle's Creed, which includes the phrase: "I believe in… the resurrection of the body…" (*Church Hymnary* Third Edition 1973, Hymn 546). In early pregnancy loss, there is often no evidence of a physical body to be resurrected. At the Sacrament of Baptism – which within the Reformed tradition is often directly associated with babies – I use the following, often quoted, words from Mark's Gospel: "Let the little children come to me; do not stop them; for it is to such as these that the kingdom of God belongs. Truly I tell you, whoever does not receive the kingdom of God as a little child will never enter it. And he took them up in his arms, laid his hands on them, and blessed them"

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[33] Mann, McKeown, Bacon, Vesselinov and Bush 2008 analysed data from 307 woman to investigate the association between antenatal religiosity/spirituality and postpartum depression. Of the 307, 30 had experienced pregnancy loss.

(Mark 10: 14b-16 NRSV). The Kingdom of God is associated with little children and so every time parents, who have had an early miscarriage and did not have a body to grieve, are present at an infant baptism they may be led to question again where their baby is in terms of God's Kingdom.

With miscarriage being such a frequent occurrence there will be many in every congregation who have gone through this experience. This raises the question as to why Monroe did not feel the support of others, and for me (as a pastoral care-giver) why nothing has been done to address this within the realm of practical theology. Little research has been carried out in this field and that which has belongs almost exclusively to nursing or medical publications.

This review has identified the need for support while at the same time has highlighted the lack of research into what kind of support should be offered, how it should be offered and by whom. Early miscarriage is clearly an under researched area of practical theology. This thesis seeks to play a part in addressing the gap in the literature while at the same time equipping me to be a better practitioner, and educating others of the need to reflect on their own practice.

# Chapter 2 - Methodology & Methods

In this chapter, I will highlight the major differences between quantitative and qualitative research before setting out the reasoning behind my choice of methodological approach. Thereafter, I will describe the methods employed to enable the women who volunteered to share their experiences and to tell their story.

## 2.1 Study Design - Qualitative or Quantitative?

The table below sets out some of the differences between these two ways of undertaking research and some of their advantages and disadvantages.

| Characteristic | Quantitative research | Qualitative research |
|---|---|---|
| *Type of data* | Phenomena are described numerically | Phenomena are described in a narrative fashion |
| *Analysis* | Descriptive and inferential statistics | Identification of major schemes |
| *Scope of inquiry* | Specific questions or hypotheses | Broad, thematic concerns |
| *Primary advantage* | Large sample, statistical validity, accurately reflects the population | Rich, in-depth, narrative description of sample |
| *Primary disadvantage* | Superficial understanding of participants' thoughts and feelings | Small sample, not generalisable to the population at large |

Figure 2: The main differences between qualitative and quantitative research methods (VanderStroep and Johnson 2010, 7)

There are numerous definitions of qualitative research such as those by Norman Denzin and Yvonna Lincoln (1994, 2), Immy Holloway (1997, 2) and Kirsti

Malterud (2001, 398). However, I have found the following definition particularly helpful in guiding my own practice:

> Qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world. (Merriam 2009, 13)

This gives clarity and provides a locus to ensure that qualitative research engages with the ways people themselves understand and interpret their experiences. However, I am aware that some still question the validity of such approaches to creating knowledge, as subjective experience is embraced rather than excluded in qualitative research.

The pro-genitor of practical theology, Friedrich Schleiermacher, understood Christian theology to be empirical, not speculative (Gerrish 1984, 21).[34] This sentiment expressed his conviction that theology must be rooted in rigorous interrogation of lived experience. Descriptions such as empirical and rigorous might be thought to require the use of quantitative methods and yet, much contemporary practical theological research is undertaken through qualitative means. Qualitative approaches employing hermeneutical tools and methods borrowed from the humanities are sometimes described as producing 'soft data' (Burns and Grove 2005, 23 & 24). This generates the criticism that qualitative research lacks the objectivity and rigorous control required by 'hard science'. However, a 'scientific' way of doing practical theology employing statistical categories and quantitative measures is not always the best (Pattison 2007, 263), for it may minimise or ignore interpretation, practical wisdom and understanding (Pattison 2007, 282). Iain Crombie and Huw Davies argue that qualitative methods have a significant role when the focus of enquiry is to explore experiences (1996, 73-86) and, as Alan Bryman pointed out, their valuable

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[34] Schleiermacher believed that theology is second-level reflective activity on the lived experience of faith, particularly *communal* faith. "He concerned himself with facts and phenomena — with real, live religion, not simply with 'God' as a philosophical construct. He understood Christian theology to be (in his terms) 'empirical,' not 'speculative'" (Gerrish 1984: 21).

emphasis is to attempt to see through the eyes of the people being studied (1984, 78). Qualitative research recognises the complexity and richness of the human experience (Holmes 1990, 189 & 191). It is person-centred and can, in itself, be seen as an attentive and pastorally caring way of engaging with others in the production of knowledge (Holloway and Wheeler 1996, 8). This is supported by the work of Mary Moschella who, in her book *Ethnography as a Pastoral Practice: An Introduction*, is not concerned with the unengaged academic task of research for the sake of knowledge production but to achieve life-altering prophetic change within a community of faith (2008).

Every researcher needs to consider which research method is most suited for their research topic (Davies & Hughes 2014, 26). In this study, the purpose of qualitative research methodology is to explore the experiences of the participants which cannot be done in a numerical way. It uses non-numerical or verbal data and focuses on understanding human beings and their perceptions. Unlike quantitative research, it uses a small sample of subjects that has been 'purposively selected'(see section 2.2.3).[35] This will allow the experiences of those who have lived through a miscarriage to be heard in order to try and understand what it was like for them, and to gain a sense of how they felt, and still feel, as they continue to cope with their loss.

### 2.1.1 Chosen Methodological Approach - Theoretical Framework

Methodology has been described as, "a framework of theories and principles on which methods and procedures are based" (Holloway 2005, 293). It is the scaffolding which supports the means of data collection. In giving consideration to the methodological approach, I am conscious that I am seeking to learn of experiences as they have been remembered. However, Norman Denzin notes that, "there is no clear window into the inner life of a person, for any window is always filtered through the glaze of language, signs, and the process of signification" (Denzin 2014, 2). In seeking to enable women to tell their stories, hear these stories and share them, I am conscious that, "stories, like the lives

[35] Purposeful sampling is a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Patton 2002, 230).

they tell about, are always open-ended, inconclusive, and ambiguous, subject to multiple interpretations" (Denzin 2014, 5). Care must be taken to ensure that the filter of the researcher is as clear as possible when interpretations are being made.

The theoretical framework for this research is drawn from action research combined with a feminist theological approach. I shall, first of all, describe action research before highlighting the implications of adopting a feminist standpoint as a male researcher investigating the experiences of women.

#### 2.1.1.1 Action Research

This is a practical theology thesis in which research was undertaken to participate in the work of God in the world. As identified by Swinton and Mowett, one of the tasks of practical theological research is to investigate and interpret the lived experience of people of faith (2006, 6). In fact, they argue that practical theology is, "fundamentally action research" (Swinton and Mowett 2006, 255).

Action research, as defined by Peter Reason and Hilary Bradbury (2008, 4), is:

> a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

This is a useful definition. However, action research has a complex history because it does not represent a single academic trajectory but an approach to research that has emerged over time from a broad range of disciplinary sources, including education, psychology, social policy, community development and international development (Brydon-Miller, Greenwood and Maguire 2003, 11). It has also proliferated a myriad of sub-terms, such as practical action research,

participatory action research, community-based participatory research, and other forms of participative inquiry. However, the purpose of *all* action research is to impart social change, with a specific action (or actions) as the ultimate goal (Greenwood & Levin 1998, 90; McNiff & Whitehead 2006, 12 &13).

Another fundamental tenet of action research is that it is a process through which practitioners "gather evidence about their practices and critique assumptions, beliefs and values embedded in them" (Elliott 2000, 209). Similarly, Jean McNiff writes that action research involves becoming aware of the principles that drive us in our work, "we need to be clear about both what we are doing and why we are doing it" (2002, 7).

This fits well within the qualitative research paradigm as it emphasises the need for action researchers to be aware of their own lens as they seek to examine the issue before them.

Reason and Bradbury advocate that the main purpose of this kind of research is to find ways of working towards practical outcomes because theory without action is meaningless (2008, 6). Stephen Kemmis asserts that, "action research aims to change practices, people's understandings of their practices, and the conditions under which they practice" (2009, 464). This view very much fits with my aim to consider attentively what I learn from the interviews with women about the support they experienced following their miscarriage, and to use it to change my own practice and to encourage others to do likewise. McNiff, in looking at action research for professional development, notes that the intention is to improve one's work for one's own benefit and the benefit of others (2002, 7).

Action researchers: "Engage in careful diligent enquiry not for the purpose of discovering new facts or revising accepted laws or theories, but to acquire information having practical application to the solution of specific problems related to their work" (Stringer 2004, 3). Action research is applied, empowering, collaborative, democratic and emancipatory.

No research method is perfect, however, and cognisance needs to be made of action research's weaknesses as a research methodology. In discussing the academic integrity of action research, Morton Levin notes that the main critique is that it,

> does not produce scientific results contributing to the general body of social science knowledge. At best, action research produced good stories without critical scientific reflection and the publications lacked trustworthy claims on reliability and validity. (2012, 135)

In order to address this criticism,

> the researcher must plan, act, observe and reflect more carefully, more systematically and more rigorously than one usually does in everyday life; and [to] use the relationships between these moments in the process as a source of both improvement and knowledge. (Kemmis & McTaggart 1988, 10)

Therefore, as Tina Koch claims, if the research is well sign-posted, "the readers will be able to travel through the worlds of the participants and makers of the story and decide for themselves whether the story is a legitimate endeavour" (1998, 1182). Producing good stories lies at the heart of all research processes and sharing these *with a detailed account of their creation* does constitute good research.

As with other qualitative methodologies, action research is subject to the criticism that when left unchecked, results are laden with subjectivity (Kock 2004, 269). There is a tendency for the researcher to be over-involved to the extent that personal biases can influence the analysis of the findings.

Despite the need to exercise caution in the way in which it is employed, action research has much to offer as I seek to explore how those involved in pastoral ministry might be encouraged to reflect upon and change their current practice. As noted by Cathy MacDonald, action research is a valuable research

methodology to be considered by any researcher wanting to take action and make changes (2012, 46).[36] Indeed, Elaine Graham argues that,

> by adopting action research methods, practical theologians are not simply concerned with change management or the techniques of activism, but with schooling people in the well-springs of tradition from which practical wisdom flows. (2013,178)

Action research is an ideal approach for those seeking to examine and reflect on practice. Therefore, often used by practitioners who wish to improve understanding of their practice (O'Brien 2001, para 9). I wish to improve how I offer support to those who have experienced early miscarriage and to share this with others who are involved in pastoral care. The strength of action research is that it focuses on generating solutions to practical problems and it empowers practitioners, by enabling them to engage with the research and the subsequent development or implementation activities (Meyer, 2000 178). It is also able to influence practice positively while gathering data to share with a wider audience (Meyer 2000, 178).

I have embarked upon this research not solely to generate knowledge or produce a theory but to take what I learn and apply it to practice. I am seeking to develop my role as a reflective practitioner by continually examining what I do and how I do it. I am encouraged by Kurt Lewin who stated that, "there is nothing so practical as a good theory" (1951, 169). However, as Mary Brydon-Miller, Davydd Greenwood, and Patricia Maguire (2003, 15) claim, action research goes beyond the notion that theory can inform practice and that it should, in actual fact, be generated through practice to achieve positive social change. Those who apply this approach are practitioners who wish to improve understanding of their practice (O'Brien 2001, para 4). Aristotle employed the

[36] In an examination of participatory action research as a methodology option. Participatory action research (PAR) is considered a subset of action research, which is the: "systematic collection and analysis of data for the purpose of taking action and making change" by generating practical knowledge (Gillis & Jackson 2002, 264).

term ‘praxis’, to unite both understanding and action.[37] Praxis entails the art of reflecting and then acting upon the conditions one faces in order to change them. Aristotle contrasted this with theoria (those sciences and activities that are concerned with knowing for its own sake). In other words, our actions should be guided not by formal theory but a form of reflection that generates a theory which guides our action. That knowledge is derived from practice, and practice informed by knowledge, in an ongoing dialectical process, is a cornerstone of action research (O'Brien 2001, para 13).

My method is akin to practical action research which focuses on a specific research question with the aim of improving practice (Schmuck 2006, 19-21). It has been defined as: “Action research which sharpens individual practical reasoning” (Kemmis 2009, 76). Specifically, in relation to my research, it aims to improve the pastoral support that I (and others) might offer.

#### 2.1.1.2 Feminist Methodology

This section acknowledges my engagement with feminist methodologies during my research journey and my understanding of the insights and challenges they offer. Having acknowledged that as a male researcher I cannot share the experiences of the participants, it also highlights the steps I have taken to mitigate (as far as is possible) the issues relating to my gender in data gathering and analysis.

Over the course of my research, I have had to challenge my scientific bias for objective knowledge in many instances. Just as feminist theorists, “came to believe that objective knowledge (supposedly unbiased, rational, disembodied, based upon the God’s-eye view of things) had to be the subject of critique” (Bennett, Graham, Pattison and Walton 2018, 51), I came to reject the positivistic ideal of producing an impersonal, value-free and objective piece of research. I have learned that, “the partial understandings generated from

[37] In The Nichomachean Ethics (2009 edition) Aristotle (384-322 BC) set out how he had divided the world into things that change and things that do not which led him to distinguish between two main branches of knowledge. Aristotle described the knowledge of the unchanging as theoria and knowledge of what changes as praxis, which includes knowledge of things done.

acknowledged positions are at least accountable for their perspective and can be judged as such" (Bennett, Graham, Pattison and Walton 2018, 51). This is why I have not left myself off the page and have included a reflexive prologue.[38] By doing so, I have acknowledged my personal history by making use of autobiographical reflection throughout the research process, which is noted as a positive asset in research practice (Bennett, Graham, Pattison and Walton 2018, 136).[39]

Feminist methodology is distinctive in that it is shaped by feminist theory, politics and ethics and reflects women's experiences. It considers women's situations, concerns, experiences and perspectives (Ramazanoğlu & Holland 2002, 16). Liz Stanley & Sue Wise (1990, 37-39) also argue that no research method or technique of data collection is, in itself, specifically feminist, rather it is a particular epistemology that is distinctively feminist. Epistemology is our understanding of what constitutes knowledge, how it is produced and by whom, how it is distinct and how it is to be investigated and by whom (Stanley 1997, 167). Feminist research values the knowledge that women have generated and seeks to affirm the validity of standpoint (Haraway 1991, 107-113) and strong objectivity (Harding 1995, 331).[40]

In its efforts to listen to the lived experience of women, feminist research deeply values qualitative approaches. As stated, in contrast to the quantitative paradigm, qualitative researchers are generally more concerned with validity, rather than objectivity and reliability, and put less emphasis on finding *the facts* than understanding the complex nature of truth. Feminist research avoids traditional understandings of detached objectivity by establishing an interactive relation with the research participants, and always seeks to ensure that the

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[38] See Elaine Graham in reference to researchers who follow convention and 'leave themselves off the page' (2017, 9).

[39] Bennett, Graham, Pattison and Walton refer to Miller-McLemore (1994) when they speak about feminist practical theologians writing themselves in to their research projects (2018, 136).

[40] Strong objectivity is a term coined by feminist philosopher Sandra Harding who suggests that starting research from the lives of women actually strengthens standards of objectivity. Strong objectivity is posited in contrast to scientific objectivity since strong objectivity takes into consideration researcher bias, something that Harding argues can never really be removed (Harding 2005). Strong objectivity argues that there is androcentric bias in research because male researchers attempt to be a neutral researcher, where Harding argues that is not possible (Ramazanoglu and Holland 2002, 50-52).

research is transformative (Creswell 1998, 83). It begins with the experiences of women, recognises the researcher as a part of the research process and acknowledges that the beliefs of the researcher shape the research process (Harding 1987, 9). As will be discussed later, I chose semi-structured interviews as a means of data collection, which are often used in feminist research as they give greater agency to participants and are claimed to, "convey a deeper feeling for or more emotional closeness to the persons studied" (Jayaratne 1983, 145). Adopting this approach helps give greater focus to the participants.

As well as advocating greater attention to the lived experience of women, feminist methodologies are attentive to the power relations implicit within research contexts. Ann Oakley argued in 1981 that interviewers were assumed to perform masculine traits including objectivity, detachment and authority, while interviewees were to be recruited into positions characterized by feminine traits including compliance, obedience and submission to authority (1981, 31-41). She argued that new ways of practising and thinking about the dynamics of power relationships in the research context were needed. The relationship between an interviewer and interviewee is now increasingly recognised as containing implicit power relations (Kvale 2006, 496). A number of feminist researchers go further and describe the interview as a site for the exploitation and subordination of women (Hollway and Jefferson 2000, 30). In line with this perspective, some would forcefully argue that men do not have the experiential knowledge of womanhood (in embodied and subjective terms) and therefore lack the social imagination required to carry out research on women (Mies 1983, 121-122). Barbara Du Bois plainly believes that, because of the considerations mentioned, men cannot adequately conduct research on women (1983, 108).

Len Doyal and Ian Gough (1991, 53) counter this prohibition by arguing that all human beings have basic ‘objective’ needs which can be classified as physical health and autonomy and therefore, judgments concerning research should be based on the position of the researcher with regards the promotion of objective human needs. However, simply affirming that I am responding to an objective human need (the need for research into the experiences of those who have had

an early miscarriage) would fail to address the real dilemmas that a male researcher interviewing women should acknowledge.

Nicola Slee, writing from a feminist standpoint, suggests that: “under patriarchy, much of women’s experience has remained invisible, unnamed and underground” (2004, 172). Early miscarriage has remained invisible, unspoken (as opposed to Slee’s ‘unnamed’) and underground. I believe that feminist inspired men can join with women in seeking to address this situation in whatever ways are open to us. Miscarriage needs to be acknowledged by and within society, and not remain as a taboo subject few speak about. Society’s silence needs to be broken and people’s experiences need to be given a voice. Robert Bogdan and Sari Biklen describe giving voice as: "empowering people to be heard who might otherwise remain silent" (1998, 204) or who have been silenced by others.

Within the Christian tradition, male imagery and symbolism for God predominate. However, (as argued by Slee 1988, 4) there is a rich mine of female images; images of God as Mother, Midwife, Lady Wisdom, Housekeeper and Bakerwoman, which provide affirmations of women's experience. The image of midwife is very pertinent with regards to this study. Midwife is a female term now used to describe both female and male nurses who are trained in assisting childbirth. As a man researching amongst women, it was interesting to compare my role as a researcher to that of a male midwife. On looking at publications which examine the role of male midwives I note how important it is that patients have a right to decline care provided by a male nurse (Poliafico 1998, 40). Within the realm of this research project participants had every right to decline to take part, although clearly those who are hesitant about talking to a man about intimate bodily issues are not likely to have come forward as participants. However, it is insufficient simply to acknowledge that women have freely chosen either to participate, or not, in this project. As a male researcher I must take steps to address issues of power relations that still complicate and distort relations between women and men. This will include being aware of the complexities of gendered relations in my research

encounters, and not claiming to have a full understanding of what my research participants experienced.

In a recent contribution, Oakley re-appraises the arguments put forward in her 1981 publication (noted above) and discusses the way her work has been incorporated into a narrative about feminist methodology. She goes on to say: "Since the 1970s the research methodology literature has hugely benefitted from researchers' willingness to confront and discuss the ethics and practical realities of social research; this is a discussion that needs to be pushed further" (2016, 209).

I have great sympathy for all these research insights. I am aware my role remains problematic in the domain of feminist research. It is the view of some that empathy or sympathy of men cannot be the replacement for a deeper internal awareness of the sufferings or experiences of women as it is simply not possible for men to have the feelings of being women (Berliner & Fallen 2008, 6). This is something I must simply acknowledge as a male researcher. However, I come to this research with three decades of experience in ministry, in one parish. I recognise that I am not fully equipped to offer appropriate support following early miscarriage. Utilising my adapted version of John's Model (see Appendix 1), I have reflected on my role and what I am able to offer. Central to my reflection are the consequences of my actions for those in my care. As acknowledged in the Reflexive Prologue, my lack of knowledge has been a driving force behind undertaking this research journey to equip and enable me better to support grieving parents. I am motivated by the fact that women have reached out to me for pastoral support. Further, I have been inundated with volunteers to participate in my project and, subsequently, with requests to speak with me about their miscarriage. This I view as evidence of the legitimacy of my role as I seek to build on and develop my practice in this research process.

In this context, I return again to the aims of my research. In order to identify how ministers (and other pastoral care givers) might become better practitioners in their support of those who have experienced early miscarriage, I have interviewed women to learn from their experience. In doing so, this research

sought to be feminist in its methodology and make spaces for women's voices to be heard. In her *Handbook of Feminist Research,* Sharlene Hesse-Biber describes feminist research in the following way:

> It asks new questions: going beyond correcting gender bias in dominant research studies; centralizes issues of power, authority, ethics, and reflexivity in the practice of research; and is typically conducted at the margins of traditional disciplines. (2007, 16–17)

I am acutely aware that I need to be faithful to the research participants, not only in how I conduct the research but, in how the spoken word is represented academically in the written word. Kay Standing in *Writing the Voices of the Less Powerful* addresses this very issue when she says: "It is the ways in which we represent and interpret the women's voices which reinforces hierarchies of knowledge and power" (1998, 190). By presenting my own circumstances and reasoning for undertaking this journey, I hope that the readers of this thesis will be sufficiently informed so as to make their own judgement of how gender has affected this research.

### 2.1.2 Reflexivity and Credibility

In this section, I discuss the use of reflexivity to ensure that the research process was credible and the findings generated can be deemed as convincing. As noted above, this is essential particularly when making use of action research.

#### 2.1.2.1 Reflexivity

The feminist psychologist Sue Wilkinson argues that at its simplest reflexivity involves 'disciplined self-reflection' and distinguishes between three forms of reflexivity (1988, 494). First, 'personal reflexivity' which is similar to what others have termed 'self-reflexivity' (Lather 1993, 685) or 'recognition of self' (Pillow 2003, 181), focuses on the researcher's own identity where research becomes *an expression of personal interests and values* and is therefore an essential aspect of the feminist research paradigm. This form of reflexivity recognizes the reciprocal relationship between life experiences and research. Second, 'functional reflexivity' involves reflection upon the nature of the

research including the choice of method and the construction of knowledge in order to reveal assumptions, values and biases. Third, ‘disciplinary reflexivity’ focuses on the form and development of a discipline or sub-discipline; including, for example, how the traditional paradigm of psychology has operated to exclude women and stall development of a feminist psychology (Wilkinson 1988, 494-495). I have found it helpful to bear in mind all these three forms as I have developed my research project.

Another useful definition of reflexivity is:

> A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions. (Malterud 2001, 483-484)

As Swinton and Mowat observe, this means that,

> [p]ut simply, reflexivity is the process of critical self-reflection carried out by the researcher throughout the research process that enables her to monitor and respond to her contribution to the proceedings. (Swinton and Mowat 2006, 59)

Adopting such a reflexive approach ensures that the researcher and those who read their work are in a position to evaluate any influences the researcher might have had on the process.

Qualitative approaches acknowledge that the researcher and the research cannot meaningfully be separated (Koch 1998, 1187) and that neutrality is impossible. The values, assumptions, prejudice and influence of the researcher must be acknowledged and taken into account (Hand 2003, 29). Therefore, the role of the researcher should be subject to the same critical analysis and scrutiny as the research itself (Rice and Ezzy 1999, 41). Reflexivity is not simply an internal process of self-examination, its mechanisms need to be communicated to the readers of the research (Manias and Street 2001, 239). In

other words, a reflexive approach, the approach being adopted here, attempts to make the whole research process as transparent and open as possible.

I have travelled along a huge learning curve while carrying out this qualitative research project. Objectivity and neutrality were formerly always central to my thinking and approach. However, as Graham asserts, this approach is ultimately untenable since, “dealing with the realms of human value, meaning and understanding recognises that levels of interpretation are unavoidable” (2017, 5). Mark Constas writes that, “questions concerning the credibility and status of qualitative inquiry are related to the privatization of qualitative analysis” (1992, 253). He argues that researchers should make all aspects of their analysis open to public inspection. To do so is to be reflexive which is essential to ensure validity within and throughout the research process. Reflexivity entails being aware of one’s effect on the process and outcomes of research based on the premise that, “knowledge cannot be separated from the knower” (Steedman 1991, 53). In carrying out qualitative research, it is impossible to remain ‘outside’ our subject matter; our presence, in whatever form, will have some kind of effect. Being reflexive takes account of this researcher involvement. It has been proposed and accepted as a method that qualitative researchers can and should use to legitimize, validate, and question research practices and representations employed by themselves and others (Pillow 2003, 175).

Reflexivity particularly requires researchers to critically reflect on their research relationships to ensure that due consideration is given to the impact of unequal social relations, whether of gender, race, class, age or disability, and to the risks of reproducing relations of exploitation or disempowerment within the research. Being reflexive will help to address the interaction component of the interviewer-interviewee relationship, or, what Steinar Kvale called: “the asymmetrical power relations of the research interviewer and the interviewed subject” (2002, 9). Keeping a reflexive journal has been an important tool in my own research. It has not only been a data source contributing to my overall process of analysis, but has also provided a documented first-hand account of my reflections concerning interviewer bias and preconceptions that may have negatively influenced the findings.

Having begun this research process out of reflection on my current practice, I am very much aware of the claim by Mats Alvesson and Kaj Sköldberg that: "Reflection involves turning attention 'inwards' to focus on the researcher, the researched, society more generally, the intellectual and cultural traditions, and the 'problematic nature of language and narrative' in the research setting" (2009, 9). Reflexivity may trace its roots of dependency to this idea of reflection. However, it is necessary to differentiate this form of reflection and its use in the philosophical sciences from the use of reflexivity and self-reflexivity as methods in social science research (Pillow 2003, 177).

Corrine Glesne and Alan Peshkin caution researchers to be wary of the desire to justify their own experience. It is important to be interested in the topic, but a researcher cannot allow emotional attachment to,

> preclude the open, exploratory learner's attitude that is necessary for good data collection and analysis. (1992, 14)

Anselm Strauss and Juliet Corbin caution that: "The trouble is that researchers often fail to see much of what is there because they come to analytic sessions wearing blinders, composed of assumptions, experience, and immersion in the literature" (1998, 75). Norwegian philosopher Hans Skjervheim paraphrased a well-known parable, "we do not see the beam in our own eye because it is the beam we see with" (1996, 127). In order to address this (and be reflexive) I have kept a detailed journal. As evidenced in the Reflexive Prologue I have reflected on my own position and my research journal has provided the opportunity for me to examine critically my role within this research process. In the chapters that follow I describe each stage of my research to ensure validity.

Reflexivity is important as a means to demonstrate one's awareness of the difficulties of research and by raising questions serves as a means to validate and secure the research process. Indeed, in terms of my research, I am acutely aware of my own position and commend Wanda Pillow who advocates:

> the necessity of an ongoing critique of all our research attempts … with the realisation that many of us do engage in research where

> there is real work to be done even in the face of the impossibility of such a task. (2003, 92)

However, Zoë Bennett, Elaine Graham, Stephen Pattison and Heather Walton argue that reflection and reflexivity do not enable us to escape the problems that come from our own deep identification with ideologies and communities nor does it enable us to deliver research purged from the contingencies of our contexts. They write,

> those of us who seek to work reflexively *within* the theological tradition must become acutely aware that this also a discourse of power containing the same processes of repression, forgetting, unsaying, marginalisation and control that are evident everywhere else. (2018, 45 [their emphasis])

They go on to conclude that, "All research is impure and imperfect" (2018, 54). I argue that by evidencing reflexivity in my own research my role is being acknowledged.

#### 2.1.2.2 Credibility

Much has been written in the literature about credibility and validity yet there seems to be confusion as to the meanings attributable to each of the terms. In terms of this research, credibility refers to the procedures utilised to ensure that the methods were reliable and the conclusions valid. In turn, the definitions used by Denzin and Lincoln (1994) have been adapted and adopted:

> Validity, the degree to which the findings correctly map the phenomenon in question; Reliability, the extent to which the findings can be replicated by another researcher. (Denzin and Lincoln 1994, 100)

Credibility is a major concern for any researcher, particularly so when using qualitative methods. Quantitative studies have an established basis for determining validity through the use of pre-tested measures and scales which are open to statistical analysis. However, it should not be assumed that

quantitative researchers have a simple solution to the question of validity (Fielding and Fielding 1986, 68-69) since the act of analysis is an interpretation, and therefore (of necessity) a selective rendering. Indeed, Amanda Coffey and Paul Atkinson regard analysis as the, “systematic procedures to identify essential features and relationships” (1996, 9). Analysis is, therefore, a way of transforming the data through interpretation.

There are many different approaches and traditions within qualitative research and therefore there are widespread concerns about quality. Regardless of the methods utilised there is a need to show that any findings are the result of a robust, defensible and rigorous process. That way, any claims that come to be made will be the result of evidence-based research, producing well-founded and plausible arguments that others who have similar experiences will recognise (Miles, Huberman and Saldana 2014, 312).

Some researchers recommend that the rigour of qualitative research findings should be judged using the same criteria and terminology that have been constructed to test the validity of quantitative studies (Cutliffe and McKenna 1999, 374; Silverman 2005, 223-224). Indeed, Martyn Hammersley asserts that researchers are not simply faced with a stark choice between words and numbers, or even between precise and imprecise data, but rather a range from more to less precise data (1992, 163). Indeed, John Cutliffe and Hugh McKenna, in reviewing published literature, argue that it is inappropriate to use quantitative terms as a measure of credibility for qualitative research and that the researcher must make explicit what means have been used to establish such credibility (1999, 379). This is especially true when small sample sizes are used. A qualitative researcher has to show that any findings reported are genuinely based on critical investigation of all the data gathered and are not dependent on a few well-chosen examples – this is described by David Silverman as the problem of ‘anecdotalism’ where many qualitative researchers present, "a few, "telling" examples of some apparent phenomenon, without any attempt to analyze less clear (or even contradictory) data" (Silverman 2001, 34). This anecdotal approach to the use of data means that brief conversations and snippets from unstructured interviews are used as evidence to support a

particular theory when, in fact, the representativeness of such fragments is not discussed (Bryman 1988, 77).

There are no validated instruments or standardised methods which all qualitative researchers must use. However, the researcher must demonstrate rigour to ensure credibility that their findings reflect the experience of the group (or phenomena) under investigation. The Cabinet Office of the British Government (2003) has developed a useful framework for evaluating qualitative studies. The framework suggests eighteen questions (see Appendix 2) that can be applied to any piece of qualitative research in order to check its reliability. Not all eighteen questions have to be answered positively, but the more that can be, the more likely the research is to be reliable and accepted by others as such.[41]

One way of attempting to assess whether qualitative data is credible is when others recognise the experiences after having read accounts of them (Guba and Lincoln 1981, 110). Cutliffe and McKenna take this a stage further when they argue that the most useful indicator of the credibility of a study is when the practitioners themselves, as well as the readers of the theory, regard the findings as meaningful and applicable in terms of their own experience (1999, 379). However, more strenuous attempts are required to establish the credibility of qualitative research if it wants to gain and maintain credibility in contexts dominated by scientific paradigms (Schutz 1994, 416). In order to establish credibility in such situations, Guba and Lincoln (1989, 122) recommend that researchers leave an audit trail so that decisions made in the data analysis can be checked. Matthew Miles and Michael Huberman recommend 'memoing' which,[42] in addition to being another important data source in qualitative research, record what the researcher hears, sees, experiences and thinks in the course of collecting and reflecting on the process (1984, 69).

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[41] In terms of my own research, I have attempted to address each of the eighteen questions and in the writing up of this Thesis have sought to provide information to enable my readers to make a judgement on its credibility.

[42] Memoing will be discussed further within 2.2.7 'Interviewing'.

### 2.1.3 Section Summary

In this section, I have summarised the theoretical framework adopted for my research and indicated the importance of conducting the research in a way that is reflexive to ensure validity and credibility to any findings. In doing so, I acknowledge my own position and the way it affects both the research process and the outcomes that follow.

> A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate and, the framing and communication of conclusions. (Malterud 2001, 483-484)

By being reflexive I acknowledge that social researchers cannot be separated from their autobiographies and will bring their values to the research and how they interpret the data (Devine and Heath 1999, 27).

Having previously disclosed my personal interest in miscarriage, and as such my desire to add meaning and understanding to my own experience, it was essential to highlight the steps taken at each stage of the process. This enables the readers of this thesis to be aware of the lens through which I have undertaken the research. In the section to follow, I will describe the methods employed and each step of the research process. I paraphrase Bennett, Graham, Pattison and Walton: “there is important work to be done and [I am] seeking the best possible ways to do it.” (2018, 44.)

## 2.2 Methods: Telling The Story

This section sets out the reasoning behind the methods employed in order to allow the participants to *tell their story*. Under the subheadings of Interviewing, Interview Questions, Ethical Considerations and sample size I shall highlight my reasoning for adopting the approaches taken.

### 2.2.1 Interviewing

Interviews have been chosen as the principal means of generating data in this research as they allow the subject to use their own words and provide a richness

of information rooted in the individual's experience. They have been described as yielding, "rich insights into people's biographies, experiences, opinions, values, aspirations, attitudes and feelings" (May 2001, 120). Kvale remarks that the qualitative interview, "is literally an inter view, an interchange of views between two persons conversing about a theme of mutual interest", where the researcher attempts to, "understand the world from the subjects' point of view, to unfold meaning of peoples' experiences" (1996, 1-2). An interview is: "a face-to-face verbal interaction in which the researcher attempts to elicit information from the respondent, usually through direct questioning" (Gillis & Jackson 2002, 466). According to Shulamit Reinhartz and Lynn Davidman, "interviewing offers researchers access to people's ideas, thoughts, and memories in their own words, rather than the words of the researcher" (1992, 19). Philip Barker (1991, 213) claims that the undisputed advantage of interviews remains the richness and spontaneity of the information collected which is greater than through a self-reported questionnaire. Interviews also allow the participants to choose their own words and to make their point directly to the researcher.

In the *Handbook of Qualitative Research,* Andrea Fontana and James Frey claim that the interview subject, who is described as the 'other', "is no longer a distant, aseptic, quantified, sterilised, measured, categorized, and catalogued faceless respondent, but has become a living human being, usually a forgotten or an oppressed one... up to now sociologically invisible, finally blossoming to full living colour and coming into focus as real persons, as the interviewer recognizes them as such" (2005, 696). In other words, researchers are realising that interviews are not neutral tools for gathering data but active interactions between individuals which in itself leads to negotiated, contextually based results (Fontana and Frey 2005, 698).

Using more focussed rather than an open-ended interviews provides more structure and control for the researcher (Miles and Huberman, 1994). However, I chose to use semi-structured interviews as they provide some coherent framework which makes it easier to interpret the responses (May 2001, 123). Peter Wimpenny and John Gass argue that research questions must arise from the researcher and therefore a conceptual map of the issue already exists (2000,

1490). However, Barney Glaser, from a grounded theory perspective, recommends that researchers should set out with no preconceptions and allow their subjects to lead their thinking (1992, 104). This is difficult to achieve.

There are undoubted benefits of interviewing but there are also inherent weaknesses that require to be acknowledged. The literature points out some of the disadvantages of interviewing (Burns and Grove 2005, 397-398; Polit and Hungler 1995, 132-133). They are time-consuming in terms of planning, travel, and the length of the interview itself. They take a lot of time to transcribe, analyse and code, and the quality of the data generated is largely dependent on the skills and expertise of the interviewer (Guba and Lincoln 1981, 187-188). Whenever people's experiences are taped and transcribed, the interpretation of the transcripts can be dramatically weakened by the failure to record apparently trivial, but often crucial, pauses and overlaps (Silverman 2005, 183). Also, it is tempting to treat the verbal responses gathered in an interview as an appropriate substitute for the observation of what actually happens in practice (Heritage 1984, 236).[43] These issues will be addressed under the title 'Credibility' below.

### 2.2.2 Ethical Considerations

When conducting research, Sharlene Hesse-Biber and Patricia Leavy (2005, 97) offer the following advice:

> Bear in mind that it is you, the researcher, who has initiated this process and involved others (your subjects). Consider this carefully as you contemplate your ethical obligations to your research participants, but as you think through these issues, do so with your own 'humanness' in mind – be realistic and fair to all involved.

Ethical research conforms to a set of moral principles and practices which aim to prevent any participant from being harmed as a result of the research (Liamputtong 2009, 37). Ethical theories provide a framework which contains the

[43] As John Heritage noted in his exposition of the writings of Harold Garfinkel, while referring to Harvey Sack's development of conversation analysis.

principles that might help determine an ethically appropriate action. Utilitarianism is an ethical theory that gauges the worth of an action by its consequences and states that we ought to do the greatest good for all persons affected. Deontological theories state that acts have intrinsic properties that make them right or wrong – not simply their consequences. In terms of conducting a research study, it is necessary to look at how these theories impact on such issues as the sample used and the methods employed for recruiting the participants, as well as the research itself. This is the approach advocated by Tom Beauchamp and James Childress (2009, 99-140). In order to achieve this, it is necessary to look at four principles contained within both theories:

- beneficence – acting in such a way as to benefit others;
- non-maleficence – causing people no harm;
- respect for autonomy – the ability to decide an act on the basis of reason, be self-determined;
- justice – what is the fairest thing to do.

It must be recognised that by taking part in my research the participant would be recounting sad and emotional memories of their experience at a time of loss, which, in itself, may be harmful and may fall into the category of maleficence. This research project involves vulnerable people and so care was exercised to make sure they were informed that the study might evoke painful experiences (Liamputtong 2009, 32). Steps to address this problem included following the University processes and obtaining ethical approval (see Appendix 3). This study involved interviewing women who have lost a child during the first 20 weeks of pregnancy, which (of course) is a sensitive and sometimes confidential subject. However, a decision was taken only to involve participants whose miscarriage had taken place more than ten years previously – thereby ensuring that a significant time period has elapsed. Furthermore, by self-selecting to take part in this research it might be assumed women were willing to talk about what they experienced.

The Participant Information Sheet acknowledged that miscarriage is a very sensitive and emotional issue which is not often spoken about.[44] Listening to the experiences of women, some of whom are retelling their story for the first time, required great sensitivity. Due to the nature of this research, I ensured the participants' needs were central in all stages of the process. It is acknowledged that the nature of the relationship between the researcher and participants was vital in ensuring that those who had volunteered to participate felt safe, had trust in the researcher and that support mechanisms were in place. As stated by Declan Fahie in an article about doing sensitive research sensitively:

> Providing interviewees with a voice to articulate their, sometimes, distressing stories is a privilege. [45] It is incumbent on researchers, both novice and experienced, to ensure that their research journey is ethical, methodologically sound, moral, and ultimately, honest. (2014, 30)

As already noted, this is an area of sensitive research as it involves the private sphere of women through deep and meaningful conversations about their life experience which may not have been previously voiced (Robertson 2000, 531-532). In acknowledging this, the risks and benefits of the research need to be balanced. The reminder by Hesse-Biber and Leavy quoted at the beginning of this section informs me that having initiated this process I must "contemplate [my] ethical obligations to [my] research participants … and be realistic and fair to all involved" (2005, 97).

Alexander Capron considered that respect for people is the recognition of participants' rights, including the right to be informed about the study, the right to decide whether to participate, and the right to withdraw at any time (1998, 182-183). This study sought to gain an understanding of what people actually experience so that those who are called upon to offer support are better equipped. All the participants gave informed consent, following the procedure

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[44] See Appendix 4.
[45] An Irish Research Council Post-Doctoral Research Fellow.

recommended by the University of Glasgow.[46] The principle of informed consent aims to ensure that,

> the provision of information to participants, about purpose of the research, its procedures, potential risks, benefits, and alternatives, so that the individual understands this information and can make a voluntary decision whether to enrol and continue to participate. (Emmanuel, Wendler, and Grady 2000, 2703)

As part of the informed consent process, the participants were also informed that the research was being carried out as part of a postgraduate thesis towards the award of D.P.T. (Doctor of Practical Theology) based within the School of Critical Studies, University of Glasgow, and also of the potential outcomes.

### 2.2.3 Sampling Strategy

Unlike quantitative research, qualitative research normally involves a small sample of subjects that are purposively selected because the researcher thinks that they can best contribute to an accurate understanding of the issue (Wright and Schmelzer 1997, 74). As already noted, this is in contrast to most quantitative studies which use large numbers to make a claim of being able to generalise to the population as a whole. But sampling is a major problem for any kind of research. As Howard Becker points out, it is impossible to study every case of whatever we are interested in, and that every study tries to find out something that will apply to the whole by studying a few examples (1998, 67).

Convenience sampling was utilised in this study as it uses the most readily available and accessible people (Polit and Beck 2009, 309 & 319).[47] A major disadvantage of this method of sampling is that those who chose to take part may be atypical of those who have experienced early pregnancy loss, and it must be acknowledged that there will be different experiences of miscarriage. My data reflects this and, as highlighted within the limitations section of Chapter 5,

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[46] See Participant Information Sheet (Appendix 4).

[47] Convenience sampling is a specific type of nonprobability sampling in which people are sampled simply because they are "convenient" sources of data for researchers (Battaglia 2008, 149).

further research would be welcomed. Also, while conducting the interviews as a researcher, all of the participants knew that I was a minister and, to some, was their minister. That, in itself, constitutes a pastoral relationship. However, I had no involvement (and/or knowledge) of their miscarriages either because I was not their parish minister at the time (in 11 out of the 12 participants) or was not informed (in the case of the twelfth participant). However, being known to the participants, even at a distance, may have had an influence on their decision to take part. It cannot be ruled out that some of the participants volunteered because they were favourably disposed to their own minister, and so wanted to share in this research. On the other hand, the contrary may also be true.

Thought must be given to why participants wished to volunteer. Early pregnancy loss is a deeply emotional matter and one that they have learned to live with over the years, it was still something that was asked during the interview process. Historically the Hawthorne Effect (a term first coined by Henry A Landsberger in 1950) – that is, the effect on responses by the knowledge that the participant is taking part in a research study – is cited. However, the participants voluntarily agreed to participate out of interest in the research question rather than through obligation, therefore, their experiences, feelings and emotions must be valued. That is, cognisance needs to be taken of the effect on responses generated by the knowledge that participants are taking part in research. However, in an article in the New York Times by Gina Kolata, Richard Nisbett is cited as calling the Hawthorne Effect a 'glorified anecdote': "Once you've got the anecdote … you can throw away the data" (Kolata 1998, para 5). This is very dismissive, but it helps to bring to the forefront the power of anecdote and narrative. That is why full and thorough research is required, and particularly so in this study. It would be easy to find a very emotional, heart-wrenching quote from one grieving parent and assume every grieving parent is going through the same kind of experience. This clearly cannot be assumed.

### 2.2.4 Sample Size

In this section, I will give some consideration (and therefore justification) for my choice of sample size.

In a systematic analysis of their own data from a study of sixty women, Greg Guest, Arwen Bunce and Laura Johnson concluded that for studies with a high level of homogeneity among the population, "a sample of six interviews may [be] sufficient to enable development of meaningful themes and useful interpretations" (2006, 78). Other researchers have tried to suggest guidelines for qualitative sample sizes. Kathy Charmaz suggests that 25 participants are adequate for smaller projects (2006, 114); Jane Ritchie, Jane Lewis and Gillian Elam view the ideal number as being less than 50 (2003, 84); Green and Thorogood conclude that no new data emerges from transcripts after the first 20 interviews (2009, 120).

The sample size for this study was 12. The number was chosen deliberately to be in excess of suggested minimum sample sizes, for example, six (as above) or ten (Atran, Medin and Ross 2005, 753; Creswell 1998, 65 & 113). It would be unethical to conduct more interviews than is necessary to gather the data required for the study, however, my inexperience as an interviewer was (in part) compensated for by a slightly larger sample size. It would also allow for any unforeseen issues arising during the interview: for example, the failure of the recording device or participants wishing to withdraw from the study after data collection had been completed.

### 2.2.5 Risk Assessment

In accordance with University procedures a Research Ethics Risk Assessment and Management plan was carried out which can be found in Appendix 5. This process alerted me to the potential risks of the interview process to both the participant and the researcher. I identified what these risks were and how they might be managed. I also noted any mitigating factors. At each stage of the research journey, I was conscious that the topic under discussion was a sensitive one which might cause distress to those taking part. Confidentiality was another issue that needed to be at the forefront of my mind. Some were speaking about their miscarriage perhaps for the first time and would not want their identity to become known, or that they were taking part in this research project.

### 2.2.6 Confidentiality and Consent

Confidentiality was maintained in accordance with the university's guidelines.[48] All personal details were anonymised. The recordings and transcripts were kept in a locked filing cabinet within the researcher's study (at home) and will be destroyed upon completion of the thesis. Electronic copies were stored on a password protected computer, also located within my study and will be treated similarly.

As already noted, before beginning each interview the participants were asked to give informed consent (see Appendix 6). I reminded them that I was there as a researcher and stressed that I would not respond to any matter raised in the interview that was outside the research question, though I would, afterwards, arrange to meet and discuss any such matters as their minister at a later date. Each participant was also reminded that the Participant Information Sheet contained contact details of a retired colleague who would be willing to offer pastoral care, or arrange for someone else to provide pastoral care, should they request it following the interview or upon reading the transcript of the interview. It was emphasised to each participant that they could halt the interview and withdraw from the study at any time. In such cases, all material gathered would be destroyed. Copies of the transcript were made available for comment and/or amendment to ensure that the participant was content that it reflected what they had intended to say. Only one participant took up the offer to read the transcript, after which she replied simply wishing me every blessing with this important work.

In order to anonymise the data, each participant was assigned a code name (F1, F2, etc) which was used to identify the audio recording, transcript and field notes.

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[48] The University of Glasgow, College of Arts Ethics Committee Guideline - Ethical Issues in Interviews http://www.gla.ac.uk/colleges/arts/research/ethics/

### 2.2.7 Pilot and Main Study Interviews

Having explained my methodological approach and the methods employed in carrying out my research, this section gives an outline of the interviews, both for the pilot and main study.

During the period while I was awaiting ethical approval, I received approaches from several individuals who wished to talk with me about their miscarriage. I had to decline to talk with them within the confines of the study I was undertaking, but I did agree to meet with them as their parish minister, solely in a pastoral capacity. One was a mum who had lost several babies through miscarriage (within the ten year parameter). She realised that it was outwith the scope of my research but wanted to speak with someone who, in her words, "knew a wee bit about what she was going through." A wife and husband asked me about how they should deal with friends who had just lost a child. In conversation, I sensed that while a friend had miscarried, this was being used as an opportunity to discuss their own grief as it became apparent that they had experienced more than one miscarriage. I was also contacted by one woman who had experienced her miscarriage over fifty years previously, and spontaneously (with obvious emotion as she started to cry) mentioned the actual date of the loss. To be anxious to talk about an event fifty years in the past indicates that the event in itself must have had a major impact on the individual. The final approach that was made outwith the study parameter was from a mother who simply hadn't taken in the fact that the study was for those who had lost a child at least ten years previously.

These requests and encounters provided anecdotal evidence, which backed up by the lack of literature, that there was a significant lack of support and understanding for those who had experienced early miscarriage.

#### 2.2.7.1 Pilot Study

My primary motivation for conducting a pilot study was to gain experience in interviewing and to inform the construction of my prompt questions. It also served to familiarise myself with transcribing and carrying out data analysis. However, as often happens, it generated information that was hugely significant

for my overall project and as I had ethical permission to use this, I was glad to include it as an important aspect of my work. The three interviews not only informed my interview questions and technique, they also generated a wealth of data that deserves to be acknowledged and recorded.

The women were all from within my own congregation who had experienced an early pregnancy loss at least ten years previously. They were interviewed using a series of prompt questions (Appendix 7). These were sufficiently structured to meet the aim and objectives of the study) while ensuring that the data collected were consistent (Brink 1989, 165).

Each of the participants had formed a view as to the purpose of the research. Their view was largely self-constructed as the invitation to participate came from a brief article in the parish magazine saying I was undertaking academic research into the religious and spiritual support needs of parents who had lost a child during early pregnancy. The participants had sought me out simply to talk about their own past events. In fact, it became quite a challenge to postpone our discussion until I had reached the point of obtaining ethical approval and making arrangements for an interview to take place. I had been unaware that any of these women had suffered a miscarriage, even though I knew two of them extremely well having been actively involved as their minister: for one, during a prolonged illness and for the other having known her for over twenty years, having conducted funerals, weddings and baptisms for immediate family members.

From the initial contact, there was no doubt in my mind that their miscarriages had been suppressed not necessarily from their own consciousness (that would be determined within the interview) but from discussion with others. These mothers had been deeply affected by their miscarriage. Indeed, even at this initial contact stage (and for two it was within a very public setting) there were tears. These women who were to become research participants were (in my opinion) desperate to talk, they were desperate to help, and they desperately wished for something positive to be the result.

One phrase from the pilot which still echoes in my mind was: 'I know this is not what you want to hear!' It was only used once during the formal recording of the interviews. However, my journal notes had the phrase (or variations of it) at least four times in each case, either at the invitation to participate stage, immediately prior to switching on the tape recorder or after the recorder was switched off. The more I reflected on this, the more I became convinced that these participants were sharing with me their experience of miscarriage, as they remembered it and have reflected on it over the years, regardless of whether it would help my research question or not. Furthermore, these comments were pointing towards a deeper issue, that being, the 'unspeakable' nature of early pregnancy loss for many women.

On completion of the pilot, the initial prompt questions were supplemented and adapted prior to commencing the main study (Appendix 8).

#### 2.2.7.2 Main Study

The main study consisted of twelve interviews. I have already detailed the process followed in terms of obtaining my sample and the conduct of the interviews. In this section, I will briefly comment on the interviews themselves, much of which was derived from my field notes (a summary of which can be found in Appendix 9).

Participants for the main study were sought by issuing information notices in my church magazine which goes to every member. Such notices were also sent to fourteen colleagues, in my own and neighbouring Presbyteries, who agreed to include them in their own church magazines. In addition, I made contact with three local Presbyteries and requested that my notices be issued to local parishes.[49] Two participants were recruited through Presbytery contact, the rest through my own magazine and word of mouth thereafter. Those who made contact were made aware of the purpose behind the research, the exclusion criteria and a clear statement that the research findings would be used to

[49] A Presbytery consists of a group of churches within a geographical area and has monthly business meetings at which ministers and representative elders attend. This allowed for contact with approximately 180 congregations. Since I received the required number of participants there was no need to follow-up or widen the geographical search.

produce a thesis.[50] They were also informed that I am a parish minister researching how I (and other pastoral care givers) might better support women who have experienced early miscarriage. A demographic profile of the participants can be found in Appendix 10.

Each volunteer was asked for their preferred location for the interview. Ten selected their own home. Two of the interviews took place in other locations, one in the person's own church vestry and the other in the vestry of my church. Prior to conducting the interviews, I carried out a risk assessment which can be found in Appendix 5. Only one participant (F12) brought another person with her for support (her mother). The meetings lasted approximately two hours in each case. However, some of this time was spent in informal conversation to put both the researcher and the interviewee at ease. The recorded interviews varied in length from twenty five minutes to one hour and twenty minutes.

These interviews were also audio recorded which allowed for the reproduction of a complete and accurate account of what was actually said, rather than relying on my selectively taken notes, which increased data reliability (Holloway 1997, 94-95). As a technophobe, the caution issued by Kirsten Easton, Judith McComish and Rivka Greenberg (2000, 704) that equipment failure and environmental conditions might seriously threaten the research undertaken, was borne in mind. They advise that the researcher must at all times ensure that the recording equipment functions well and that spare batteries, tapes, and so on, are available. This proved to be sage advice. The Interview with F11 had to be paused twice as the batteries ran out of power and, after replacing, the recording device stopped working for some reason. I then finished the interview using the recording function on my mobile phone.

Field notes (or memoing) are a secondary data source in qualitative research. It is the researcher's field notes that record what the researcher hears, sees, experiences and thinks in the course of collecting and reflecting on the process (Miles & Huberman 1984, 69). Since the human mind tends to forget quickly,

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[50] Via the Participant Information Sheet.

field notes by the researcher are crucial in qualitative research to retain data gathered (Lofland & Lofland 1999, 5). The researcher must be disciplined to record, subsequent to each interview, as comprehensively as possible, but without judgmental evaluation, for example: “What happened and what was involved? Who was involved? Where did the activities occur? Why did an incident take place and how did it actually happen?” (Groenewald 2004, 15). However, field notes in themselves involve interpretation and so must be seen as part of the analysis rather than data collection (Morgan 1997, 57-58).

I took copious notes before and during each interview recording such things as setting, ambience, location of the participant in relation to the researcher, the participant’s poise and posture. I paid particular attention to the participant when there was a prolonged silence and correlated their hand movements or whether there were tears in her eyes.

Immediately after the interview, and on returning to my car, I jotted down some immediate impressions as to the session and what happened. Thereafter, later in the evening, I made time to reflect on the interview itself and write a reflective summary.

My initial reflections on the interviews echoed those of the pilot study. The interviewees wished to assist me in my research which was often referred to as being very important. However, the motivation behind participating was to do something that would be of help to others who are going through what they experienced. The creation of the I-Poems and coding analysis in chapters 3 & 4 present the details of what was recorded in the interviews. Yet, it appeared obvious that these women did not receive what they would have viewed as appropriate support.

### 2.2.8 Data Analysis

Following each interview, the audio recording was listened to several times as recommended by Holloway (1997, 94-95) so as to become familiar with the words of the participant in order to develop a holistic sense of what had been said. The interviews were then transcribed before being analysed. The

transcripts were read through several times to get a greater understanding of the contents. As will be discussed in detail in the next chapter, I-Poems were created, and thereafter a thematic categorical approach was employed as advocated by Burnard (1991, 461). This enabled descriptive codes to be attached to responses that follow a similar theme. These were then sub-divided for ease of analysis. Following the identification of these codes, they were grouped together in a thematic way to reflect any common patterns elicited from the data.

Great care was taken in interpreting the data obtained. It is acknowledged that in qualitative studies the research and the researcher are not unconnected (Hand 2003, 15-16). Therefore, as Helen Hand (2003, 18) suggests, self-critique is vital in attempting to achieve rigour by making every stage in the process open and transparent. Another issue to be considered is the limitation of interviews themselves. Interviews, as a method of data collection, may not represent what actually happens in the 'real world' (Robson 1993, 126). That said, by recording the interviews, the actual words of the participants can be quoted which are in turn an expression of their inner feelings and thoughts.

### 2.2.9 Educational Intervention and 'Focus Groups'

As has already been mentioned, this study fell into two separate stages. The first addressed the first three research objectives and provided the data required to carry out the second. Having analysed the data from the interviews of the twelve participants who had experienced early pregnancy loss, this was then presented to three groups of ministers as an educational intervention/resource for their ministry. This was done through the vehicle of ministers fraternals. It followed the plan as per Appendix 12 and had as its aim: to learn of current practice, educate about the need for support and explore how current practice may now change. In order to facilitate these aims I identified three outcomes for each session:

- ministers should become more aware of the frequency of early miscarriage.

- ministers should recognise the support needed following early miscarriage.
- ministers should reflect on their future practice in light of what has been learned.

In the context of my research, the fraternals functioned as 'focus groups' in that I asked members to reflect upon their current practice and the impact of my educational intervention. I also asked members if they were motivated to change their current methods of supporting grieving families in the light of what they had encountered and learned.

Focus groups are considered a socially orientated process and a, "form of group interview that capitalizes on communication between the research participants in order to generate data" (Kitzinger 1995, 299). A focus group generally consists of seven to 12 individuals who share certain characteristics relevant to the focus of the study (Marshall & Rossman, 2006). Focus group interviews are becoming increasingly popular within qualitative research as they explore what individuals believe or feel in addition to why they behave in the way they do (Rabiee 2004, 655). Focus group research is quite simply a way of collecting data by utilising a small group in discussion which is focused around a particular topic or set of issues (Wilkinson 2004, 177). Focus groups are often supportive by nature, particularly when they are composed of people with similar concerns. Rosaline Barbour indicates that such groups offer participants a relatively safe environment in which to share their experiences and also address any power imbalance between the researcher and the participant by taking advantage of the naturally occurring peer group (2005, 743). The focus group sessions were approached using the same ethical principles as per the interviews and a 'Research Ethics Risk Assessment and Management Plan' was prepared for them (See Appendix 11).

The whole educational intervention session was audio recorded, not just those parts where participants were specifically asked to contribute, as questions or comments at other times would constitute data in their own right. It was also useful to issue an evaluation form which provided me with guidance, suggestions

and perhaps more data which would assist in presenting future educational interventions.[51] In designing the form, I kept in mind that this was an evaluation of the session and of whether the learning outcomes had been met. Francis Quinn and Suzanne Hughes (2007, 185) are of the view that learning outcomes and assessment of learning are inextricably linked, in that assessment normally requires the student to demonstrate achievement of the learning outcomes. To do this using little time after a short session required the evaluation form to be easy to answer, as a lengthy questionnaire with open questions would take too long to complete, may not get the attention it deserves, and be difficult to analyse (Reece and Walker 2007, 413). In addition, I was aware that if the participants' expectations of what it was they were being invited to participate in had not been met, it would be useful to have feedback as to why not. This would serve as an indicator that my communication, in advance, was lacking.

An opportunity was also given for general feedback. At the end of the evaluation form, I left space for any other comments the participants felt would be helpful for the planning and delivery of such a session to future groups.

Like the one to one interviews, the data generated by the focus groups were transcribed and analysed. This proved to be very time consuming, and with the benefit of hindsight it would have been beneficial to have someone to moderate the group sessions allowing me to concentrate on taking notes while watching the dynamics of the interactions between group members. Indeed, the data gathering process would have been much improved if the sessions had been video recorded as it proved very difficult to adequately note who was speaking at any given time as well as watching for body language cues.

According to Krueger (1994, 77), rich data can only be generated if individuals within the group are prepared to engage fully. To this end, he advocates the use of homogenous groups. This was the case for this research study as the focus groups members were all parish ministers from within a limited geographical setting, and who were known to each other. They consisted of varying levels of

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[51] See Chapter 4 and Appendix 18.

experience in ministry, were of mixed ages and sexes. However, on average two thirds of the fraternal members were female. This raised the question as to why? Even though there is an increasing number of women entrants into ministry (now making up more than half), there is still a historical predominance of male ministers. Were male ministers disinclined to take part? Did they view the topic under discussion as something not relevant to them? This would take further research to identify the reasons. However, it was disappointing as this research study was about improving one's practice as a minister and being better equipped to offer a more appropriate pastoral response.

Another disappointment within this stage of the research was the difficulty of getting ministers' fraternals to agree to take part. I had initially set out to use six fraternals to present my educational intervention. Contact was made via my local Presbytery which has eleven fraternals within its bounds. Despite there being an initial positive response, only one actually agreed to take part. I made direct contact with colleagues in other geographical areas with whom I have a personal relationship to ask if they would arrange for their fraternal to take part. This resulted in two other groups being arranged. One of these groups consisted of several students in training for the ministry. The difficulty in obtaining six focus groups was personally disappointing in that colleagues were not prepared to help with my research, while at the same time learning something that may be beneficial to their ministry. The lack of clergy response in relation to miscarriage research was commented on by Puneet Singh, Kearsley Stewart and Scott Moses who were examining the role of ritual via a mailed survey and received a response rate of only 4.6% (2004, 52).[52]

Despite setting out to present to six fraternals, after discussion with my supervisor and extending my request to three other Presbytery areas without a positive response, we agreed to settle with three.

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[52] Singh, Stewart and Moses quote Therese Baker who claims that a mail-in survey would typically have a 50% response rate, improving to 70% with rigorous follow-up (1999, 216). Their own response rate was 4.6% from 500 surveys issued with follow ups.

### 2.2.10 Section Summary

In summary, this section has reviewed the methods employed and their suitability for allowing the participants an opportunity to tell their story.

## 2.3 Chapter summary

This chapter has presented the reasoning behind my methodological approach and of the methods employed in carrying out my research project. I have also noted a few reflections on both my pilot and main study interviews.

# Chapter 3 - Hearing the Story

Having given the research participants the opportunity to recount their experiences of early pregnancy loss, this chapter presents their accounts. This work represents an act of story-sharing that for many participants was taking place for the very first time.

Given the unusually sensitive and yet powerful nature of the stories the interviewees shared, I quickly became convinced that the familiar processes through which narratives are translated into data in much social research would be inappropriate in this case. I needed to find ways to engage with narratives that preserved their integrity and would enable them to speak powerfully to others. I, therefore, decided to employ two forms of data analysis and presentation. The first of these entailed the construction of I-Poems. These are vivid 'first-person' articulations of experience that are increasingly used when accounts of experience have a quality of testimony to them. The second form of analysis, which will be presented in the following chapter, is the more familiar one of engaging attentively to qualitative material in order to develop coding categories that identify and articulate key themes.

## 3.1 I-Poetry

As I progressed in my research I gave some considerable thought as to how I would convey the stories of my participants to others. I had contemplated using anonymised case studies. However, at the Practical Theology Summer School in Twickenham (July 2017) one of the participants presented a paper in which she described her use of I-Poems. Her research focus was completely unrelated to mine but on hearing her presentation I immediately realised the potential of this form and began to see my data in a new light. I grasped how the stories I had been privileged to hear might be presented in a more meaningful way.

The use of poetry has gained legitimacy as a rigorous, substantive, and valuable contribution to qualitative research in recent years. It provides a dynamic and creative means for a researcher to document lived experiences (Zambo and Zambo 2013, 4). Creating poems has, therefore, become an extremely important

resource for many qualitative researchers (Ely, Vinz, Downing and Anzul 1997, 136). Ivan Brady claims that, “poetic processes can be used both as tools of discovery and a unique mode of reporting research, that there are activities and domains of participation in life that can *only* be accounted for realistically with qualitative methods, with poetic-mindedness” (2009, xv). Indeed, sifting through data is the process of synthesising meaning from prose and is, in itself, a work of creative making (Glesne 1997, 205-207). Furthermore, poetry represents an imaginative awareness of experience that is expressed through meaning, sound, and rhythmic language and which also evokes an embodied response (see Flanagan, 2007).

Poetry enables findings to be represented in ways that give additional impact to the data, and a resonance to silenced voices: seeking to reveal the diversity of people, emphasising the complexities of lived experiences, allowing voices to be heard, and, “captur[ing] the essence of the how, the why, the what” (Carroll, Dew, and Howden-Chapman 2011, 624). Crucially, it is a means to say what might not otherwise be said (Cahnmann-Taylor 2009, 14).

However, using poetry as a means of data presentation and analysis is controversial. A literature review conducted by Monica Prendergast identified more than forty different terms associated with the use of poetry in research (2009, xx-xxi). She goes on to reference various authors who urge caution when using poetry for research purposes. Their concerns are that the use of poetry may push the boundaries of traditional research as it interrogates dominant narratives and is unfamiliar.

However, resistance to the use of poetry in research might also demonstrate an allegiance to particular epistemological and methodological approaches. The use of poetry is more likely to be criticised, for example, by those who adhere to a positivist paradigm in research and are seeking to generate data that they believe objectively represents a particular context or experience. In contrast, it is likely to be favoured by researchers who have a critical or constructive approach to the generation of knowledge as it can interrogate dominant narratives, as it presents what is unfamiliar in new forms and it pushes the

boundaries of traditional research practice. Furthermore, as Marlene de Beer argues, poetically represented data is also particularly suitable in conveying dynamic tensions in categories and feelings, and engaging with uncertainty and ambivalence (de Beer, 2003, para 2). In other words, it is an important way of expressing complex feelings and understandings which may not have settled into coherent narrative forms. Therefore, poems are an effective research tool (within action research in particular) to enable people to find their voices and express their insights (Sullivan 2005, 117).

One increasingly popular method of using poems within research is to construct I-Poems. I-Poems are developed differently from poems which are created as imaginative works in order to respond to particular themes and contexts. Rather, they are constructed following data analysis based on the 'Listening Guide' designed by Carol Gilligan (1982).[53] This process guides the listener in tuning in to the story being told on multiple levels and to experience, note, and draw from his or her resonances to the narrative.

The 'I'-Poem method of interview analysis is, therefore, faithful to how participants represent themselves in interviews because it focusses on first-person statements (Edwards and Weller 2012, 203). It provides a means for the participant's own words about their own experiences to be heard very directly by the researcher. It is a means whereby the individual can be heard *before* the researcher produces an abstract, analytical account of their story. As Mikel Brown and Gilligan say, I-Poems focus on, "how she speaks of herself before we speak of her" (1992, 27-8).

In terms of this research study, I-Poems are extremely useful since they display interviews in the process of accessing meaning in relation to themselves (Edwards and Weller 2012, 204). I-Poems provide an opportunity to take extracts from an interview and present them in a way which allows a re-telling of the

[53] "Researchers using the *Listening Guide* first interrogate their data in order to understand who is speaking, to whom, in what order, and why. Important to this method is uncovering each individual's narrative in terms of the context (where they are), the characters (who is there), and the plot (what is happening, when, with whom, and why)" (Zambo and Zambo 2013, 5).

participant's story using the participant's own words. Because of this, they also represent a privileged way of allowing the interviewees to speak to others beyond the immediate research context. They were not only a way to present data, they became a very important resource in my attempts to share the results of my research with ministerial colleagues.

### 3.2 Constructing the I-Poems

I-Poems were initially developed to track changes and continuities across participant interviews over time. However, I have adapted this method of analysis to identify the most personally significant themes within particular interviews. As a means of ensuring an accurate representation of the interviews, I constructed twelve I-Poems.

Gilligan advocates that I-Poems are created sequentially through the interview. However, having used semi-structured interviews, my transcripts were not so much a narrative of a life experience; rather portions of narrative in response to questions. Therefore, in constructing a poem based on 'I' statements, I found it more productive to theme the I-statements rather than to allow them to emerge chronologically. To create the I-Poem, each use of the first person 'I' and accompanying text was highlighted. These highlighted portions were cut and pasted (in separate lines). Thereafter, lines relating to similar themes or topics were placed together to form the I-Poem.

The themes that I identified and used were:

1. The actual event

2. The participant's reaction

3. Interpretation including the expression of guilt or blame

4. Support

5. God / Church

6. Thought / Think

I found it useful to begin with statements which referred to the physical event and how the participant reacted to it. I then collated interpretations of the event which usually included ascriptions of some form of blame or guilt for what happened. Following these themes, I grouped together statements referring to support, and those relating to God and the Church. The last category was the most difficult to place. Initially, I was going to begin the poems with “I thought” or “I think”, but when it came to putting the poem together, these did not lie neatly together; however, they did fit well within the latter half of the poems.

My version of the I-Poems produced, in theory, a much more vivid account of each woman’s experience of early miscarriage than normal forms of data analysis could convey. The words used were those spoken by participants, with only minor grammatical or tense changes which would not affect the meaning of what was said. Having constructed the ‘I-Poems’, I tested them out on someone who had participated in the pilot study to see if she could relate to them – not as telling her story, but as telling a story she could resonate with. I also showed the poems to a parish minister (who was not part of the fraternals) to gauge his reaction from a pastor’s perspective to determine whether the poems conveyed to him a sense of what the interviewees had experienced. This also proved helpful when I began putting the educational programme together.

My analysis of the I-Poems is discussed in the next chapter. However, such is their inherent power in conveying the lived experience of the twelve women interviewed, I believe that they deserve to be included in the main body of this thesis and not confined to an appendix. Here, stories are being told for the first time. Stories that have been suppressed for years, from women who were courageous enough to volunteer to participate in a research study so that their experiences might help others in the future. I believe that these twelve I-Poems serve as a vehicle for raising awareness of the issues and needs that follow early miscarriage.

I had intended to present the findings to clergy in groups, as anonymised case studies. However, upon reflection, to do so would dilute the individual accounts. It would also allow those participating in the fraternals sessions to question whether the case studies were accurate accounts of people's experiences and not a collection of specially selected snippets collated for effect. The I-Poems themselves were anonymised and therefore could be presented simpliciter. Fraternal participants were informed that they were the actual words spoken by women who had experienced early miscarriage.

As discussed in Chapter 2, qualitative research cannot generate measurable results in the same way as quantitative studies. This is particularly true in relation to the creation of I-Poems. In order to validate the data presented, an audit trail must be clearly evident. By way of example, the process followed for creating an I-Poem for F8 is detailed in Appendix 14.

### 3.3 The I-Poems

In this section, the I-Poems are presented without commentary. They stand alone and convey a very powerful and poignant presentation of twelve women's recalled experience of early miscarriage.

**F1**

I just wakened up one morning and had a pain
I lay on my back for 15 weeks
I knew everything that could be done was done for me
If I had been a bit later I might have managed.
I never got any explanation

Something I could not do,
I can do lots of other things but
I couldn't produce babies.

I don't know how I felt
I was just crying all the time
I was in a state
I need to know what had happened.
I wasn't going to be beaten

I realised that it had been disposed of by my husband
I felt as if I had let him down
I mean my husband was the most support

I don't honestly know what would have made it better.
I had to accept that was not for me
I think you just got to accept that what's for you won't go past you
I think you've got to accept that it's not meant to be
I did feel that help was needed

I don't remember speaking face to face very much with anybody
I didn't feel part of that church
I must say the Methodist Church was quite supportive.

I don't think a funeral, no

I always felt annoyed with people who were so upset about miscarriage when they had family already
I thought you have no right to be so upset because they've got one child.
I don't know if that's reasonable or not?
I don't know if it would have been easier just never to have conceived at all.
I have survived.

**F2**

I was at work actually
I had gone to the bathroom
I was bleeding
I was upset
I just knew

I'm having a miscarriage

they asked me what I wanted to do
I opted for surgery.
I didn't want it to be natural
I just wanted the embryo away.
I just need to get this sorted.

I felt out of control

I had a D&C[54] and that was horrible
I just got the procedure done
I was put in a ladies' ward
I could hear the other women whispering 'I wonder what she's in for',
I don't want to talk to people about it

I thought I was fine

I had a bit of control back
I've dealt with it
l went back to my work
I didn't want people coming up saying 'that's terrible, that's a shame'
I didn't want to deal with their sympathy or pity

I was able to cope with it

I had gone through a miscarriage
I suppose my way of dealing with it was, it was cells
I didn't give it a name,
I decided that it was a boy
I was very much it has happened, let's move on

I did have support

I did use my faith
I got strength from my faith
I did pray.
I never prayed for the baby to be fine.
I just prayed for the strength to get through

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[54]Dilation and curettage (D&C) is a brief surgical procedure which removes tissue in the uterus.

I wouldn’t necessarily have told you

if I had a different relationship with the minster
I knew him well but I didn’t know him well enough
I suppose probably just a note from my minister
I suppose sometimes a knock on the door
I don’t mind talking about it now

I think just listen to them
I think just listening to them

**F3**

I was twelve weeks
what have I done,
had I done something wrong.
maybe I was never going to have a family
I wonder what my life would've been like

I think because there was no support or help
I think every other nurse would say things like 'just think all the fun you'll have trying again'
I think it was these platitudes that people thought were funny that really got me
I know what they were trying to do but it wasn't working.
all I notice is that everybody else is pregnant or pushing a pram

part of me was angry because why should I teach these other people's children when I can't have any of my own
I hadn't given up hope totally
I say, never forgot, you don't forget

each time I fell pregnant again it was in your mind
I didn't stop you thinking about the three that I lost
I was just thankful for the three I had
I've now got children and grandchildren, you still remember it.
I remember when my daughter fell pregnant it all came back

I didn't blame God but found it hard to accept that that might be the way he wanted things to be.
I don't think it would've even crossed my mind to have a funeral
I just never even thought about that
I mean it probably was well known

I was a Sunday school teacher
I was always at church.
I don't think visiting was one of his fortes to start with
I don't think he would've had a clue about the situation
I actually found his visit very uncomfortable

I think, people don't allow the family to grieve when it's a miscarriage and you do.
I think it's different but you still go through that process because you've still lost what was going to be your baby, your child.

**F4**

just been told that I'm not pregnant any more,
that I'm not gonna have this baby and now
I need to go to the hospital and have a D&C.

I don't remember how
I knew that that there were girls in other rooms having abortions.
I just felt I was there to get cleaned out. And nobody mentioned a baby or…
saying goodbye

I was very angry after the D&C. Angry with
I would see women on the street if they had babies , I think it's anger and denial.
I had to be explaining all the time what I've been through.

I don't really cry, it's not something I do,
I just don't cry very much. I remember crying a lot,
I just I just wanted to be pregnant again

Why didn't I have a baby.
I don't think there was any talk about where that baby had gone and what had happened to it
I needed to let that baby go before we were ready for another baby

I've always talked about it with the children.
and I'd always say
I've had three pregnancies to people. It's important to recognise it.

I hadn't spoken about it at all
I don't think I had any help apart from my family - not professional help, not pastoral help
I don't remember anybody sitting down saying 'how are you feeling'?

I shouted at God about why was my baby taken away.
professional pastoral care, I don't think it was really very significant
I remember reading old hymns. For me pastoral comfort came from them.

I remember being quite angry it's a grief, it's grief isn't it you know
I would've not wanted to sit and talk to my minister about a miscarriage,
I don't think. But he cared and he cared and prayed

I had been told about being okay to feel the way I felt
the most helpful thing that I had was other people saying I've been through this.
I learned something from it

I recognise - to be able to remember… to say goodbye
I remember saying to my husband ‘should we plant a tree to remember this baby?’
I said is there a book where it could’ve just been written down that this baby was here.

I think, to help people know that it is real and it matters and it’s not insignificant,
I would’ve wanted to be able to help people who were in the pain I had been in I think. Yes, you can stay in this place of pain and loss rather than enjoying life in a different way

did I get the help I needed, could I’ve been helped more?
could I’ve helped other people after I had been through?
just the opportunity to talk, I thought would be quite good for me!

**F5**

as far as I was aware everything was going fine
I went for my 12 week scan
I could have punched his lights in the way he said it
I don't believe that
I certainly wasn't happy in the way he dealt with it

I had to go into theatre
I had to go to theatre for what we would call an 'Evac' which is an 'evacuation of products of conception
I work in theatre
I would have hated for them to say either abortion, termination or anything else they think I've terminated my pregnancy and I've not
I understand from the medical side, because it's the same procedure
I certainly found as time went on things haven't changed

I think because you weren't expecting it…
every other scan I went for with every other pregnancy, you were waiting on that bolt from the blue

have I done something wrong

I've had 7 in total
I just couldn't do it again
I can't do it anymore

I knew the names I had picked but I never actually gave them a name
I would have never used the names that I had picked out
That was a name I picked for somebody else
I couldn't go back to the names I had picked.

I think they also said there was a service every year I think it was at [Crematorium]
I think that was wrong
I never ever went to any of their services
I felt that that it was nothing to do with [Crematorium]
I never ever took part in any of them but you came out of the hospital with a leaflet on miscarriage
I was asked if I wanted the chaplain and they were still saying the service in [Crematorium]
I could never take part in that because it just wasn't right
I was just so desperate to go home
I didn't want to wait for the chaplain coming
So, I declined
I really don't want to speak to somebody that I don't know
I didn't see any benefit of that

I must’ve done something wrong.

I think sometimes it's one of these subjects that people don't want to speak about
had I gone to somebody and said, I’m struggling
I think it wasn’t offered so you don’t ask.

I realise... how big a gap there is in care, pastoral care
I think for somebody from the church… to pray for the acknowledgment of what they lost
I don’t mean a funeral service
I suppose technically it's not a bereavement
I mean some kind of acknowledgment of what’s actually happened
I don’t know what you would call it but to have some kind of prayer of acknowledgement for the loss of that baby.
I wish somebody had done that.
I found that it was quite hurtful that there was so little support

I think that’s one of the things, you know, the lack of acknowledgment
I think my friends were probably the most supportive
I think the acknowledgement was actually quite reassuring
I think that’s the most helpful to actually acknowledge that your grief, your bereavement
I think for people to acknowledge your baby would go a big way and helping people to cope

I would always go and see them
I’ll go and see them
I’ll speak to them
I’ll ask them how they are doing
I’ll ask them how they feel about what has happened
I do go and see them,
I do offer to pray with them.
I offer a general prayer
that’s one of the things I find would’ve been helpful

I would’ve never asked anybody about it if they hadn’t been willing to speak,
I think it depends on people’s journey in life

**F6**

I thought I was going to find out my due date.
I hadn't shown any signs at all,
I can't recall feeling anything different
then she said, 'I'm really sorry, but I don't think your baby's still alive'
I was all over the place

I was basically crying for most of the day if I'm honest
I knew this was the place that you were supposed to come, for the good news
I went in for the procedure, in the same place as all the other mums are coming in for their scans
all I could think of was, I need to get through this,
I need to get through this and move on,

I presume it just went into the medical waste,
I wasn't sure, it was too late by this point,
I felt a bit guilty, at that point, that I hadn't thought about it,
what should I have done… you know,
I don't know a cremation, or something

I couldn't speak
I don't talk that much about it with other people ,
I don't like sympathy
but its, what I wanted to hear 'I'm here if you need me'
I'm very private, most people don't know I've miscarried

I think there's a kind of 'taboo' about miscarriage
I'm not saying it's a bad thing to have it as a 'taboo'
I'm not saying that, because I will not gladly tell people that I've had a miscarriage,
but I don't think he would know what to say or do because it's a taboo
I do think there is also a huge amount of ignorance about miscarriage

I don't think you'd ever be able say so 'what would you like from me'
I don't think they would even know…
I think any sort of caring
would probably be enough, for a lot of people and a show of love.
I don't even know what to say

I wouldn't have spoken to anybody that I didn't have to speak too.
I wouldn't have spoken to you about this, had you not said
I need to share… with other people,
that its horrendous and its not pleasant…its going to be upsetting… but you will get through it
I feel like I need… to kind of, help

I believe that baby wasn't meant to be
I do believe that something wasn't right with that baby
I can't forget about that baby, its really important
it was a baby, it was, that's the way I view it.
I was crying because that meant everything mattered, 'The baby was a baby'

**F7**

one day I felt the baby jump a big jump
I had pains in my back, and the baby came
I laid him in the wash hand basin

I gave the child a name
I found that helped
giving him a name and an identity… 'It would have been a boy'

I thought, that was going to be a life
I thought that was awfully sad,
I was not alone

I thought I was lucky
I already had a child
I had the support of my husband and my family.

I apologised for losing his son
I felt guilty, it must have been something I'd done
I was very ,very sorry

I…It was treated as a something
I didn't feel any sympathy really,
I felt they were doing their job.

at no time did I have any help from the church.
I had no visits from the Minister,
no person came from the church to help

I would have appreciated some sort of ritual
I got on with it, cause I had plenty to do,
I have my own way of remembering my child.

I felt grateful that God had said 'finish this' early
I was grateful to God for finishing a life that had started
but wasn't going to be.

**F8**

I suddenly felt cramping pains in my tummy and went to the toilet and there was some blood
I was miscarrying but lay there, trying not to move
I kind of knew myself
I was panicking
I realised that I was losing the baby and there was nothing I could do to stop it.

I think probably most of it was away by the time I got to the hospital
I had a D&C and that was it. Cleaned out
I went to the day room and somebody said 'what did you have'
I have just lost a baby, I had a D&C. You know,
I didn't have a baby.

I literally just had a D&C. That was it. It was all over.
I remember coming home and just crying all the time
I just felt bereft.
I really did feel hollow,
I felt my body had let me down that I'd let my body down

I think they don't think about the dads very much.
I cried a lot and I felt quite empty and numb
I felt quite sorry for myself
I used to play a record over and over again to make myself cry
I would torture myself sometimes … just to give myself a good cry

I know that I lost a lump of cells, bloody, you know
I thought I've just lost a baby,
I thought I believed I would have another baby
I don't want another baby.
I wanted this one.

I thought to myself have I done something.
I felt my body had let me down
that I'd let my body down
I blamed my body more than God
I didn't sort of think oh, God, you let me down

I believe God didn't mean it to be
I still went to church after it
I was still quite sad when
I realised that this baby wasn't going to come to term.
I felt there was no empathy given

I thought you won't be interested in me
I thought it was important for other people suffering
I think to make people aware of the grief in losing a baby
it wasn't like a death to other people but it was like a death to me.
it's just reassurance and listening; being sympathetic, empathetic.

**F9**

I went to the scan
I was in by myself
I thought this be a blighted ovum
I'm fine but it's just a shock
I understand what's happening

I had to go back to the scan place
I arrived to the hospital
I was in a room on my own

I don't remember a thing about it.
I just remember having a fabulous sleep.
I thought I was in sleep for hundred years.
I understand what was happening

why am I here having had to have this done and these babies can be heard

I wasn't very emotional
I wasn't bubbling and crying
I was very fortunate
I had a child

I thought, well okay if that's going to be my only child, hey-ho, that's the way life goes
I'll just get on with it
I wasn't desperate to have a child
I had a child
I was disappointed

I think your personality does play a part
I think your attitude plays a big part in how you perceive things
I took that view, we didn't get to the stage where there was an actual foetus
I am quite kind of philosophical about things
I have dealt with that and it's in a box
I think that's just something that has happened
I already had a child

I was a wee bit older
I didn't have anybody saying 'what do you expect in your age'
I don't like people to whisper and tittle tattle
I did have a child

I went to that meeting once
I went along to see what it was all about
I did go but then I thought, no.
I met that woman who was a bit worse than me
I don't want to be like that
I mean there were other meetings
I didn't go back to any more
I felt mine was totally different
I kind of felt this is not really for me
and I thought, no.

I think talking to people who had experienced something similar would be good
I think speaking about things is a best way forward.
I think bottling things up just ends up in lot of trouble in the fullness of time
I think some people find it difficult to speak to people
I couldn't have spoken to my mother

I think the first thing to do
'I hear that this has happened to you'
I think if they are not happy to talk say
'I can understand now a wee bit what you went through'.
I said, go and speak to the minister
I think he'll be quite approachable
I found quite a bit of support from him

**F10**

I'm hoping that this it, might help people understand what has been happening to them.

I got a pain
I had to wait till he came
I was angry at him [The GP]
I was just there on the bed and…, it was just sheets
I had to go to the hospital
I was lying in a bed
I had a wee fly look at the notes and it just said 'product of conception removed'
I was sent home later that day and told, 'that's it, you've lost your baby'

I didn't get a choice of having it but they're having one and they are choosing not to have it,

I've lost the baby
I wanted to know, had it been a boy or was it a girl but they didn't tell me
I didn't give it a name
I didn't even know whether it was a boy or a girl
I thought this has happened, get up and shake yourself down and start all over again

I would've not gone shopping
I think that's probably what started it
I plodded about the shops
I would probably advise everybody don't carry heavy loads.
I've thought of that many of times

I probably burst into tears the first few weeks
I did feel a wee void for a wee while
I think. It's happened and you just get up and go on

I suppose maybe if you have lost one you maybe feel more than somebody who hasn't

I would console anybody that you know if they wanted to speak about it
I wouldn't like to… if I wasn't wanted
I would sympathise with them and tell them you've gone through it and you know what they are going through … that they'll get over it.
I'd feel perhaps that I was maybe intruding a wee bit too much

I don't know if ever anybody did say anything to me
I can't think of anything that was really really hurtful

I see, well the minister probably knew but he didn't, he didn't do anything afterwards
I really didn't want him to do anyway, you know. He was there for christening and what not
I mean there are people who are used to having a minister
I would've been very happy to speak
I was a regular church person

I watch the program One Born Every Minute quite a lot.
I think it's really miraculous what they can do
I shouldn't really watch things like that because it really gets to me
I don't say mine would've lived, it was far too early
I'll never forget it.

**F11**

I don't have a name
I didn't feel a person
I do not remember anybody in that hospital talking to me

I never felt ill
I wasn't a young woman
I don't know if you feel a failure.
I had cut the grass
I didn't believe that had anything to do with it
I don't talk about it
I think all in all it was an experience you went through

I didn't like that experience actually
I didn't like that experience
I could've done without having to go to the hospital
I could've done without it

I mean that that young doctor with his flyaway comment oh, 'product of conception'
I mean that stuck with me all these years
this lady is having an abortion and I'm going no, I haven't
it made me think made me think I had done it to myself
I think terminology has a lot to answer for
I think if you use that terminology then you feel that you are guilty
I didn't know what it would be
I don't know how early you can actually tell
I don't know what would've happened to it
I would never have asked.

I was still very much in awe of these people because you are in their hands
I didn't know what to ask
I didn't say anything
as far as I was concerned, you just go on with your life
I just went back to old routine
I had a wee boy to look after

I can't take a lot of sympathy
I think that might've made it worse
I would, a visit would be appreciated
I'm not the person for it, counselling  per se

I think a woman can sometimes go in and just be there
I like to be… self-contained
I should actually say it was us losing a life, not just me
I think sometimes that the fathers don't often get thought about.

I never really knew the minister
I wouldn't like your job
I think it must be difficult for you as a minister
I'm not clever enough to give you an idea what might be needed
I think it's a, it's a hard one that
I think a show of concern
I wouldn't jump in right away
I would maybe leave it for couple of weeks
I think it's being there and showing concern.
I think that's the big thing
I think the very fact that you have shown interest and concern

I cannot say it's God's will that you lose a child
I don't see that
I just see that that is part of the natural life
I think that the feeling that I got… you always prayed.
I've always done it
I don't see it as a God's plan.
I may be wrong

I can't see why I should lose one to gain another
I just don't see that.
I got my treasure in the end
I've had three but two live children
I'm in a way really lucky

I don't… it's when you look back… it's a miss.
I think you blank out a lot
I've probably cried more about it now than I ever did
I didn't know that there was a rawness there
I think sometimes you can feel a failure

**F12**

I found out that I was pregnant fairly early
I got until eleven weeks
I knew all the signs to look for
I knew as soon as I had the bleeding that that was it starting
I had really severe bleeding that I never ever experienced before
I couldn't stand up and I knew that that was it, ending at that point
I knew when they didn't get a heartbeat

I didn't have to have any procedures in hospital
they phoned me to say that I had no issues medically and they couldn't understand why I couldn't carry a baby
I hang up the phone
I think if you want any major follow up you have to go and do it and look for on your own.
I just had to accept that I had two
there was no way that I was going to put everybody through that all over again.

I think it would've been easier for me if they said there was damage and
I couldn't have any more.
I could close the book and say, that's fine
I can't actually have any more so it's okay not to try
I could, but in my mind, I couldn't
I just knew there's no way I was going to get through that again.
I would drive myself crazy

I think once the body heals that's when my mind clicked
I was able to think about what had happened
I didn't really think about it before that
I felt angry
I did everything right.
I took all the tablets that you are meant to take,
I took everything,
I went to the midwife really early on
I did everything right and even when you did everything right doesn't always work.

I had two normal pregnancies with no problems
I had three that that weren't
I had the two already and still had problems
I found it difficult to accept
I just thought because I had children that I was okay and
I would just automatically have another one
it made me angry that I couldn't just go and have another one

I felt a bit like a failure really
I felt like I should be able to have as many as I wanted
I felt angry that I couldn't do that.
I did feel like a failure
I think not just as a woman but just in general that I couldn't do it any more
I suppose I made mine and [husband's] relationship really hard that cause I felt that that was my job.
I don't think he [husband] really knew what to do

I could see them staring at me
I don't know if they were staring at me in sympathy,
or staring at me to think why is she doing it, is she normal
I sort of nodded at them as if okay
I'm thinking no, but that's not okay.
I don't know why you are saying that, it's not okay
I'm allowed to feel upset about that one but I'm meant to not feel anything about the other ones
I never ever really thought people would say it.

when I went through it all I didn't have the support
I don't think that actually I've spoken
I don't ever speak about it really
I've just boxed it away
I think it's a very taboo subject
I don't think there's anything that people can say.
I don't know if I know if there's anything that… I don't know
I feel it should be maybe spoken about a lot more
I didn't mind talking about it to the people that knew, and knew me

I think support groups and counselling and things
I think could help people's emotional side as well
I feel sometimes that if you don't do that it will fester at you forever
I would've gone
I know it's better to… to talk about it

I would be more sympathetic
before I had gone through it I wasn't very sympathetic
I would just be more understanding
And not just brush it off the way I probably would have.
I would've done it before because I was like that
I was a very sort of clean cut type of a person
I suppose I have changed.

I would like the medical profession [to] acknowledge that it is a baby
I think that's like any death
I put that in the same category because you have lost someone, you just don't have a name
I feel maybe not for me, not a funeral, but just the way it's referred to
I would like it… it would be nice if it was acknowledged in a better way
I mean, if it could be acknowledged in anyway because
I mean it is there, it did happen.
even if there was some sort of remembrance garden, trees. You see them for everybody else
I don't see why people who lost children through miscarriage shouldn't have somewhere.

## 3.4 Chapter Summary

In summary, this chapter has presented twelve I-Poems which are a very strong way of capturing voice without filtering it. These are constructed using the actual words of those interviewed and convey twelve stories that have been transformative to me as a researcher and as a parish minister.

# Chapter 4 - Analysis of the Stories

This chapter is in three sections. The first presents a brief analysis of the I-Poems. This is followed by a broader analysis, through coding, of the reported experiences of my research participants. This identified recommendations for future pastoral care practice. At the conclusion of my interviews, I noted that there was a clear indication of a desire (and need) for support – support that they did not receive. As a parish minister, I became even more acutely aware that more needs to be done to aid those who have experienced early miscarriage. The first step in achieving this involved taking the stories that had been told to me and finding a means to share them with others. This is detailed in the third section of this chapter which describes the sharing of my findings with fraternals (by way of an educational intervention) as a means of encouraging ministers to review their practice. The educational intervention was then trialled with groups from within my own Presbytery as a further means of disseminating the women's stories and recommendations.

## 4.1. I-Poem Analysis

The I-Poems related each person's experience in a very direct and poignant way. However, they were lengthy. My initial thought was to abbreviate them, to shorten them down. That said, the question as to which parts of these participants' recalled experience to leave out? Their testimonies deserve to be heard. Indeed, as the literature search evidenced such testimonies deserved to be heard for the first time. Not only do ministers and pastoral care givers need to become aware of what such a significant percentage of women go through, as a researcher I had a duty to honour the lived experience of the participants who volunteered to be part of my research project. I have presented the I-Poems in their entirety without further editing. In doing so I offer them as a means of conveying the recalled experiences of those coping with early miscarriage which, in part, fulfils the first outcome of this project as noted in the Introduction – that being to give the participants a voice as well as serving as a means to enable ministers to reflect on their practice. Acknowledging that the act of creating the I-Poems was a form of analysis in itself, in this chapter I examine the data further. This is necessary both to analyse themes that repeatedly occur

within the I-Poems and also to highlight significant material that fell outside the I-Poem structure but constitutes important data.

In the case of F1, for example, the interview revealed that this woman had six miscarriages and had no children. The I-Poem did not reflect the real sense of pain that came to the surface during the interview: the despair, the desperate need to know why, what happened, there must be an explanation. Similarly, the I-Poem also failed to convey the hurtful comments F1 received following subsequent adoption of two daughters – these included references to the two girls not being hers. Such comments were hurtful and still continue to be made.

What was concealed by creating an I-Poem for F9 was slightly different. Most of the religious support which she received produced no subsequent 'I' statements. Clearly, it is important to analyse data in more than one way. The I-Poem produced a useful, easily readable account of part of her story, but it didn't tell the whole story. I identified sixty 'I' statements in the poem, three of which on re-reading were her thinking about what other women should do. Four of the 'I' statements referred to her already having a child and convey a sense of being grateful for a child. She expresses that she was ambivalent about the 'whole children thing' before and after marriage. She didn't enjoy the experience of being a mother to young children, so in a sense, having a child already meant that she didn't need to endure motherhood with all it entails once again because of this miscarriage. 'I had a child' had to feature prominently in the poem.

F10 had lots of issues with the term abortion, which she understood as people choosing to get rid of their baby – when her loss was not a choice. I recall the interview and didn't think there was much useful information in it until I started the I-Poem process. Only then did I see below the surface. Here was a woman who was very clear that it wasn't meant to be and had the attitude of just get on with it; but she harbours huge regrets. She uses 'just get on with it' as a coping mechanism.

In relation to F11, who reflected on a subsequent live birth after which she was extremely ill, the material did not fall into the I-Poem criteria. Yet her

experience of wanting to die so that she could be with her dead baby was a striking story. With one healthy toddler and a healthy new-born child, she retained a profound sense of wanting to be with the child that she had previously miscarried. It was only on hearing this account that the enormity of the loss through miscarriage and the sense of grief hit home. At this point in my research, my reason for undertaking this study moved from a deep interest to a sense of duty to share what I was privileged to hear and to do all that I could to equip pastoral carers, like myself, to be able to support those who have miscarried. What this account taught me was the essential need to look at data in more than one way. It is imperative to study data using different types of analysis to ensure that a greater sense of richness and breadth of information is brought to the fore.

### 4.2 Coding Analysis

I now present my analysis of the interviews using a traditional method of coding such as is routinely employed in qualitative research. Having listened to the interviews and read through the transcripts several times, I began the process of coding. During the initial step in the coding process, I identified four broad themes to be separated off:

- Recognition that it 'was a baby' & acknowledgement of loss
- Mother's emotions
- Response of others
- Comments by medical/nursing staff

These, I was soon to discover were not ideal. Since I am particularly looking at the issue of support received, I identified two main themes from the interview data and I quickly adapted the above which led to the development of these categories for coding:

- Acknowledgement of loss
- Having a baby (including personalising baby)
- Phraseology of medical/nursing staff & were these supportive or not
- Response of others (family of friends) & were these supportive or not

- Feelings of guilt (including letting partner down)
- Feelings of shame

On attempting to code, however, it became clear that the six themes above were not (on their own) adequate to pick up on the nuances of what was being said and that it would be necessary to be more specific in coding. Support was at the heart of this research project and is central to this thesis. However, it was to become more prominent during second cycle coding which employed all the interview data.

I feel somewhat embarrassed presenting any kind of coding diagram in relation to my interviewees' experience, as it visually presents what the mother went through in a neat and sequential way. This could not be further from the truth. In reality, mothers who lost their child by miscarriage described a mishmash of emotions and feelings each predicated on each other. Indeed, it was only on coding for certain words that I was able to unpick a kaleidoscope of shifting patterns to identify individual events which with every turn would merge into another complex and colourful vista. I had continually to remind myself that the purpose of this research was to determine how ministers and other pastoral care givers might better support women following early miscarriage. As such, it was important to be aware of the emotions women experience while at the same time identifying how they might be supported. Utilising I-Poems helped to convey a sense of what the research participants experienced and so the coding process focussed more on the issue of support. This led to a final version of a coding diagram, Diagram 1, which, in itself, could serve as a tool to highlight the complexity of emotional interaction. However, it draws together some of the emotions described and points to how the participants would offer support to others. This, added to the support that they personally received, enabled me to highlight what support might be valued.

Appendix 15 presents a more detailed account of the development of the coding process than it is possible, or helpful, to include in the main body of this thesis.[55]

[55] Appendix 15 includes the initial and revised coding diagrams (Diagram a and Diagram b) which were developed into Figure 3 - Coding Diagram.

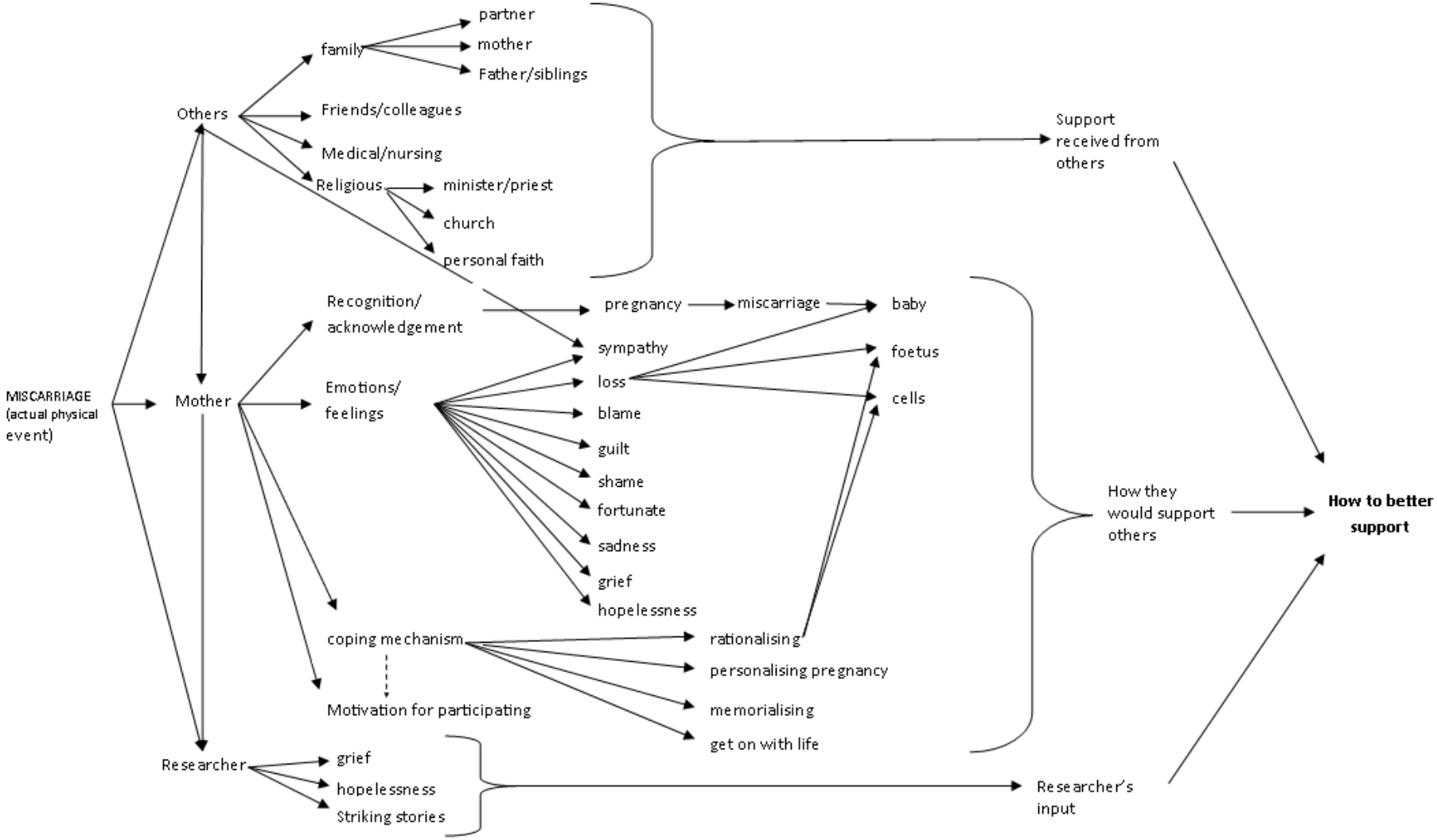


Figure 3– Coding Diagram

As the diagram indicates, the coding process served as a tool to identify, from the interview transcripts, how women might be better supported. In addressing the huge amount of data generated by twelve interviews, it was important to keep a focus on this research question. Throughout my research I have had to continually draw my mind away from focussing only upon aspects of the participants' experiences and being caught up in the grief of their situations. It was necessary to concentrate on how I might better support others who have had a similar event. As already noted in the Methods chapter, on the basis of my coding, support could be subdivided into four categories:

- Support received from the minister.
- Support received from the Church.
- Support from one's personal faith.
- Support that would have been valued.

Each of these will now be discussed in turn.

### 4.2.1 Support Received from Minister

Four of the twelve participants received contact from their minister after their miscarriage. Only one participant (F9) mentioned their minister in a positive way: "He was excellent". Three others (F1, F3, F4) related that they had a visit by their minister, albeit they described the visit as, "Uncomfortable" (F3) or "Awkward" (F4). In the case of F1, the minister visited with his wife and proceeded to compare his own situation to that of F1. He had no children and asked: "Do you think any less of [minister's wife] and I because we have no family?" He went on to describe how there are lots of other ways to live one's life than by having a family. However, for F1 such an approach was perceived as being, "really quite irrelevant".

I cannot put myself into the mind of the minister who approached his congregant in this way and can only assume that he was seeking to be helpful. By taking his wife he may have been trying to reassure F1 that she was not alone and that

there were people with whom she could share her experience. This though is only conjecture. What is important to note is that no matter how well-intended the approach by F1's minister was, it was not supportive. This reinforced my motivation for conducting this research which was to listen to those who have experienced early miscarriage and to hear what support they would value.

As already noted, both F3 and F4 reported that they were visited by their minister. In each case, the participants noted that the visits were uncomfortable. The ministers were not individuals that the participants would naturally confide in. As F3 stated, "He wasn't somebody I would have confided to." This was echoed by F4 who worded it thus, "I would've not wanted to sit and talk to him about a miscarriage." However, F4 mentioned that while the visit was "awkward", the minister cared, "he cared and prayed with us." This will be discussed more fully under the subheading of 'Support That Would Have Been Valued'. F10 reported she would have, "been very happy to speak" with her minister but, "he didn't do anything". This is contradictory in itself as she also goes on to say she, "didn't want him to do anyway."

Eight participants reported that they had no contact from their minister. However, it is impossible to infer much from this without knowing if the minister was aware of the miscarriage. Only F10 stated that the minister knew but, "Didn't do anything".

What became clear from the transcripts was the view that not all the participants would have wanted contact from their minister. For example:

- "[Minister] wouldn't have been the type to offer support" F5.
- "I wouldn't have spoken to anybody that I didn't have to speak to" F6.
- "I would have been embarrassed if [etc etc]" F8.

Three of the interviewees (F2, F3, F5) specifically mentioned that their prior perception of the individual had a bearing on whether they considered a visit would have been helpful. This indicates that the existing relationship between a person and a minister is significant. Statements used were:

- “I knew him well, but I didn’t know him well enough” (F2).
- “He wasn’t ... a person who naturally spoke and he wasn’t somebody I would have confided to” (F3). This was said even although the minister visited.
- “[Minister] wouldn’t have been the type to offer pastoral support ... It just wasn’t his thing” (F5).

Despite the ambivalence reflected in these statements, all three when referring to what they would have wanted by way of pastoral support indicated that they would encourage a minister to visit someone who had a miscarriage. This will be discussed in more detail later.

### 4.2.2 Support from Church

One of the most alarming results from the study was that only one individual reported receiving support from their church. F1 reported that the Methodist Church had been of great help. One other (F4) received support from members of her church but this was in a very informal way and was equated to being support from friends.

This was put in stark terms by F5 who commented, “And you sometimes got to the point when you think ‘they call themselves Christian’ and they can’t even ask how somebody is doing.” She went on to say, “it’s very hurtful because you think they are the people that are meant to care. These are Christians, people who are meant to show their love in Christ ... I found that quite upsetting.”

From my field notes, I recorded that F5 had gone through seven miscarriages and was actively involved in Church activities. At the point when she spoke of her miscarriages and the lack of Church recognition of her losses, she broke off eye contact and looked to the ceiling indicating an added hurt to the loss she already felt.

Only one other participant (F7) added comment in reference to support from the Church by saying, “no person came from the Church to help, nobody...” In my notes I recorded that: “There was a very strong sense of her relaying that she

got no support from the medics or the minister or the Church". This was something she wanted to tell me right away as if she had been focussing on the title of my research project, and when the interview started she told me what she thought I wanted to hear: there was no support. In fact, F7's story is mentioned in Appendix 16 entitled 'Striking Stories'.

Nine participants made no additional comment after stating that they did not receive any support from the Church. Therefore, little can be concluded apart from the simple fact that they wished to record they were not supported.

### 4.2.3 Support from Personal Faith

There were a variety of responses as to how the participants reflected on their personal faith after early pregnancy loss. What I found particularly interesting was how some of the participants used their faith as a support. F2 said, "I did feel I got strength through my faith" and she talked about praying for the strength to get through what was happening to her.

Prayer was also mentioned by two others. In the case of F8, she asked God why, "Why did you do this?" However, this is not to be taken as blaming God as she goes on to state, "I didn't blame God" and she repeated this as if for emphasis. F8 also used prayer to ask God not to let this happen again. The other participant who mentioned prayer was F11 who mentioned that she always prayed knowing that she would get support: "you always prayed. I've always done it ... you know that you'll get support."

Within this section on personal faith, the question of the role and place of God was raised in a variety of responses. At one end of the spectrum, F8 reflects, "I just believe it was something that just happened, that God didn't mean it to be." At the other end, F4 remembered, "Shouting at God about why; I asked, why was my baby taken away?" To be clear and to avoid confusion the quotation from F4 on being listened to in context was very much in question mode rather than blame. F8 was hoping for answers. She stops mid-sentence after the word "Why" and says, "I don't" then repeats, "Why." She was stressing the question she has of God.

Another response, that of F3, is located somewhere in the middle when she says, “I didn’t blame God but found it hard to accept that that might be the way He wanted things to be.”

The response of F7 reads quite differently from how it was said. She says: “I suppose I was grateful to God for [pause] finishing a life that had started but wasn’t going to be.” The words written in a transcript, without accompanying field notes, would not have given an accurate representation of the context in which those words were spoken. To be clear, F7 was not grateful to have miscarried but looked on God as taking care of the baby inside her, and since it wasn’t going to survive she thought it best in the circumstances to, “finish this early and start again.” She took comfort from this belief. However, this view is in contrast to F5 who, in referring to how others spoke to her, commented upon how painful it was to be told: “It’s just God’s way you know of getting rid of things that are not right in the world.” Such comments F5 found to be, “very frustrating and very hurtful.”

Another view of miscarriage was that of F11 who saw it as part of the natural life. She did not perceive it as part of God’s plan, nor was it, “God’s will that you lose a child.” Of the six participants who made reference to their personal faith, none of them put blame on God.

### 4.2.4 Support That Would Have Been Valued and is Recommended

The data pertaining to what support the participants would have valued are most insightful. This data comes from the interviews of women who have lost a longed-for baby by miscarriage at least ten years previously. Therefore, there has been a significant passage of time over which the participants would have had the opportunity to think about and reflect upon their experience. What has become clear to me when engaging with this data is that there can be no one scenario fits all approach. Everyone is unique and while all the participants have a shared experience of early miscarriage, the event itself is unique to every individual. The same is true for the support they received from medical/nursing staff, from family and friends, from their minister and from their church. As F4 puts it, “You did ask ... about what happened. That’s important and everybody’s

story must be different." The same principle applies to what every individual indicated they would wish by way of pastoral support.

This section does not consist of my recommendations. These will be presented in the final chapter. The material used here are the recommendations of the participants themselves which was later used within my educational intervention in the ministers' fraternals.

One of the questions on the interview prompt schedule (Appendix 8) was what advice would the participants give on how to support someone who had experienced an early miscarriage? This generated a wealth of data which was most relevant to answering the research question: "How might parish ministers (and other pastoral care givers) better support women who have experienced an early miscarriage?" The intention behind the question was to ascertain, on looking back on their experience, what support the participants would have valued.

Following analysis, the recommendations of the participants in this research study are:

1. Make contact;
2. Acknowledge the loss;
3. Listen;
4. Respond appropriately.

The data analysis for each of these recommendations is set out below:

**1. Make Contact**

What the participants in this study infer (albeit in different ways) is that contact should be made.

All of the participants had some kind of Church connection even although two were not religious at the time of their miscarriage. It was not surprising therefore that they all spoke in a positive way about the potentially supportive benefit of being contacted by a minister. One participant added a caveat by saying that, “People who are used to having a minister or are involved with the Church, they probably would be quite happy to [talk to a minister].” In other words, if a minister knows the person they should go and visit. Even F2 who did not have a good relationship with her minister at the time, and who would not have wanted to speak to him, advocated a minister making contact by phone, email or text. She also suggested that a note through the door acknowledging what had happened and offering to visit would be appropriate. These methods of contact were also suggested by F4.

**2. Acknowledge the Loss**

It must be stressed that throughout the varied experiences reported, there was a very strong plea for people to acknowledge loss and for some this meant others recognising that their baby existed. This was articulated by F5 who said, “I think for people to acknowledge your baby irrespective of whether it was just a bunch of cells ... would go a big way [to help] people to cope with things.”

The lack of any kind of formal recognition of bereavement was hurtful. This is best described by F9 who said, “If somebody wanted to have some recognition, but legally you are not allowed to have that.” The feelings of F12 speak volumes as to how she perceived others viewed her miscarriage, “It’s as if it’s just brushed under the carpet really.” She goes on to say, “If it could be acknowledged in any way because ... it did happen.” Supporting this view, F8 said, “What you’ve been through is not just a medical procedure ... to be forgotten about. It’s something that ... was a start of life there.” F5 makes the plea for, “Some kind of acknowledgement of what’s actually happened.” This raises the question of how the desire for some kind of formal recognition could be met. F4 expressed some very practical suggestions:

- “Something to remember this baby.”
- “Somewhere it could be recorded.”

- “A book in hospitals where it could’ve just been written down that this baby was here but it’s not here, they are not here anymore.”

Only one of the participants suggested some sort of funeral in the traditional sense.

- “Maybe even a cremation, or something, I wasn’t sure, it was too late by this point.” F6

In contrast, F1 stated, “I don’t think a funeral, no I don’t think so.” F3 spoke in similar terms, “I don’t think it would have crossed my mind that anybody would have thought to have a funeral service.” This sentiment is echoed by F12 who advocated having a, “small way of remembering” but goes on to say, “I don’t think I would’ve gone as far as a funeral as such.”

Contrary to what I had envisioned when I began this research project, there was no general desire to have some form of funeral following early pregnancy loss. There was, however, a desire for acknowledgement and in addition to this a yearning for some sort of record to be kept, and various suggestions were made as to how this could be done.

**3. Listen**

None of the participants who voiced the desire for a minister’s visit were seeking someone to resolve their situation. What was being advocated, rather, was that the minister should: “just listen to them” (F2). This was repeated by F8 who said, “I think its just reassurance and listening … and just being sympathetic, empathetic.” Again, the need to listen was stated by F11 who said, “Let them talk and just listen.”

Those participants who suggested that a minister should visit reflected upon how important it was to give people the opportunity to talk. F4 said that, “its good to talk to somebody … and [to let people know] what they are feeling matters” and, “Speaking about things” was recommended by F9. However, care must be

exercised to ensure that it is the person (not the minister) who does the talking. As mentioned by F11, “If somebody wants to talk, let them talk and just listen.”

F2 thought “just listening to them” would be the most supportive thing a minister could do. F3 adds reasoning to this when she says, “You can’t change it, you can’t do anything about it, just listen and let them offload.” In other words, “just be with people when they are suffering” (F4). By listening you are able to let people “speak about things” (F9). Be sympathetic and empathetic and give reassurance and, “listen” (F8). F11 adds that, “the very fact that you have shown interest and concern and are prepared to take [a] little time” will be deemed supportive by those who have been bereaved.

Two of the participants added that it would be supportive of the minister to allow people to talk about the circumstances of what had happened. By providing this opportunity, the minister would be conveying to their parishioners that, “what they are feeling matters” (F4) and, “to help people know that it is real and it matters and its not insignificant” (F4). By doing so they would be fulfilling points 1. and 2. above. In other words, they would be visiting and acknowledging as well as listening. F9 opined that, “speaking about things especially is the way forward.” This was also mentioned by F4 who said: “it’s good to talk to somebody.” Indeed, in my notes I had written that her main reason for participating in this research project was that, “its good to talk about it.”

I noted from my field notes (and the reflections that followed them) that several of the participants had not spoken about their miscarriages since they had happened. The interview with F3 was conducted in a small room in the person’s own church hall. She said that she wanted to meet there as she had dogs at home which might have been a distraction. Tea and shortbread was laid out and there was a lit candle on the table, very definitely not as a table decoration, more as a focus for spiritual reflection. With F4, I noted after the tape had been switched off that she mentioned with some surprise that she had spoken about a couple of issues for the very first time. One of the mothers who had seven miscarriages (F5) had not told her husband that she was taking part in the

project as she didn't want to upset him. After the interview, she mentioned that as the miscarriages went on each one was harder.

**4. Respond Appropriately**

Having made contact, acknowledged the loss and listened, the next step for a minister is to respond appropriately. As already quoted from F4 above, being with people is important because, "That's what we needed rather than people trying to work it out or give reasons because there was no reason for it happening." If people are happy to talk that's good, but, "if they are not happy to talk, it might be good to ask why they are not happy to talk cause, obviously letting things out is better." That said, the minister must recognise that they may not be the individual that some would wish to talk to. In that case, offer to put them in contact with someone, "who had been through a similar experience." (F9)

On completion of the interviews, I was quite sure in my mind that there was a groundswell of opinion in favour of planting a tree (or similar) as a way of remembering a lost baby. However, on further analysis of my data, only four participants made reference to this on tape. Thinking that other references must have been made, I returned to my field notes which confirmed that contrary to my perception, it was only F4, F7, F8 and F12 who made such recommendations. Of these, three were very much in favour of a symbolic action:

- F4, "should we plant a tree." However, her husband was concerned that if they did so and the tree were to die it might add to their grief.
- F7 clearly wanted some form of ritual, but in keeping with the view that it shouldn't be a funeral said, "I would have, appreciated some sort of ritual, from other people. I don't mean have a public ritual, but say plant a tree or plant a flower or … something like that, release a balloon into the sky, to sort of … say fair enough that's something that's lost."
- F12, "even if there was some sort of (sigh) like a … remembrance garden, trees."

The fourth reference to some kind of ritual was a comment about what her husband would have thought. F8 said, "I don't think [husband] would've approved of doing something so sentimental as erm, you know, planting a tree in memory of a foetus that went wrong." Interestingly, this response was about how she thought her husband would view such a thing, rather than whether she would have found it supportive. With hindsight, I should have followed this up and asked what she would like to have done.

It is important for ministers to realise that, "the very fact that you have shown interest and concern and are prepared to take [a] little time" (F11), is in itself a very supportive intervention. Prayer was also mentioned as a support. F5 noted that some can find praying with others difficult and so a minister (or pastoral care group) could advise, "what way to do that prayer." She notes that she would have found it very supportive if somebody would, "actually pray for that baby, to pray for the acknowledgement of what they lost." This was also the view of F4 who on reflecting back to her own situation found that the visit of the minister was supportive in that, "he cared and prayed with us." A comment offered by F8 should be borne in mind. She said,

> I would've been embarrassed if [Minister] had come to the door and said I heard you had a miscarriage erm I'm here to offer you sympathy and pray for you … But now, the type of person I am now erm but then I've been through other types of bereavement, so I know that it is nice to have somebody come and say how sorry they are and they share your grief.

It must be noted that at the time of her miscarriage, F8 would have been embarrassed if the minister had visited. However, twenty two years later and reflecting on her experience she would have valued some kind of contact and acknowledgement. A similar comment about valuing a pastoral visit was made by F11, to know that somebody is "coming and showing concern and they pray for you, you know, and to pray for this wee soul that's lost." The importance of making contact must not be underestimated. However, great sensitivity is required to ensure a benevolent approach, while done with the best intentions,

is not adopted. Pastoral carers must also be conscious of whether the visit was at the request of the grieving parent. If so, the individual might be actively seeking support. In contrast, if the visit was in response to being made aware that a parishioner had miscarried then pastoral support might not be welcomed at that time. There can be no general approach. Each situation and every circumstance must be considered, and the care response offered must follow the lead of those being visited.

In terms of how a minister or pastoral carer should respond, F6 makes two interesting and useful comments:

> I don't think you'd ever be able to go and meet up with a, a, a mother, or a mother and father who had lost a baby and be able to say so what would you like from me, cause I don't think they would even know … I think any sort of caring would probably be enough, for a lot of people … and … em …'You know' … a show a show of love and solidarity is sometimes, is, what people are looking for.

And:

> if somebody, who is looking for Pastoral Care from yourself … the bottom line is, you need to ask them … how are they feeling and, and try to ascertain … what, what you can do from that.

### 4.2.5 The Sound of Silence

The absence of appropriate support was often referred to. This I have described as the sound of silence.

There was, and is, often a silence from the women's partners. None of the women who participated in the pilot had spoken with their partners about it: neither their participating in the research, nor indeed about the miscarriage since it occurred. In relation to the main study, one quarter of the women's husbands were aware that they were participating, but only one offered encouragement for her decision to do so. One participant described it thus, "but

I haven't told my husband because he doesn't ... and he doesn't know, because he's never mentioned it again and I didn't want to upset him – that's between you and I." This is supported by findings from University College London and the Miscarriage Association (2014) which as I highlighted in the Literature Review was that a number of the partners of women who miscarry did not communicate about their own feelings of loss and pain.

These findings present anecdotal evidence that the person who might be expected to offer the greatest support in the case of early miscarriage is often not able, or prepared, to do so. One person had told family, friends and work colleagues of her miscarriage at the time but the subject remained one to be avoided, until now, and even then it was to be in the confidential confines of a research study. Here again, is evidence that these women must have felt a need to speak to someone about their loss. Acknowledging that they might have had an altruistic motive of seeking to benefit others in the future, the fact that they so readily volunteered shows that they did not want to leave the past undisturbed. They wanted to speak about what happened to them.

Each of the women was satisfied by the approach and support offered by the medical staff on duty at the time of their miscarriage. However, the provision of on-going care was given by way of leaflets which made mention of support groups. None of the participants followed this up. That said, there was an admission that following the miscarriage the participants became aware of other women who had also experienced an early pregnancy loss. One woman described it as, "I didn't keep it to myself, it's very common though as you will have found out, you start to tell people these things and they start to tell you of their own experiences and both my sisters-in-law had had, not a similar experience, but had had miscarriages in early pregnancy, so we all know what it was like."

What these mothers were saying was that on telling people, who had previously known that they were expecting, that they had lost the baby, others would volunteer to them that they too had suffered a pregnancy loss. With so many individuals having experienced miscarriage, there is a wealth of support to draw

on, yet it appeared that after the initial acknowledgement of shared experience nothing more was to be discussed. It was almost as if the participants had experienced an initiation rite into a closed society. Having informed family, friends, and colleagues of a miscarriage, they, in turn, would feel it appropriate to admit that they too had experienced the same thing and so one would be welcomed 'into the society' of which they were now a member. It is as if they have passed through a door into a room full of people who have all experienced miscarriage, a room where everyone will nod in acknowledgement to each other; but the room is silent, and no-one dares disrupt the sound of silence.[56]

The word silence is never mentioned in the I-Poems, yet it pervades most the recalled experiences. Not speaking about their experience is a common theme; F1 does not "remember speaking to anyone about it." In addition, F6 refers to miscarriage as a subject people do not want to speak about. However, she did not want to speak about it either, "I didn't want to speak" and later adds "I wouldn't have spoken to anybody that I didn't have to." However, that was said in an interview that she had volunteered to participate in as part of a study into early miscarriage, which may indicate that she was now ready to speak about it. A similar view was shared by F12 who revealed that she wouldn't have wanted to speak with others and goes on to describe miscarriage as a taboo subject, and F9 who acknowledges that speaking about what happened is the best way forward but is conscious that others treat it as a taboo subject. Similarly, F5 viewed miscarriage as "one of those subjects that people don't want to speak about." In contrast, F4 would have appreciated the opportunity to talk at the time and believes it would have been helpful. She describes being in a place of pain and loss which was not helped by the silence she experienced. It was clear that while

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[56] Echoes here of the song 'The Sound of Silence', written in 1964 by Paul Simon (one of the American music duo, Simon and Garfunkel) and released in 1966. The third verse is particularly poignant:

> And in the naked light I saw
> Ten thousand people, maybe more
> People talking without speaking
> People hearing without listening
> People writing songs that voices never share
> And no one dared
> Disturb the sound of silence

some may not have been ready to talk immediately following their loss, with the passage of time they were more ready to do so. F6 said that now she feels the need to share what had happened with other people. She wants to help others and tell them "that it's horrendous and it's not pleasant; it's going to be upsetting; but you will get through it." Indeed, F8 said that she participated in my study to "help make people aware of the grief in losing a baby." For some, a passage of time is necessary before they are able to talk about their experiences. Therefore, the offer of support cannot be confined to immediately following the miscarriage when it may be more likely to be declined.

### 4.2.6 Hurtful Interventions

The focus of this thesis is on support although the analysis highlighted occasions where the responses of others were negatively received. The interviews raised several instances where people unintentionally made hurtful comments. It would be easy to supply list phrases used by people who were genuinely trying to offer support. From the midwife who suggested, "just think all the fun you'll have trying again" (F3) to the comment, "Oh dear" (F7) but with no accompanying sorrow or sympathy.

Other comments received included, "You are young, there's plenty of time, you'll have another one" (F8). During the interview, F8 goes on to say, "I don't want another baby. I wanted this one." Another hurtful response to a miscarriage, for those who already have a child, was, "You've got a baby already." No matter how well intended, such a comment gave the impression of a second child being of less importance than a first child and, therefore, its passing was of lesser significance.

During the interview with F4, it became apparent that she had received many comments following her miscarriage which she found hurtful. She spoke about receiving, "These three cards" with comments written on them such as, "All things work together for good." This had obviously been extremely difficult, even although she acknowledged they were saying "these things because they just wanted to help." However, she added, "Aye, right! There was nothing good about this."

There was also the view expressed to women who had miscarried, as mentioned by F12, that when the pregnancies weren't planned there was less pain involved: "It's okay because they weren't planned." This implied that an unplanned pregnancy gave a different status to the baby.

In the Chapter 5, I will reflect on this further. Suffice to note that well intended comments can be hurtful. Here is evidence to support one of the aims of this research which was to make the issue of early miscarriage more widely understood. One respondent (F4) took the view that she had learned from receiving hurtful comments and, therefore, was better able to support others, "I think it cured me of saying stupid comments to other women having a miscarriage."

### 4.2.7 Terminology

On analysing the interviews, it was clear that the terminology others used to describe their experience had a lasting effect on many of the participants. Noting my own context of encountering hidden miscarriage and (attempted) abortion within my family, I must confess that it had never occurred to me to align miscarriage and abortion within this research. However, this issue was something that was raised during the interviews by the women who found references to miscarriage as (spontaneous) abortion very hurtful. As women raised this, it deserves to be shared so that others might hear how the description of miscarriage as abortion (common within a medical context) can have a lasting effect on people's lives.

I was conscious that the topic of abortion had been mentioned several times during the interviews. This encouraged me to return to the data to determine if this was a recurring theme. This proved to be the case as nine participants (F1, F3, F4, F5, F6, F7, F8, F10, F11) had made mention of this issue.

The subject of abortion was mentioned in three different ways.

1. Anger and resentment of individuals choosing to terminate their pregnancy when the participant was unable to have a successful

pregnancy. It should be noted that this was one participant's view (F1) who had seven miscarriages and went on to adopt children. In her interview, she revealed that she was in hospital for some time while still pregnant and on the same ward, "girls were coming in there and having abortions and going home and I was sitting watching ... all this happening." F1 added, "You are not doing what the rest are doing and trying to get rid of ..."

2. Those participants, two thirds of the interviewees, who required a medical intervention following the discovery that their baby had died in the womb. This was the case with F3, F4, F5, F6, F7, F8, F10 & F11. They spoke in terms of the references made by medical professionals that the procedure they were undergoing was an abortion. This caused hurt and anger as this was not a choice that the participants had made. The procedures may well be the same, but a change in terminology would be very supportive to grieving individuals.

   F3 spoke about abortion after the tape was switched off. In my field notes, I noted that she hated the phrase, "spontaneous abortion" and much prefers the term miscarriage. She also discovered that her General Practitioner had used the word abortion in her notes. The word 'spontaneous' was missing and this she found very hurtful and upsetting. Another issue that was raised was that a work colleague had an abortion at about the same time and who was able to return to work earlier than F3. This I noted to be significant. In essence it was the same procedure, but one was an elective abortion and the other non-elective. Both lost their babies but in the case of F3 it was a longed-for baby. Hence the use of the term 'longed-for' in the introduction to this thesis.

   Similarly, F4 raised the issue of abortion. She had been taken into a ward to, "get cleaned out" as she described it. A routine scan had identified that her baby was dead. On admission to a ward, she realised others were there to have what was described as an 'elective abortion', and that the

staff used the word abortion freely. This she found to be very unsupportive.

F5, a nurse by profession, who had seven miscarriages had strong views on terminology. She said, “I would have hated for them to say, you know, either abortion, termination or anything else because automatically when you hear that you think that’s somebody’s choice.”

F7 miscarried at home and subsequently fell pregnant very quickly even although she had a birth control device fitted. When she went to the hospital, she was offered a termination, which she described as something that horrified her.

When arranging to interview F8, she spoke to me about her miscarriage between her two children. She was taken into a maternity ward and was surrounded by new mums. I quote, “I was asked ‘What did you have?’” In response, she spoke these words to me, “I had an abortion because that’s what it was – not that I was wanting one.” F8 went on to add that nobody came and said “sorry”. She got no comfort and mentioned that miscarriage is taboo.

In the case of F9, she did not see her miscarriage (hospital induced) to be as *harrowing* (her word) as that of those who had an abortion. Her miscarriage happened, she didn’t have a choice to make and so was very matter of fact in saying that she had it and moved on.

On reviewing my notes concerning F10, I noticed that she had strong views about the phrases ‘products of conception’ and ‘abortion’. This had struck me as interesting as F10 had been very pragmatic and spoke in terms of a loss of cells rather than a baby. There was a contradiction on the recording as she had commented that on her medical notes there was no mention of a baby, only products of conception. This had been a point of annoyance for her as was the term abortion. F10 focussed on voluntary

abortion where people chose, “to get rid of baby when others were desperately wanting one.”

F11 was of the opinion that the term miscarriage was much more gentle. Other phrases she found to be very unsupportive. Indeed, when a young hospital doctor used the term ‘products of conception’ and went on to say, “This lady has had an abortion”, it left her feeling guilty as if she had a choice in the matter.

3. One participant mentioned that some people refer to their abortions as miscarriages. It would be speculation to give a reason for this. However, F6 as a secondary school teacher involved in guidance referred to pupils being out of school ostensibly due to miscarriage when, in fact, it was an elective abortion. She spoke of the term miscarriage being used “erroneously” and that some people use this word as, “their get-out clause” to hide the fact that they had an abortion. In her view she believed that others, on hearing of her miscarriage, would talk about her behind her back that in actuality it was an abortion. She goes on to say,

> a’ve seen and witnessed em ... a lot of pregnancies, em ... in young teenagers, em ... some of which, have ended ... by miscarriage, and from rumours, some of them are not, but ‘you know’ ... we’re not here to judge it not ... its em ... and some of them will be miscarriages, but they get gossiped about anyway.

This led F6 to speculate that her miscarriage would be viewed as an abortion by others.

It is clear to me that a change in terminology around early miscarriage could be an extremely supportive move in itself. It can be argued that while this is more situated within the medical and nursing domain, descriptions and phrases have had a lasting effect on the women who participated in my study. There is no easy answer, but greater consideration needs to be given to holistic care as recommended by WHO, so that each individual is responded to in a way that

they would find supportive. Regardless of the intent behind certain terminology, words like abortion and products of conception can have a lasting (and negative) response for those who have lost a longed-for baby.

### 4.2.6 Language

In identifying what would be supportive, what is said and how it is said is of major significance. Just as I argue that miscarriage should be normalised in discussion, society (with a lead from the medical profession) needs to address the terms used. I am very aware that not every loss is of a much longed for baby and so simply referring to 'losing a baby' may not be universally helpful. Some may not identify their loss as being of a baby. Others who 'lose' a baby may have chosen to terminate their pregnancy. Assumptions must where possible be avoided, and the language used appropriate for each individual. However, part of the reasoning behind choosing twenty weeks gestation as the limit for my research was the widely accepted medical practice that thereafter the term baby was used. Research must be conducted to ascertain what terms and descriptions might prove helpful and supportive as it is clear from my study that the current descriptors such as 'products of conception' or 'bundle of cells' which may have undergone a 'spontaneous abortion' or were requiring 'evacuation' or an 'abortion' or a 'D&C' were causing additional upset to the women who were losing their baby.

The women in my study have indicated that such language can be less than helpful and, at times, very upsetting and hurtful. It was quite clear on reading my interview transcripts that terminology is significant, and that inappropriate phraseology caused deep and lasting hurt. F6 has feelings of guilt that her baby was (she presumed) disposed of as medical waste, and she believes something more should have been done with the baby's remains. Terminology is mentioned frequently by F11. A glib comment by a junior doctor referring to her baby as a 'product of conception' has remained with her. She also refers to other people assuming she was having an abortion which, she says, "made me think I had done it to myself." Inappropriate descriptions are, therefore, adding to the hurt and loss at a time of great sensitivity, while at the same time leaving a long-lasting impression.

Another participant (F5), speaks about terminology in a very pertinent way. She was, and still is, a nurse in an operating theatre where an 'evac' would be carried out. This, she describes as the "evacuation of products of conception" and is aware that some of her colleagues would refer to this procedure as an 'abortion' or 'termination'. Coming from a position of understanding the realities of those who care for patients did not diminish the impact of such words and phrases on her, and yet by virtue of her profession she was complicit in their use before, between and after her seven miscarriages.

Reflecting on terminology, I cannot improve on F11's words, "I think terminology has a lot to answer for."[57] She goes on to add, "I think if you use that terminology then you feel you are guilty." Addressing how miscarriages, associated medical procedures and what is lost by miscarriage are referred to would help prevent the compounding of guilt that some women might feel. More sensitive use of language would also promote a culture of support by recognising that for those who have longed for a baby, it was their baby that has been lost.

I am conscious that the ethical approval limiting my research to those who had experienced an early miscarriage to at least ten years previously may leave my conclusions open to the criticism that they may only be relevant to a particular period in time, and that current practice may be quite different. With respect to language, however, little has changed, as is evident from an on-line article by Anna Medaris Miller, senior health editor at U.S. News, published in 2018. Miller quotes Dr Zev Williams, an obstetrics and gynaecology consultant, who comments that "There are so many terms we use that are confusing to patients, and even to clinicians" (2018, para 4). Miller goes on to say that "miscarriage is one area in which unfortunate language choices can reinforce women's shame and isolation" (para 5). She also highlights the unhelpful description of the phrase 'spontaneous abortion' which I have already mentioned. Other terms

[57] On learning that her baby had died F11 was admitted to hospital, where a doctor had used the term 'products of conception' and a nurse, in speaking to a colleague, referred to her being in hospital for an 'abortion'.

such as ‘pregnancy failure’ she notes as being particularly hurtful (para 9) as it conveys a sense of the mother having done something wrong and, by inference, apportions blame. The term D&C is more acceptable to those requiring a medical intervention and is preferred, according to Miller, to the more modern description of ‘uterine aspiration’ or ‘uterine evacuation’ (para 11). At the end of her article Miller quotes one mother who had experienced early pregnancy loss who said “I think the language is making us feel guilt and shame and more isolated and alone.”[58] This recent evidence supports my view that the reported experiences of my interviewees are not isolated. This is further evidenced by a study reported in the Nursing Times (Stephenson 2020, para 1-26) and highlighted in the Guardian Newspaper (15th January, 2020) which, in response, published abbreviated accounts of their readers’ experience of miscarriage (“Readers on the pain of Miscarriage”). These published accounts highlight that much still requires to be done to support those who have experienced early miscarriage. Lack of support and inappropriate terminology feature strongly. Nicole (London) wrote that “while it was a ‘bundle of cells’ to doctors and ‘not a viable pregnancy’ it was a dream to be pregnant.” Eleanor (Northhampshire) says that the health professionals who dealt with her were “clearly ill equipped to cope with any mental health implications.” Bibi (Austria) describes how “it didn’t matter if my kid was technically not a human being but just a lump of cells – it was my kid, and it was gone.” Language matters.

Admittedly, those whose stories are noted in the Guardian may not be representative. They submitted their accounts and wanted to share their experiences. However, these experiences echo those in my study. Eleanor (Northhampshire) says her family “struggled to understand the impact it had on me.” Nicole (London) thinks “it is difficult for people to understand what it means to lose a pregnancy early on.” Anonymous writes “friends and family haven’t really known what to say and had little understanding of the trauma I was suffering. Bibi (Austria) relates that everyone kept telling her how it would be okay and that she would get pregnant again. She says it was like being told “who cares if you lost

[58] Quotation from an interview with Julie Davidson who describes her own experience and is author of the book *From Conception to Confusion*.

your child? There would be others." As has been seen in this thesis, well-meaning advice can still be very hurtful. Another anonymous contributor says such advice actually hurt the most; for example, "at least you know you can get pregnant" and, "my friend had seven miscarriages (as if it's a competition)." These accounts not only provide an up-to-date echo of the findings of my own research, they also show that the experiences I have reported are not restricted to a limited geographical area.

A second anonymous reader writes "My relationship broke down because of what happened and I am extremely isolated because my friends are at a loss to know how to support me. It doesn't seem to be a thing that anyone speaks about." Kat (Stockton–on-Tees), while noting that she required no aftercare or support, describes the insensitivity of receiving a twelve week ultrasound letter, a phone call from the midwife to book another appointment and an invitation to book a cervical smear (which could not be done until at least twelve weeks post pregnancy), all after her miscarriage. Only one of the respondents printed in the Guardian (Liz, Shoreham-on-Sea) records that her family provided a lot of help. However, she added that mental health support was almost non-existent. Such experiences parallel those reported to me by the women in my research study.

The heading of the article in the Guardian serves not only as a title for what was to follow but to convey to the rest of society a sense of the significance of what some may feel, "In my head I was already a mum and then suddenly I wasn't." It is essential, therefore, that we acknowledge and address such feelings. We must confront this silence surrounding miscarriage. This thesis seeks to do just that.

The Nursing Times article which generated the response in the Guardian referred to research involving more than 650 women who had experienced miscarriage or ectopic pregnancy, and reported that nearly 30% had suffered post-traumatic stress while a further quarter experienced moderate to severe anxiety, and one in ten had moderate to severe depression.[59] Professor Tom Bourne, one of the

[59] The paper to be published by the American Journal of Obstetrics and Gynaecology reports findings from a questionnaire survey involving 537 women who had suffered a miscarriage

lead authors, comments, “This research suggested the loss of a longed-for child can leave a lasting legacy and result in a woman still suffering post-traumatic stress nearly a year after her pregnancy loss.” One of the co-authors, Jessica Farren points out: “early pregnancy losses are still shrouded in secrecy, with very little acknowledgment of how distressing and profound an event they are.” In discussing the implications of their work, the authors of the research note:

> The fact that such a high proportion of women experience symptoms that are suggestive of PTSD and that these symptoms persist over time is important. It is recognised that PTSD in other contexts can have a significant impact on work, social interaction, healthcare utilization, and risks in future pregnancies. Given the annual incidences of miscarriage and ectopic pregnancy (which may rise further if the trend towards later childbearing continues), this points to a significant public health issue. (Farren, Jalmbrant, Falconieri, Mitchell-Jones, Bobdiwala, Al-Memar, Tapp, Van Calster, Wynants, Timmerman, and Bourne 2019, 1.e.11)

The need for support must not continue to be overlooked. Commenting, Jane Brown, chief executive of the pregnancy loss charity Tommy’s, said the research showed the need for urgent improvements in support. With this I would concur as my own study has identified a similar lack of support.

### 4.2.7 Emotions and Feelings

In order to equip those who seek to support, the I-Poems provide a reservoir of first-person statements which can be drawn upon to raise awareness of some of the emotions and feelings which have been experienced by those who were interviewed. I would urge caution against generalising. The interviews are those of the women who participated in my study and so the stories they relate are theirs. The emotions and feelings are theirs, though, as I have discussed in the previous section, these are similar to recently published self-reported accounts

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before twelve weeks and 116 women who had experienced an ectopic pregnancy. The responses were compared with 171 women who had healthy pregnancies.

of early miscarriage. Care must be exercised to ensure that every person who is offered support is treated as an individual with emotions and feelings that may be quite different from any reported here.

In a recent newspaper article by Jennifer O'Connell, with a sub-heading "I blamed myself for not wanting it enough." Dr John Kennedy of the Sims fertility clinic in Dublin is reported as saying, "the more we learn about miscarriage the more we appreciate all that we don't yet understand" (2019, para 3).[60] He adds, "A miscarriage is not caused by any action or inaction on the part of the woman" (para 5). In the same article, Deirdre Pierce-McDonnell, who is chairwoman of the Miscarriage Association in Ireland and who has personal experience of miscarriage, offers a reminder that there is more than one way to grieve and that "no reaction – sadness, disbelief, anger, envy, fear, shame, guilt, pride, relief, a sudden and overwhelming love – is more valid" (para 10). The plethora of feelings elucidated in the I-Poems also serve as a reminder that there is no one way in which women will grieve following their loss, and those who care for them must be aware of this.

Feelings of guilt and shame were expressed by F5, F7, F8, F11 and F12. These, I believe, to be extremely pertinent as they highlight that, in addition to coping with the loss of their baby, they are also trying to cope with the idea / some sense that they were to blame for what happened. In many cases there may never be an explanation of why a woman miscarried and, therefore, the woman may not stop blaming herself. Indeed, F5 and F7 had both miscarried between 9 and 23 years previously and still wondered what they had done wrong or having been done incorrectly. This is perhaps an unfortunate consequence of the word miscarriage where the word itself points to something having gone wrong. Reassurance, such as that offered by Dr Kennedy above, that the women have nothing to blame themselves for must be a priority. F5 posed the question, "have I done something wrong?" and repeated this later conveying the sense that this is a feeling she continues to live with. One participant, told of her guilt in a very painful way, "I apologised for losing his son; I felt guilty, it must have

[60] See The Irish Times online, 30th November 2019

been something I'd done; I was very, very sorry." Twenty-three years after the event, F7 was still blaming herself for something that was not of her making, neither had she been provided with the opportunity to bring out into the open her feelings and address them.

Mention must be made of the place for names in relation to early miscarriage. While much of the published material that I have drawn on for the literature review focussed on late miscarriage, stillbirth and neonatal death, the significance of giving the baby a name is quite different in early miscarriage. Where there is a Christian faith, it is not unusual for ministers to be called upon for baptism in cases of late miscarriage, stillbirth and neonatal death. Indeed, this prompted my previous research where I sought to explore what to do in such situations and how to do it. For cases of late miscarriage, stillbirth and neonatal death there is a Baptismal Certificate with the baby's name on it, the baby is recorded in the Baptismal Register and (where appropriate) on the Cradle Roll of the family's local church. However, in early miscarriage this is mostly impossible. In my recommendations in the final chapter, I urge that some means of recording the baby's existence be made available. The church should take the lead and give serious consideration as to how this might become a reality. However, here again, I would urge caution as there can be no one solution fits all approach. Two of my interviewees welcomed the idea of giving their baby a name (F3 and F7), but others chose not to personalise their bump (F8, F9, F10, F12) or wee bundle of cells (F4) and should not be pressured into doing so or made to feel guilt for not doing something that others thought important. Therefore, adapting the traditional means of recording though the registration process would not provide a simple solution.

I would encourage everyone called upon to offer support to read these I-Poems. They were conceived as I set out to find a means to convey to fraternals the experiences of those who have lost a longed-for baby. What came out of their creation was a deep and meaningful sense of loss that has largely gone unnoticed. They serve as a handle to open the door into a silent room where few are able to share their grief and be supported. By opening the door, the I-Poems

break the sound of silence and give a voice not just to twelve women I interviewed but to others who have experienced an early pregnancy loss.

### 4.2.8 Section Summary

This section has presented an analysis of the interviews by way of I-Poems and coding. In making reference to the silence experienced by my research participants together with the effect of (what I describe as being) hurtful support, inappropriate terminology and the impact that language has on the emotions and feelings of grieving parents, I conclude that support is lacking. However, this thesis seeks to elicit what support would be appreciated and how ministers (and other pastoral care givers) might be better equipped to offer more appropriate support. To this end, four recommendations have been identified as coming from the women themselves. These are: Make contact, Acknowledge the Loss, Listen, and Respond Appropriately.

## 4.3 Educational Intervention at Ministers' Fraternals

Having conducted interviews, formed I-Poems and collated the women's recommendations for improved ministerial practice, I considered ways to share the story with my colleagues. As described in the Methods Chapter, I utilised existing groups (ministers' fraternals) who volunteered to learn of my research and how it might guide their ministry. I have been conscious that the experiences of my interviewees are from at least ten years ago and so am aware that current ministerial practice may be quite different. This educational intervention attempted to identify current practice (which will have developed over time) and to raise my colleagues' awareness about the support needs following early miscarriage. In this section, I detail the responses of those ministers as to how they might review their ministerial practice having heard the stories of the women who participated in my research study.

My literature review and interviews provided rich resources of information to share with other ministers. However, it was challenging to decide how to communicate this in a manner that would be helpful, provoke engaged

discussion and possibly lead to transformed practice. In the end, I decided on an educational approach that would consist of three main elements. These were:

1. An information leaflet that provided a succinct overview of the pastoral challenge of early miscarriage. This is presented as the 'Picture and Sayings Leaflet' (Information Leaflet; see Appendix 13). As outlined in the Methods chapter, this contained images that were meant to represent the emotions people experience: the joy of learning about pregnancy and the grief following loss. The sayings were taken from my Literature Review and were selected to emphasise the prevalence of miscarriage, and the effect it has on many people.

2. The I-Poems. Early in my research (as I have already noted), I had intended to use anonymised and fictionalised case studies in an educational intervention. However, on reflection, I feared that some may perceive these as being created for effect and not representative of the actual experiences of women who ministers might encounter in their pastoral duties. Using the poetic testimonies of my interviewees avoided any such misunderstandings. Each one told a story in a moving and compelling way, and therefore were ideal as a vehicle for sharing the story of early miscarriage.

3. A summary of the four recommendations made by the interviewees concerning the pastoral support they would have considered helpful.[61]

Each fraternal session (see Plan in Appendix 12) began with an introduction and an opportunity for questions. The information leaflet (Appendix 13) was then used to focus the ministers' minds with images depicting good news of anticipating a successful outcome to pregnancy. The ministers were then invited to un-fold the leaflet to see the image of an empty photo-frame which was used to represent a missing life. The rear of the leaflet contained some quotations about miscarriage which the ministers were asked to reflect on. After the initial

[61] Make Contact, Acknowledge the Loss, Listen and Respond Appropriately.

period of discussion each member of the fraternals was invited to select and read two of the I-Poems. Time was given for further reflection. Following the consideration of the I-Poems, which enabled the ministers to encounter the narratives of women experiencing early miscarriage, the discussion moved on to the recommendations made by the interviewees concerning pastoral support.

In order to record and learn from the ministers' responses to the educational intervention, I recorded and transcribed their comments in the manner that focus group data is usually recorded within qualitative research. Each speaker was given the identifier of MIN and a number, and in the few cases where it was not possible to determine if a speaker was a new contributor, I assigned them UKN (to represent that they were unknown) and a note of which Focus Group (FG) they were part of. Transcribing these sessions was very time consuming and the responses generated were difficult to categorise. However, I was reassured by the view expressed by Sue Wilkinson that there is, "no single canonical – or even preferred – way of analysing (focus group) data" (2003, 203). The practicalities are that focus group data is, "voluminous, relatively unstructured and not easily analysed" (2003, 203). The sections below outline the ministers' responses to the three aspects of the educational intervention and include their reflections, as noted on the evaluation forms (Appendix 18).[62] Each minister was issued with a form and nine were returned. They were largely supportive and encouraging, with only one being negative. However, even that respondent added that they thought the session would be "very useful" for their ministry.

Researching ministerial practice before and after participating in such a focus group could (and perhaps, should) be a research project in itself. Nevertheless, this was an extremely helpful part of my study. It has provided me with much to consider when I reflect upon how the practice of pastoral carers might be transformed, and how I might share in this process. However, I must acknowledge the difficulty of recruiting fraternals and reflect on the motivation of those who did participate.

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[62] These were completed anonymously.

Being a minister of long standing and having served on the committees and courts of the church in a variety of capacities, I am well used to the difficulties of encouraging ministers to volunteer. Ministers have enough demands on their time without an added commitment which might, or might not, prove to be of value in their ministry. To be involved in a student research project would not be top priority. Indeed, I would myself shy away from such invitations and would prefer instead to receive a summary of any findings or recommendations which I could glean for information helpful to my own situation. From my own experience, I would only give up time to participate in something which I recognised as having real value in my own setting and was of interest to me. This approach, I speculate, may be widespread. In agreeing to become involved the ministers may therefore not be representative and may have come to the topic because it piqued their interest or because they were favourably disposed to improve their practice. This would be a sign of a reflective practitioner; therefore, those ministers would be more inclined to reflect on their current practice and change it in light of what they had learned.

The selective nature of attendance by ministers negated some of the benefits of using a fraternal as an existing group who were used to discussing issues and topics of interest to them. On listening to the recordings again, it became clear that what was said were comments of individuals responding to me rather than in discussion with each other. Only on a few occasions did a discussion ensue and when it did, it was usually to negate forcibly another minister's apparent practice (for example, in response to MIN 3 who stated that he would still not visit).

Reflecting on the experience of each attendee, only two had been in full time ministry for over ten years and approximately half were within their first five years. This indicated that the majority were relatively inexperienced and may have been more open to continual learning.

In presenting the data from the focus groups sessions, I will do so under headings for each of the four recommendations.

### 4.3.1 Responses to the recommendations

I set out below the response of my fellow ministers to the recommendations made in the light of their new understanding of the pastoral challenge early miscarriage represents.

Recommendation 1. Making Contact

Several ministers provided reasons for not making contact. They expressed it in terms of having been told about the miscarriage but fearing the parents may not have wanted them to know. One stated:

> I wouldn't want to be the person to make things worse. MIN 3

This was followed by:

> I would probably say to the … person who's told me, to to say to them that I'm available to speak to. MIN 4

Another commented:

> I'm probably over thinking it but I'm looking at all the other circumstances of if I made that phone call, that person doesn't realise I know about it. Am I actually adding to the stress and the grief that they are going through? MIN 9

MIN 16 was worried that the timing of the visit might not be ideal:

> you just arrive and there's 12 cars on the drive and you go in and you know, there's loads and loads of people there and they might not want to speak to you in a way they would speak to you one to one. MIN 16

One minister offered a quite different reason for not visiting. She expressed concern it could have had been an unwanted pregnancy:

> the woman is both relieved that she's no longer pregnant but also feels guilty because she is feeling relieved. MIN 13

The negativity towards making contact was countered by encouragement from other ministers to make a visit regardless:

> I think personally I feel as if we can take that risk of doing the wrong thing. MIN 8

> There's gonna be times when you get it wrong but I think it's worth taking the risk. MIN 17

The women in my study were clear that they would value contact *of some kind* after miscarriage. However, the ministers were not in agreement about whether this recommendation was something they felt should guide their practice. Some ministers were very clear and concise about their duty to take this pastoral initiative as these responses indicate:

> if you hear about something, go and do it. MIN 1

> If I knew someone, I would certainly make that phone call. MIN 2

One of the ministers admitted to being unsure about how to respond, and was seeking further information about early miscarriage and appropriate pastoral interventions:

> I would say I would definitely make that phone call or even a note through the door or something … I actually came here thinking how, I do not know what I would do because I have no experience. MIN 7

Others, while suggesting they would make contact, added caveats such as:

> I think it would depend on the relationship to me and the person. MIN 4

A third category of responses came in the form of reasons for not assuming contact would be valued. Comments recorded include:

> I would probably phone them first and ask if they wanted me to come and see them. MIN 5
>
> could I cause more damage by making that phone call? MIN 6
>
> I wouldn't want to be the person to make things worse. MIN 8
>
> if I made that phone call, [and] that person doesn't realise I know about it. Am I actually adding to the stress and the grief that they are going through? MIN 15

As stated earlier, some ministers seemed very concerned to offer a rationale for their current practice. This is evidenced by phrases such as

> we might want to hold back … but we do make ourselves available by one means or another. MIN 1
>
> I'm available to speak to, but I'm not sure how comfortable in that situation I would be. MIN 13
>
> Maybe you are not the right person. MIN 8
>
> if you phone, you know they can put the barrier up. MIN 6

It would be wrong to speculate beyond what was actually said. However, the transcripts reveal that some ministers were more engaged with justifying their current practice rather than reflecting critically upon it or addressing how they could offer better pastoral support in future. This being the case, only one minister stated quite clearly that he would not change his approach:

> I would still not visit. MIN 3

This brought an immediate and pointed response from a colleague:

> Don't you feel a bit sorry, obviously YOU fail these people for saying that. MIN 1 (YOU is my typed emphasis, I have used capitals to reflect the force with which the word was used, and my noting of the emphasis in my field notes).

Having listened to the recordings and re-reading the transcripts, it is clear that a number of ministers were hesitant to make contact for fear of not receiving a positive welcome. However, as the discussions developed, there was an element of encouragement by some to look beyond their own feelings of how their contact would be perceived over time:

> I think if you are turned away at the door though, later on they would appreciate it. MIN 2

> I think it would be really good if somebody from the church went to show that, actually, the whole village is thinking about them. MIN 18

One minister added, as if to justify the need to do something:

> We've got to remember that one in four women ... miscarry. UKN[63] FG1[64]

Another made an interesting statement confirming that the session had not only been beneficial but an affirmation that by making contact she wasn't doing anything wrong:

> I feel hundred times better after that, which was good to know you hadn't done the wrong thing. MIN 4

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[63] UKN represents a focus group member whose voice I could not distinguish from the tape as being a new contributor or one that had already spoken.

[64] FG represents speaker was part of Focus Group 1.

I was encouraged by another response which highlighted reflection, minor struggle and continued uncertainty as to how he should make contact. He says:

> I'm going to a stranger invading their space … I'm seeing it from my uncomfortable ability, as well as a male, of not really having dealt with this before and not have having that life experience. MIN 7

Another minister, speaking from personal experience, also offered encouragement to her colleagues:

> it was really horrible but you know, it's eh, they were grateful. They were grateful that somebody went, and that somebody was thinking about them. MIN 21

It was interesting to note that the majority of ministers within the fraternals seemed to imply that they do make contact. Yet, this is not congruent with the reported experience of those grieving. This is a dichotomy that needs further examination and might be evidence of the reflective nature of the ministers who contributed.

<u>Recommendation 2. Acknowledge the loss</u>

Of the four recommendations examined, acknowledgement was the most difficult to separate as a category in its own right. I would argue that many of the responses above about making contact were indicative of a desire to acknowledge the loss miscarriage entails. By telephoning, texting or visiting an implicit acknowledgement was made that the person had experienced a significant loss.

In terms of current practice, there were no specific comments regarding acknowledgement. However, after reading the I-Poems, there were direct references. These included:

> What they want is us to acknowledge it. MIN 1

> I would like to acknowledge. MIN 8

Others were more specific:

> life that is going to be missed and, actually, we recognise that. MIN 7

> you are interested, you think it is important. MIN 11

Reflecting on the brevity of responses under this heading highlights a significant area where ministers are clearly unsure as to what they should do and how they should do it. However, as the responses to the fourth recommendation indicate most of the ministers who contributed were prepared to review their practice and were seeking the knowledge of how to do so.

Recommendation 3. Listen

Little was mentioned in the fraternal focus groups about listening. In fact, only three comments were noted. The first was:

> I just sat and I listened. MIN 2

The second was a reflection that ministers do need to allow people to share what had happened:

> I just think that it's just, it's really important that this is shared. MIN 1

This was echoed by the third comment which recommends what ministers should do when they visit; and that is:

> To give an opportunity to voice the silence. MIN 20

As I have reflected on the educational intervention sessions, I noticed that there was only the above comment which referred to the silence in which experiences of early miscarriage are still shrouded. It would have been useful to explore this further; to enquire if ministers were aware of the perceived silence that exists following early miscarriage which, to some grieving women, is an important issue.

The ministers were recognising how important it was to provide an opportunity for people to voice what is currently silenced. This involves not only listening but enabling 'voicing' to happen. The need to facilitate this was expressed eloquently by one minister:

> we don't actually give people spaces in which they actually feel like it's an environment safe for them. MIN 7

By listening we are creating the space which will enable parents to voice their thoughts and feelings. This action alone would, in part, help to fulfil the final recommendation.

Recommendation 4. Respond Appropriately

One wished to know more about how they could respond appropriately:

> I would actually want to offer something. UKN FG1

Only one minister expressed the argumentative view of child death as discussed in the Literature Review. However, it is evidence that such a view still exists:

> I think because if it's already dead, I think if the baby is already dead; it's too late. MIN 3

It should be noted that this was met with what I recorded in my field notes as, 'incredulous silence'.

In terms of the aim of this study, a number commented positively on how they had been challenged to rethink their practice. One minister stated that the presentation had encouraged her to reflect creatively on how to respond appropriately:

> I'd want to offer like some kind of acknowledgement, some kind of wee service in where actually and from … this and from the discussion I think I actually know you got to take lead from … people

> that have experienced that, you know, and it's not just about offering solutions, it's just about listening. MIN 13

Further encouragement was contained in the following comment which highlighted the importance of making space for reflection on pastoral practice in relation to miscarriage:

> Exactly what we are doing tonight, thinking how can we be there for people in their faith, because there has been a spell where maybe church hasn't been that good at doing that. UKN FG3

I interpreted this as an acknowledgement that current practice has not been appropriate. It was a subtle way of expressing that the Church has not provided the support that the women in this study would have appreciated. On an evaluation form it was commented:

> One of the things that this highlights is how much is actually missing from ministerial training.

This last comment fits well with my own experience as expressed in the Reflexive Prologue. Ministerial training can be improved and, with regards early miscarriage support, is a matter all denominations should attend to.

In terms of asking ministers to reflect on their practice, one final comment serves as a summary of the pastoral challenge of early miscarriage:

> I quite often think that it's where people are at their lowest, where they hit the rock bottom, when they are on their knees and they are full of grief … You might find that, that's actually when they need you. MIN 2

It is difficult not to disagree. However, knowing that you are needed by those experiencing a low point in life is quite different from knowing how you should respond.

Returning to the central issue of how ministers might envisage changing their practice, it was clear that all bar one of those who completed the evaluation form had been motivated to do so. They spoke about:

> not minimising the loss; coming alongside; listening; acknowledging; and taking the lead from the person being visited; not just seeking solutions that the minister thinks will help.

One wrote eloquently:

> I am not the fixer, rather the enabler to allow both the men and women to voice their silence and work with them on their journey.

This comment is one with which I would concur. Indeed, having been involved in this research project I would encourage all involved in pastoral care to adopt this into their practice. None of us can be the fixer, but all of us can enable grieving parents to voice their silence as we travel with them on life's journey.

There was only one response which did not signify that the minister would change his/her practice:

> Not sure – my thoughts were that a death is a death-![65]

By starting this feedback comment with "Not sure", it could be interpreted that this minister was now giving some deeper thought to early miscarriage. That said, it is difficult to extrapolate much from that one sentence.

Some ministers responded in a way which indicated a degree of prior reflection on this pastoral challenge. For example:

> I don't think there's a, there's a, this is what I would do. I think every case would be very different. MIN 11

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[65] Dash and exclamation mark from original.

Creating a safe environment for people to voice their experience and share their emotions should be encouraged. One comment gives context:

> we don't necessarily get to grips with the fact that God is there in the times of grief and times of suffering and it's okay to say, "God, I'm really annoyed that this has happened." MIN 4

Another comment suggested a resource to support grieving parents as they sought to bring their feelings and emotions before God:

> And … you can use, you know, you can use Psalms, you can use Lamentations, you know, not to, you know, within that, be like it's okay, be as angry as you like. Be angry at me. MIN 9

It was surprising that these were the only two comments noted that offered advice to colleagues as to how they might respond appropriately. Encouraging parents to express their emotions of grief and loss can be very supportive. This is also true of enabling them to know that anger does not need to be hidden and it can (as did the people of the scriptures) be expressed to God. This reference to the Psalms and Lamentations is discussed in Chapter 5 which reflects on scripture and tradition as a resource upon which ministers and the wider church can draw.

In relation to the educational intervention as a whole, the comments received by way of the evaluation forms are best represented by what ministers recorded as taking away from the session. Expressions of:

> What not to do or say; there is no one approach fits all; to listen and take the lead from each individual; the need to acknowledge the death of a baby; listen to what the bereaved actually want; what <u>not</u> [their emphasis] to say and what to do.

Such comments provide evidence that for six of the ministerial participants the sessions had been beneficial in aiding their response to early pregnancy loss.

### 4.3.2 Section Summary

In this section, I have presented a summary response to my educational intervention in which ministers' fraternals served as 'focus groups' enabling me to come to an understanding of the challenges involved in developing transformed pastoral responses to miscarriage. I acknowledge that I have found this material difficult to thematise due to the enormous amount of data generated and my inexperience as a researcher. In retrospect, I now understand that another person acting as the sessions' facilitator might have been valuable, as this would have enabled me to focus more acutely on what was being said, and not said, by colleagues. Video recording the sessions would also have been helpful as identifying each individual speaker from the recordings was difficult and, at times, impossible. However, it is clear that enabling ministers to hear the stories of those who had experienced early miscarriage, through the presentation of the I-Poems, had initiated reflection.

Researching ministerial practice before and after participating in such a focus group could (and perhaps, should) be a research project in itself, with the educational aspect of fraternal group meetings being a separate session. Nevertheless, this was an extremely helpful part of my study. It has provided me with much to consider when I reflect upon how the practice of pastoral carers might be transformed, and how I might share in this process. I am also seeking to understand how my learning might be put at the service of the wider Church.

## 4.4 Chapter Summary

I have been privileged to hear and share the stories of women grieving the loss of a longed-for baby. In this chapter I have presented an analysis of the interviews and highlighted the reported lack of support, evidenced by what I have described as 'silence'. I have also identified four recommendations for support that would be appreciated. These are that pastoral care givers should: make contact, acknowledge the loss, listen, and respond appropriately.

This chapter also detailed how the women's stories were shared with others by means of an educational intervention at ministers' fraternals. The I-Poems proved to be a stimulus for reflection and the four recommendations a basis for discussion about pastoral practice. Most of those attending were minded to change their pastoral practice in response to early miscarriage.

## Chapter 5 - Sharing the Story

As has already been outlined, this is an action research project which has the ultimate aim of improving practice. In keeping with the definition offered by Reason and Bradbury, my research sought to,

> bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities. (2008, 4)

This chapter seeks to fulfil this definition. Having highlighted the need for action to support those who have experienced early miscarriage, I now reflect on the scriptures and my theological understanding that guides my practice. This will be presented in three sections.

The first section discusses the support that can be found within the scriptures and focuses on the biblical laments and how they might be used in private and public contexts. This section draws on the experience of Israel and its use of lament, comparing it to the place of lament in the Christian church. The next section outlines how my theological understanding of early miscarriage has developed having undertaken this research project. Finally, section three presents a reflection on the implications for my ministry as I seek to improve practice.

### 5.1 Reflection on scriptural support.

I have argued that support is essential following early miscarriage. This section picks up on a comment within the Introduction where I suggested that we need to reflect and learn from the scriptures and tradition to ensure that what we do under the banner of belief is relevant and appropriate. In examining the scriptures, lament psalms provide evidence of the support available in the expression of traumatic experience and provide a rich resource for the nation Israel approaching God during times of national crisis and personal trauma. Nancy Lee claims that all laments originate from the common impulse to give voice to pain (2010, 5). This is also noted by Leslie Allen who describes the Book

of Lamentations as, "a liturgy intended as a therapeutic ritual" (2011, 8). Therefore, the laments found in scripture should be examined and drawn upon where appropriate as a resource of support for those who have experienced loss. This section, in seeking to be a first step in helping give a voice to those who have experienced early miscarriage, addresses the support that lament may offer.

In the scriptures, the significance of human suffering is affirmed (Stone 1999, 21). This is particularly so in the laments. The Old Testament has three main sources for lament. The Book of Psalms contains both personal and communal laments, with one third of the book being laments (O'Conner 2002, 9), which is greater than the number of praise psalms. The Book of Lamentations, as its title suggests, consist of lament,[66] as does the book of Job where the prophet is wrestling with his beliefs about God and his experience of God.

Brueggemann notes that within the Jewish tradition, "an adequate relationship with God persists and requires a human voice that will speak out against every wrong perpetrated either on earth or by heaven" (1997, 22). This is evidenced in the book of Lamentations where human voices of pain and resistance, and not the voice of God, fill the first five chapters (O'Conner 2002, 1-3). Bringing one's pain to God is an, "act of hope that fully expects a response from a hearing God" (Brueggemann 2008, 232). In other words, individuals and communities believe that God hears their lament and they expect God to respond. According to C. Hassel Bullock,

> There is a place in biblical faith for this kind of boldness before God. The psalm of lament carves out a spiritual niche for us where

[66] The historical backdrop of this text is, "a very specific and traumatic type of loss and change that has befallen a community and left it shattered" (Allen 2011, 4). In 587BC Jerusalem was laid to waste by the Babylonian armies. Nathaniel Carlson, while not wishing to diminish the significance of this historical event, compares and parallels the experience of those traumatised by violent assault and sexual abuse to "the sacred is profaned, identity is stripped and expected helpers never come (2015, 66). Against this background the people lament.

> we can use the colloquial language of life's hurts and still stay in the vocabulary of faith. (2001, 138)

Therefore, those experiencing trauma should be encouraged to share their hurts and be reassured that within the context of faith it is alright to do so.

According to Daniel Estes, the "focal point" of the lament is the psalmist's complaint (2005, 166). As noted by Serene Jones (2003, 269), Calvin's commentary on the psalms highlights that they provide, "a textural theatre wherein traumatised persons can adopt identity scripts that strengthen their faith, even in the midst of the harm they are experiencing." Historically, the psalms have provided a focus and a legitimisation to the faithful that have aided those dealing with trauma. Similarly, Gerald West (2016, 222) has shown that Job 3 can offer survivors images and metaphor to facilitate talking about their trauma. While Job's experiences are quite different from those who have experienced early miscarriage, Job helps to legitimise the desire to share with God the immediate reality of personal experience and to do so in one's own words.

Federico Villanueva believes lament psalms are not merely requests for God to act (2008, 253). In a later publication he also claims that the laments challenge people to confront their sufferings and struggles, and invite people to approach God in order to pour out their hearts to God (Villanueva 2017, 11). Within the pain and suffering of early miscarriage it is difficult to envisage how God might be called upon to reverse the loss, but God can still be called upon as a means whereby people can lay before God their inner thoughts and feelings. The laments, therefore, offer support, comfort and hope for the future. John Goldingay agrees, claiming that laments consist mainly of, "expressions of pain and protest" (2006, 62). By drawing on lament we have a means through which individuals, and worshipping communities, might express the pain of loss that they are experiencing.

It should be noted, however, that lament is not passive. It does not encourage others simply to accept their lot. Lament takes the traumatic experience and

forcibly poses the question, 'Why?' Walter Brueggemann asserts that lament psalms are "protests of expectant change" (1992, 85). Sixteen years later he continued to maintain that the purpose of lament is to "summon God back into action trusting that … things may change" (Brueggemann 2008, 232). Similarly, Broyles (1989, 14) argues that a lament psalm, "does more than simply bemoan current hardship. It seeks change." Lament has within it, "a profound yearning for a transformation that will end the unbearable reality of present arrangements" (Brueggemann 2008, 232). The laments, therefore, are a ready resource to call upon in a time of suffering and have much to offer as a potential for support.

There are no written psalms or songs of lament in the New Testament. However, the early church had the existing laments to draw upon. Moreover, lament texts occur throughout the New Testament and can be found in the Gospels, and to a lesser extent in the epistles and Revelation. Jesus uses lament on the death of his friend Lazarus, as he approached Jerusalem and on the cross. The first of these examples should serve as a reminder to the church that just as Jesus wept over the death of his friend, the body of Christ (the church) can and should lament losses in life. It can be argued that Jesus embodies the full pattern of lament: Jesus is God's answer to Israel's lament seeking restoration. In other words, in proclaiming the kingdom of God Jesus enacts the nation's laments in his life, death and resurrection (Brueggeman, 2008, 225-226).

This is particularly relevant when considering the anguish experienced by those who mourn the loss of a much longed-for baby. The cry from the cross is a lament asking why God has forsaken Jesus.[67] Moltmann argues that the Father forsakes the son and the son is lamenting the absence of God at a time of great need (in Solle 1979, 111-117). Jesus' cry of abandonment can, according to Moltmann, be read as a unique and unprecedented expression of loss (1974, 150). However, the basic assumption of biblical lament is not absence. The tearing of the temple veil "transfers the place of God's presence from its hiddenness in the Holy of holies to the openly godforsaken cross of the dead

[67] "My God, my God, why have you forsaken me?" (Psalm 22:1a)

Jesus" making God uniquely present – rather than absent – at Jesus' death (Bauckham 2008, 267). The cry from the cross can therefore be seen as his (and therefore God's) identification with those who suffer.[68]

At times of tremendous grief some believers may question their faith. How is it possible to worship, "a God who hides at a time when God is needed" (Tesfai 1994, 14)? Nevertheless, God is not absent. Just as God is present in the pain of the world as seen in the crucifixion, Christians can also be comforted by the response of Jesus during his time of suffering and his plea for help.[69] Jesus does not forsake these petitions. Jesus responds and offers God's salvation through forgiveness, healing and restoration. Indeed, Martin Ebner argues that, "Belief in the resurrection of Jesus and the corresponding hope for resurrection is the theological basis for lament before God" (2001, 75). The church itself stands with those who mourn and offers God's comfort with the hope that all those who mourn will receive perfect comfort (Ford, 1999, 88). However, the perfect comfort that Ford refers to may be difficult for grieving parents to comprehend.

In seeking to offer comfort, experience suggests that the church does not make use of lament as it might. In his commentary on the Book of Lamentations, Robin Parry comments on the often observed contrast between Israel's embrace of lament in the Old Testament and the far more ambiguous reception of lament in the Christian church (2010, 206). Claus Westermann writes,

> It would be a worthwhile task to ascertain how it happened that in Western Christendom that lament has been totally excluded from men's relationship with God, with the result that it has completely disappeared above all from prayer and worship." (1974, 25)

Forty-five years on, this absence has still to be fully addressed and the benefits of incorporating lament into worship appreciated.

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[68] see Jacqueline Grant who identifies Christ's suffering with the oppressed and lowly, and his corresponding empowerment and liberation of the weak and downtrodden (1989, 212-20).

[69] see Matthew 15:21, Matthew 21:25 and Mark 10:47.

Brueggemann sees biblical lament as a means where victims are empowered (1986, 60). The absence of lament in worship leads to the loss of voice of people in pain since modern worship conditions the faithful to speak only praise and doxology. “A community of faith which negates laments soon concludes that the hard issues of justice are improper questions to raise at the throne, because the throne seems to be only a place of praise” (Brueggemann 1986, 64). Worship must be more than an act of praise. In fact, regular use of lament would help create a strong foundational support for individuals while, at the same time, serving as a reminder to the congregation that suffering is not anathema to faith.

The consensual relationship with God, according to Brueggemann, allows the behaviour, “to take initiative with God and so develop over against God the ego strength that is necessary for responsible faith” (1986, 66). Christian tradition has tended to emphasise lament as penitence rather than protest (Nitsche 2000, 133-53) and, as claimed by Westermann, “we can say that in a certain sense the confession of sin has become the Christianised form of lament” (1974, 33). By taking this approach, the church has deprived Christians of the solidarity of God in their suffering.

Brueggemann adds, “Where there is no lament through which the behaviour takes initiative, God is experienced like an omnipotent mother” (1986, 61). Current practice encourages the individual only to praise God. This Brueggemann describes as, “bad faith which is based in fear and guilt and lived out as resentful or self-destructive works of righteousness” (1986, 61). This limited expression of faith must be confronted and addressed both in terms of public and private worship.

June Dickie, in examining the importance of lament in pastoral ministry, describes lament as being “little understood or practised in most contemporary church communities” (2019, 1).The loss of lament in public worship has been a loss for the church and for individuals of faith as they seek to cope with the experiences of loss and trauma.

Brueggemann writes:

> One loss that results from the absence of lament is the loss of genuine covenant interaction because the second party to the covenant (the petitioner) has become voiceless or has a voice that is permitted to speak only praise and doxology. Where lament is absent, covenant comes into being only as a celebration of joy and well-being. Or in political categories, the greater party is surrounded by subjects who are always 'yes men and women' from whom 'never is heard a discouraging word'. Since such a celebrative, consenting silence does not square with reality, covenant minus lament is finally a practice of denial, cover up, and pretense, which sanctions social control. (1986, 60)

Brueggemann's description of "consenting silence" is in my view helpful. The lack of lament in public worship has effectively removed the voice from those who live with hurt and sadness, which would enable them to bring their experiences before God. As I conclude in my recommendations, the church has colluded in the silence surrounding miscarriage. In order to break this silence, the value of lament requires to be re-examined.

Nathaniel Carlson argues that the "neglect of lament isolates trauma survivors (including others who suffer and grieve) from the language they need to both hear and speak in the corporate worship of God's people" (2015, 54). This isolation (or silence as I have described it in this thesis) may increase the pain people experience.

Additionally, Carlson quotes Marva Dawn, as evidence of the lack of lament, when noting that "the lament psalms are not even printed in the Lutheran Book of Worship and they rarely appear in the Sunday lectionaries of the Episcopalians or Roman Catholics" (2015, 53). The same is also true in my own denomination, the Church of Scotland. This leads to a denigration of the role of lament within the traditions of the church, which (in turn) relegates it to being subservient

within public worship and as a consequence in people's personal approach to God.

Carlson, who examined the repertoire of SongSelect, noted that this leading worship resource did not include lament among its nine hundred and fifty worship themes (2015, 53).[70] This is supported by the pastor and song writer Glenn Packiam who identified that in classical music when sadness is the relevant emotion, the musical structure is a minor key (n.d., 16).[71] [72] He concluded that in the 104 most sung praise and worship songs in the United States over the past twenty five years, only nine have a minor motif (Packiam n.d., 16).[73] He also noted a corollary in pop music, which highlighted the modern preference for avoiding sadness.

One of the recommendations from my research is that we must seek to break the silence and normalise discussion around miscarriage. Therefore, worship leaders should be encouraged to embrace lament and acknowledge sadness which is part of the experience of life. Regularly incorporating lament as part of ordinary worship would help to break the silence many experience in their grief. They would hear about, and be familiar with, a God who cares. Carlson quotes Ronnie Janoff-Bulman who claims that only one quarter of those who experience significant psychological distress seek professional help (Carlson 2015, 54). Therefore, the church with the wealth of Biblical resources at its disposal has a wonderful opportunity to support the large percentage who might otherwise go unsupported. For the past forty years scholars have urged the need for lament. It is our responsibility to use it and to do so purposefully.

Marva J. Dawn and Walter Brueggemann argue that "if religious communities are to be authentic they must incorporate lament within their worship services" (as

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[70] SongSelect is a database of over 100,000 songs for worship.

[71] In a study published on-line with no date.

[72] This is also supported by the musicologist Deryck Cooke who states that, "Western composers, expressing the 'rightness' of happiness by means of a major third, expressed the 'wrongness' of grief by means of the minor third, and for centuries, pieces in a minor key had to have a happy ending – a final major chord (the 'tierce de Picardie') or a bare fifth" (1959, 57).

[73] Accessed via statistics in Christian Copyright Licensing International (CCLI), parent company of SongSelect.

quoted by Snow, McMinn, Bufford, and Brendlinger 2011, 113). Lament should be incorporated into the lectionary and regularly used as part of worship. However, while largely absent, laments can still be read or used as an introduction to prayer and/or utilised in sermons. Such use would be an effective way of helping to bring language to the sadness in people's hearts while challenging the assumption that Christian life is always happy or victorious.

In advocating for greater use of lament, Dickie identifies four benefits. The first being that there is an opportunity for the hurting person to tell his or her story. She goes on to describe how having one's pain acknowledged is enormously liberating. As a person relates their suffering, they express it again in the context of having a hearing (Hamann 2005, 123).

The second benefit noted by Dickie is that the practice of lament enables Christian witness to be authentic. "If we are to be a community that cares, there is a need for a 'listening attitude' (Dickie quoting Hamann 2005, 83) offering one's presence and one's ears to those in pain" (Dickie 2019, 3). In other words, for the church to be a caring community it must be attentive to those in need.

Thirdly, Dickie suggests that lament enables us to face up to the realities of life. She quotes Denise Ackermann:

> The scriptures have given us a language that can deal with suffering. In the ancient language of lament, we have a way of naming the unnameable and crying out to God and naming situations that are unbearable. (2001, 25)

This is an essential aspect of what we seek to do in supporting others in coping with their trauma.

Finally, Dickie asserts that lament reveals that God is not complacent about suffering and engages with the one who complains rather than rebuking or crushing them. Dickie concludes that, "pain voiced and processed becomes the basis of a new relationship with God, one that is more mature and able to

process differently" (2019, 3). Approaching the use of lament in this way helps resist the view of a comfortable God who resists pain.

My research is not focussed on the use of lament, yet the points raised by Dickie are pertinent to identifying ways to support those grieving the loss of a longed-for baby through miscarriage. The recommendations that have come out of my research resonate within the first three points elucidated by Dickie. Giving people the opportunity to tell their story and relate their experiences enables them to know that we care and God cares.

Some of the lament psalms may be deeply personal. However, they are not private. They were part of public worship and shared by the worshipping community. By utilising lament in ordinary worship, Christians will become familiar with a God who cares for them and so will turn to God for care. Dickie poses the question:

> Has the time not come to restore this much-needed aspect of our faith [i.e. lament]? Are we to allow those in pain to simply turn away from the church, finding no place to rest their heavy hearts or let their tears flow and be supported by their brethren? (2019, 8)

By incorporating lament into the life and witness of the church, Christians will be able to draw on the resources utilised by generations as they seek to find comfort and support during times of loss.

Such an approach is encouraged by Eugene Peterson who writes in *Five Smooth Stones*, "When others join the sufferer, there is consensual validation that the suffering means something" (1980, 145). He then goes on to add,

> Again, when the community joins in the lament, sanction is given for the expression of the loss, the outpouring of emotion is legitimized in such a way as to provide a catharsis and then renewal. (1980, 145)

This would be a significant stride forward in the breaking of the silence surrounding miscarriage within the Church. Just as one should strive to normalise miscarriage in conversation, we must normalise the inclusion of pain, grief and loss in worship. Susan Smith in her study of Christian ritual, writes that, "experiencing lament with all its feelings can be the first step in healing: the core outcry from an unspeakable pain" (2012, 97). If lament is absent from worship, it adds to the silence around miscarriage. However, if it is regularly included, then it will not appear out of place and people may view the church as a natural locus where their sorrows are acknowledged.

Choosing hymns and songs that deal with sadness and difficult emotions, even when in the unpopular minor keys would, in part, help to portray the church as a place where the traumas of life are recognised and acknowledged. Packiam also suggests utilising the sermon as a means of introducing lament to enable a congregation to understand the role of lament in the life of faith (p19). He cites the example from his own congregation which sought to link human experience with a psalm of lament and a moment in the life of Christ, from which three themes emerged each week,

> First, that the Christian is never alone, even in her suffering, for Christ is there; secondly, because Christ took our suffering upon himself, went to the cross and down to the grave, our suffering is not meaningless; and finally, because Christ was raised from the dead, our greatest pain—even our death—will not be the final word. (Packiam n.d., 20)

Adopting a similar approach would enable congregations to incorporate the significance of lament as an integral expression within worship. In offering support to those who have experienced early miscarriage, ministers (and other worship leaders) must ensure that the resources which have been effective in the past are utilised in the present. Worship should provide the voice of lament as a place to speak to a world where personal loss is normally overlooked, unless in the context of a funeral. Those of us who lead worship must provide the

means whereby others can express their pain, and that doing so is recognised as part of the normal Christian life.

In summary, we must not ignore the pain and trauma experienced by individuals. Biblical lament can serve as a powerful tool when ministering to trauma victims. Brueggemann has reflected on biblical lament over many years and notes that the issue of pain is crucial to Israel's portrayal of God (1992, 18). Ken Stone notes that while ignoring the realities of pain may be comfortable, engagement with lament aids in the design to end pain while allowing a growth in the understanding of God (1999, 25). For too long the church has found it comfortable to ignore the reality of those who have experienced pregnancy loss and in doing so has been complicit in building the wall of silence that grieving parents encounter.

In this section I have indicated how lament was an important part of Israel's history. Lament should also play an important part in the life of the Christian church. It is a way for a person or group experiencing pain to move closer to God, even if God is viewed as being the cause of suffering (Westerman 1981, 273). In the modern world lament continues to be a means by which people can deal with the traumas they experience in life.

**5.2 Changes to my Theological Understanding**

As I hope I have made clear throughout, this thesis is a work of practical theology as action research. The changed praxis generated does not only involve questioning pastoral practice but taking a deeper look at the theology underpinning ministerial practice. In this section, I offer my own, brief, theological reflection on this topic.

Reflecting on the support available from scripture and tradition has only been part of my journey as I seek to develop my theological understanding. The writings of Jones, who I have referred to in the previous section, have challenged me to think deeply about how those who have experienced early miscarriage might be strengthened by faith.

Jones describes, in her book *Trauma and Grace*, an encounter with a young woman for whom the communion ritual triggered terrifying memories of her abuse. Jones realized that,

> when one becomes aware of the extensive wounds that events of overwhelming violence can inflict on the soul, bodies, and psyches of people, one's understanding of what human beings are and what they can do changes. (2009, 11)

This led Jones to resolve that,

> if the church's message about God's love for the world is to be offered to those who suffer these wounds, then we must think anew about how we use language and how we put bodies in motion and employ imagery and sound. (2009, 11)

I have already indicated the importance of language when relating to a grieving parent. This was in terms of descriptions used and how they were received. However, the church has an opportunity to shape the language surrounding early miscarriage as it seeks to frame a theological response.

In my research, not only have I engaged with feminist theology – something I now recognise as being long overdue – but my research journey has prompted me to think theologically about early pregnancy loss. Reflecting on his work as a practical theologian and as an educator, R. Ruard Ganzevoort comments that:

> Many pastors experience a wide gap between their practical work and their theological knowledge and they lack the skills and the procedures to make the connection. If they attempt to make a theological interpretation, they feel that it is either irrelevant to the situation, or overpowering the people they work with. (2008a, 15)

It is essential that ministers close the gap between their practical work and their theological knowledge. I believe that carrying out the functions of ministry is practical theology in action. However, what is done and how it is done must be

underpinned by theological reflection. This is a task which should be led by the Church (and is one of my recommendations in the next chapter). However, those called upon for support must be aware of the challenges of trauma (including miscarriage) to theological thinking.

Judith Herman in her book *Trauma and Recovery* notes, "It was once believed that [traumatic] events were uncommon" (1992, 33). In support, she adds that in 1980 the American Psychiatric Association described traumatic events as "outside the range of usual human experience" (Ibid). However, trauma is now seen as part of human experience and as such, "we must take trauma and violence not as strange exceptions to an otherwise 'nice' world" (Ganzevoort 2008, 13). Trauma is not an unusual or rare experience and, therefore, deserves to be addressed.

In writing from the perspective of a counsellor, Norman Wright proposes that, "the heart of trauma and crisis is loss" (2011, 4). Miscarriage is a loss and, therefore, can be viewed as a traumatic experience. I have argued that loss through miscarriage is not a rare occurrence for a significant portion of the population and, therefore, must be recognised as part of the embodied experience of people.

Ganzevoort uses the term trauma to, "refer to shattering life events and we invoke the expectation that those involved suffer deeply and will be affected for the rest of their lives" (2008b, 19). He goes on to describe how the experience of trauma connects directly to the fundamental issues of theology – which include: the question of suffering and theodicy; the issue of guilt and innocence; and the centrality of forgiveness and reconciliation. This raises the question of how we can make sense of painful experiences (including perinatal death) and still believe in a loving, caring and powerful God (2008a, 12-13)? At the root of Christianity is a story of deep traumatisation and, Ganzevoort reflects,

> how the suffering of Jesus relates to our suffering, how his victimization relates to our victimization, and how his resurrection may relate to a possible new life for us as well (2008a, 13).

However, making a comparison between Christ's suffering and our own is not unproblematic. Andrew Schmutzer focusses his thoughts on how a person's trauma affects their relationship with God: "Our relationship with God is realized in a body; when the body is 'broken' and traumatized, so can one's relationship with God be — utterly traumatized" (2009, 79). It is difficult to relate this to Ganzevoort's view that,

> The suffering of Jesus then may be read as an affirmation of solidarity with victims, and the Eucharist may be interpreted as not only salvation for the guilty, but also for the wounded that share in the brokenness of the body. (2008a, 13)

For those who are suffering loss, knowing that Jesus is in solidarity with them might mean little if their relationship with God has been broken.

Ministers (and pastoral carers) must not shy away from those in their care who may be feeling 'utterly traumatised', and be aware of what Jennifer Beste describes as some of the difficulties trauma survivors have in maintaining faith and trusting God. She asks the question: "Does lack of faith demonstrate that God does not offer the grace of faith in Christ, or does it signal a failure of God's grace to overcome the debilitating effects of trauma?" (2007, 130).

I am encouraged to pursue responses to trauma in my theological reflections by the writings of Shelly Rambo. Rambo has demonstrated a particular concern in her work to explore the difficulty that Christian tradition has in responding to life after traumatic events. In terms of the findings of this research, I must concur. The Church has not responded adequately to the trauma of early miscarriage and this is evidenced, not only by the experiences of the women who shared their experiences but, by the ambivalence of the response of ministers. Rambo is of the view that the traditional theological position has been that, "Wounds must be erased" (2017, 36) and this has led to a failure to acknowledge the persistence of the effects of trauma in people's lives. She argues that: "The resurfacing of wounds and the capacity to examine them (as Jesus invites Thomas to plunge his hand into Jesus' side) allows for past trauma

to breathe and 'be tended'" (Rambo 2017, 89). Ministers (and other pastoral care givers) must be encouraged to reflect upon the effect early miscarriage has on individuals and mould their pastoral response around practices that respond to the women's four recommendations in order that people's trauma might be 'tended'.

Miscarriage is experienced as trauma by many women, and if this fact becomes more widely recognised (as I argue it should) it would also become a theological challenge.

> People who have experienced trauma are not simply healed and enabled to begin life anew. The push to move beyond the event, to a new and pure place is not just a misconception about traumatic survival: it is a dangerous move that threatens to elide the realities of traumatic suffering. (Rambo 2010, 4)

The shattering nature of a traumatic event is frequently re-experienced and re-enacted in new forms as time moves on, causing further wounding and disruption to people and communities. Trauma returns and remains.

> The challenge is to account for what remains – to provide a discourse of remaining that can speak to life in the aftermath and to the shattering of familiar frameworks by which persons and communities have orientated themselves in the world. (Rambo 2010, 8)

A similar perspective is articulated by Maggie Ross who states that we need to understand healing for what it really is,

> it is not a vanishing act, but rather learning to live with, in, and through pain, to adjust to our wounding, which cannot ultimately be denied, and to be willing to risk opening to change that will lead to transfiguration. (Ross 2007, xviii)

In the light of the enduring effects of trauma, Rambo encourages theologians and pastoral practitioners to delve deeply into their own understandings of God

in order to respond to the challenges trauma represents for faithful people. She advocates a new approach. She is of the opinion that:

> Trauma presses theologians to seek new language to express God's relationship to the world … Amid the claims about redemption and new life there must be theologians who testify to the undertow, to witness the pull of death in the tenuous territory of the aftermath. (Rambo 2010, 14)

To this end, she uses Holy Saturday as a theologically rich location from which she addresses trauma. She highlights the discomforting aspects of constructive narrative theology which doesn't only serve to console with reassuring stories but awakens and disturbs. By moving through narrative and into poetics, contemporary theologians are seeking to remind us that new wine cannot be contained in old skins; new modes of acting and speaking must be created that are accountable to the painful realities that confront us. Rambo goes on to draw upon the work of Rebecca Chopp and advocates a radical poetics of theological testimony.

> This way of speaking with wounded words is theological speech; in its movements of unsaying and saying, apophasis and cataphasis, it has the potential to witness to what remains – to the always here… For Chopp the work of testimony and truth telling must be met with a refashioning of theology as poetics. (Rambo 2010, 164)

Simone Weil, who has been described as writing with passion while thinking poetically (Hollingsworth 2013, 208), believes that exposure to the perfect purity of God can be healing and that many trauma survivors do find their solace by imagining their lives as being part of the grand narrative that culminates in resurrection, even when visible scars remain (Weil 2001, 83-142). Rambo also seeks to reflect upon resurrection in a manner that does not erase the woundedness (scars) of those who have suffered trauma. In her reimagining of the encounter of the disciples with the resurrected Christ in the Upper Room hope surfaces out of woundedness:

> They are on lockdown in the aftermath of his death. It is unclear how long they have been there, but he appears in their midst, as if out of nowhere. He offers no explanation for the display of the wounds. Some say it was to confirm his identity, to prove he was the one he claimed to be. But the wounds bring back memories. They remind them of what they wanted to forget. The events in the Upper Room tell a story about wounds that surface, testifying to wounds that have never passed away'. Histories of suffering return in this space, both perilous and promissory. His body tells truths about the past, but it also signals a future. It speaks something more, not beyond history but across it. The past is alive, but they hold its difficult truths in tension. He sends them out, with life-giving breath. Stepping out, a new collective life takes shape. (Rambo 2017, 71)

Rambo's work on trauma does not focus upon the situation of women who have experienced pregnancy loss and, as I have argued, this is a topic that is rarely seriously addressed within theological thinking. An exception is the work of North American theologian Serene Jones who courageously reflects upon her own experience as a theological resource. Jones describes reproductive loss as "a topic that enables serious reflection on the traumas embedded in the everyday lives of those around us and the theology one might bring into play to imagine grace breaking into the space of devastating loss" (2009, 128). She suggests an, "image of God 'standing with' … the woman ravaged by grief at the loss of her hoped-for children" (2009, 146). She uses an image of the Trinity:

> When Christ is crucified, God's own child dies … this death is the death of hope … it is the death of a possibility that has never been … this is a death that happens deep within God, not outside of God but at the very heart – perhaps the womb – of God. (2009, 148)

Jones' argument is not that women should imagine their own suffering as an act of redemption but as, "a morphological space within which they might imagine God's solidarity with them, as those who lose a future they had hoped for and who carry the weight of loss inside themselves" (2009, 149). Jones admits that

her work is still in the process of development but she, nevertheless, offers it as a new narrative which might "enable the return of a future and the possibility of grace to take hold of those traumatised by loss" (2009, 150).

The fact that my interviewees so readily volunteered in my research shows that they did not want to leave the past undisturbed. They wanted to speak about what happened to them, but it must not be assumed that the act of speaking about such a traumatic event does, in itself, bring about healing. Indeed, as Heather Walton states we must be aware of assuming that voicing trauma is redemptive work. Walton writes, "It is now frequently claimed that the work of storytelling lies at the heart of the healing encounter between those who suffer and those who seek to meet this suffering within the resources of faith" (2002, 2). However, as Walton goes on to argue, "narrative cannot always restore what has been lost in trauma" (2002, 4). This is affirmed in the introduction to the edited collection *Tense Past: Cultural Essays in Trauma and Memory* in which it is argued, "there is nothing liberating in narrative per se ... merely to transfer a story from embodied symptoms into words is not necessarily to exorcise it" (Antze and Lambek 1996, xix). We must be cautious that in affirming the desire of women to speak about their experience we do not assume that the narrative process is automatically healing and restorative.

The more I reflect on the loss and trauma of early miscarriage and seek the resources to offer appropriate support, the more I resonate with the words of Moschella, "The pastoral care provider must listen to both the comforting stories of hope and the disruptive stories that, "awaken us to uncomfortable truths" (2008, 146). As ministers, we must address these uncomfortable truths.

Suffering has been described as the starting point for all pastoral and practical theology (Cooper-White 2012, 23).[74] As a parish minister, I am called to support my congregation and parish through the events of life including times of

[74] Throughout this thesis the term patient is oft repeated. All of the participants had received care from the medical community and as such had this description assigned to them. The word 'patient' comes from 'patiens' which refers to suffering.

suffering.[75] I continually seek to identify an appropriate caring response for every individual I am called upon to support. Having my own experiences of close personal loss, I resonate with the words of the theologian Nicholas Wolterstorff who wrote after the death of his son:

> If you think your task as comforter is to tell me that really, all things considered, it's not so bad, you do not sit with me in my grief but place yourself off in the distance away from me. Over there, you are of no help. What I need to hear from you is that you recognise how painful it is. I need to hear from you that you are with me in my desperation. To comfort me, you have to come close. Come sit with me on my mourning bench. (1987, 34)

This thesis presents a greater understanding of the support needs following early miscarriage. It is the product of a continuing cyclic journey of reflection and learning and reflection as a means to inform my practice. [76] I am, therefore, better equipped to sit on Wolterstorff's (and that of other people's) mourning bench. It also encourages ministers (and other pastoral care givers) to reflect on how they might better support by reviewing their practice which is both the origin and the end of theological reflection (Graham, Walton and Ward 2005, 170). Practical theology is often, as Pattison says, deeply committed to the notion of understanding leading to and from action, or praxis and aspires to be transformative in both theory and practice (2000, 11).

Ever mindful that this research has been undertaken as part of a Practical Theology Degree, the insight offered by James Woodward and Stephen Pattison in their introduction to the *Blackwell Reader in Pastoral and Practical Theology* is particularly relevant: "Practical theology cannot change the world on its own … However, it can make a real difference to its practitioners and the context that surrounds them" (2000, 11). This practical theological project has enabled

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[75] Suffering is described by Jurgen Moltmann as: "the open wound of life in this world" (1993, 49).

[76] This is often referred to as the pastoral cycle or Kolb's Learning Cycle (1984). The end result of the pastoral cycle is a change in practice or belief (Cameron, Reader, Slater, and Rowland, 2012, 117).

me, as a practitioner, to reflect on the theological implications of early miscarriage while affording me the opportunity to review how I minister to those who have experienced early miscarriage.

In this section, I have taken the opportunity to think theologically about trauma and loss. I have also offered some insights into the language that the church might use as it grapples with the uncomfortable reality of early pregnancy loss while providing a theological response. As a pastoral care giver, I must endeavour to go beyond a perfunctory visit. It is not sufficient to merely fulfil the recommendations of making contact, acknowledge the loss, and listening. In order to effectuate the fourth recommendation and respond appropriately, I must recognise the trauma experienced by grieving parents and help enable them to voice their woundedness. Such an approach would not only encourage discussion of early miscarriage but would be significant in helping to break the church's silence. As a representative of the church, the church would be seen to respond to those who have lost a much longed-for baby.

**5.3 Implications for My Own Theological Understanding of Ministry**

In this third section I aim to show how my reflections have shaped my own understanding of ministry. I will outline ways in which my practice has changed and highlight some pastoral resources that I have developed as a resource for myself and others.

I am encouraged by Willmore D. Eva, the former editor of *Ministry* magazine, who writes as a description of theology and ministry:

> Here the attempt is made to relate the revelation of God in the Bible and in life to the ebbs and flows, highs and lows, joys and sorrows, of the people of the congregation. Because of its rough-and-tumble nature and the almost raw, organic constraints that are part and parcel of doing it, this theology unearths, when conducted with any care, some of the purest forms of truth. In many ways it is the kind of theology done by the characters and writers of the Bible itself. (1998, 4)

As a parish minister who has sought to learn how I might minister more effectively, Eva's description of my role as one which takes scripture and relates it to the events people experience in life is apt.

One of the most significant passages of scripture in my own calling to ministry is Isaiah 6, 8: *Then I heard the voice of the Lord saying, "Whom shall I send, and who will go for us?" And I said, "Here am I; send me!"* I have always sought to go and be with people as they journey through life to support and comfort. However, as I have acknowledged in the Reflexive Prologue my practical theology education did not prepare me for every aspect of parish ministry. I am encouraged by Miller-McLemore who, not only, identifies practical theology as an academic discipline but as an activity of faith undertaken by believers. She adds that the ultimate purpose of practical theology lies in the pursuit of an "embodied Christian faith" (2012, 5). In other words, a faith that is practised and worked out through lived experiences. This thesis represents a lived experience which has shaped my ministry in the way I care for (and support) those who are grieving the loss of a longed-for baby.

As a parish minister and researcher, I have an even greater awareness that more needs to be done to aid those who have experienced early miscarriage. A changed culture needs to be developed to dispel the notion that miscarriage need not be discussed, only acknowledged. Acknowledgement is extremely important, but on its own is not sufficient. To properly acknowledge that an individual's loss is a significant and important event requires listening to their story, if they wish to tell it. It is only through attentive listening that an appropriate response can be made.

The four recommendations that were articulated so clearly by the interviewees are predicated in knowing that to a grieving mother who has lost her longed-for baby, the loss is often regarded as the loss of a real person.[77] Terminology is important. None of the participants raised any concern with the word miscarriage. Yet, I would assert that attempting to break the taboo and

[77] Make contact, Acknowledge the Loss, Listen, and Respond Appropriately.

normalise discussion about miscarriage within society, requires moving miscarriage from being the focus of what has happened to making ‘what was lost’ the focus, and for the women in this particular study that was the loss of their baby. This, in itself, could merit a sea-change within society whereby miscarriage is recognised as more than a medical event, but the loss of a life (or potential life) and, for some, the loss of a real person, which was something Lewis made reference to in 1978.

At the outset of this process, I imagined that parents would look for a cause (or blame) while seeking some kind of coping mechanism to deal with their emotions and feelings (see figure 4).

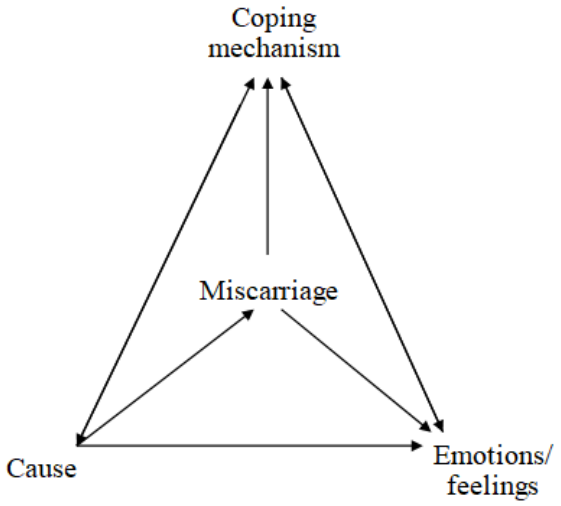


Figure 4 – Diagram showing focus of miscarriage

What my research revealed is that every profession, every individual, needs to ensure that they attend to those in their care in a personal, not clinical way. In order to reflect this necessary cultural change, I have altered the diagram shown in Figure 4 to one that I believe is more appropriate and supportive (see Figure 5).

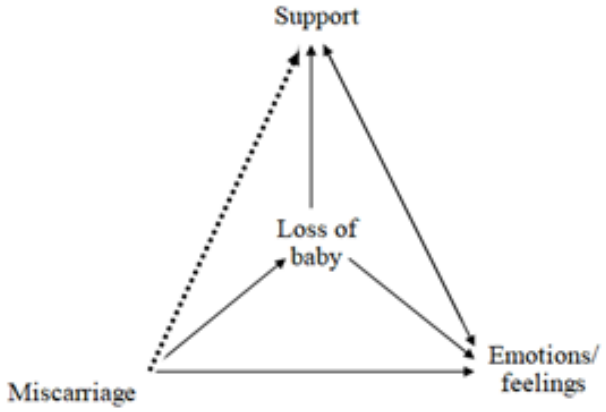


Figure 5 – Revised diagram showing focus of miscarriage

Moving miscarriage to the corner of the diagram and placing loss of a longed-for baby at the centre, immediately acknowledges to a grieving parent that their child existed, it was a life. Their loss can be mourned just as much as would any other bereavement. The link between miscarriage and support is still there but now is represented as a broken line to infer that support is not guaranteed and sporadic (at best). I would advocate that we need to be aware that for those who have lost a longed-for baby, recognising this loss should be central to pastoral support.

If I, as a minister, and other pastoral care givers, were to take full cognisance of how significant acknowledging the loss of a longed-for baby was (and is), it would be a huge leap forward towards a change in practice.

This study has utilised Action Research and it has enabled me to bring about changes in my own professional practice. Throughout my ministry I am often made aware of a miscarriage through a comment from a family member, friend or neighbour. Conscious that it was seldom a direct request to visit, I hesitated and would make a mental note of what had happened. I am now proactive and make contact, rather than wait to receive some kind of deliberate invitation to visit. I am also more comfortable with the thought that I might not receive a warm welcome. Individuals may not be ready to talk or share their story – it is their story, and so I know not to take the absence of a welcome or a reticence to talk as a personal rebuff. By making contact, I am also acknowledging their loss

and treating them as I would any other grieving family. Neither do I believe I *need* to offer anything other than a listening ear to enable grieving parents to tell their story. I strive to treat every pastoral encounter as unique and allow those who are grieving to set the agenda and then respond appropriately. However, I am also conscious of the NHS advice that there may be a need for, "rites or prayer or sacrament, or simply for a sensitive listener" (NHS Education for Scotland 2009, 6). The need to be a sensitive listener – and how to achieve this - is something I would encourage all my pastoral colleagues to reflect upon.

I was conscious that I did not know how to respond after learning about an early miscarriage. If I knew of a woman in this situation, I always visited once but was unsure of my role and purpose, and was often relieved when the visit was over. On reflection, I understand that I had done the right thing without knowing what the right thing to do was! Now, I appreciate that miscarriage is not something to shy away from, and by visiting I am helping to break the silence of miscarriage.

My practice is now to visit on several occasions, paying particular attention to significant dates when I do so. The response received has invariably included a statement noting the number of weeks or months since the loss of the baby. Yet, even when the date is not mentioned, nor the reason for my visit, I am certain that the significance is not lost. This, I believe, is one of the most supportive actions I take.

Before undertaking this research, I had never given any consideration to overtly naming the loss people have suffered. I am no longer afraid to say 'you have lost your baby' or 'what you have lost would have been your baby' when my informed pastoral judgement leads me to deem this as appropriate. This is also the point where I give space and listen to the response and, in most cases, it becomes quite clear whether the person wishes to speak about the miscarriage or not. This, I view, as the most important aspect of listening: attending to the cues given and responding to them. I would add here, that even if the loss is not spoken about, a pastoral visit undertaken in this way is not adding to the silence as I have made contact, acknowledged the loss, listened and responded appropriately.

In seeking to respond appropriately, I have developed liturgical resources for my own reference and use. These can be found in Appendix 19, and I offer them to all involved in pastoral care in the hope that they might stimulate further thought and reflection before being applied, as appropriate, to each individual (and unique) situation. They should not be viewed as providing all the necessary resources for pastoral care following early miscarriage. Much akin to the practical theology cycle, they have been drawn together after reflecting on three decades of ministry and an academic reflection on how to support better those who have lost a longed-for baby through miscarriage.

During my studies I have been amazed at the growing number of individuals who, in conversation, have asked about my research and initiated a discussion about their own loss. This has often been in a public setting. I am now conscious that this might be the only opportunity through which that person has begun to share their story. In consequence, I seek to create space for them there and then, as I fear a perceived rebuff (no matter how busy I might be) would be more than a lost opportunity, it might be confirmation that no-one (even a minister who is researching this very topic) wants to listen.

Undertaking the Doctorate of Practical Theology has given me the opportunity to take a step back from practice (from ‘doing’ ministry) to focus on one aspect of my role and reflect on why I do it, how I do it and how to do it better. As a result, my ministry has changed. I have a greater understanding of miscarriage as trauma, and of the need for ministers (and the church) to voice this. I now utilise lament in both pastoral care and worship in a way that engages with the trauma of loss that parents have experienced (and are living with).

This section summarises the changes to my own ministerial practice having been afforded the opportunity to listen to the experiences of others and to reflect theologically on them.

## 5.4 Chapter Summary

This chapter has examined the resources that scripture provides for the support of those who have experienced an early miscarriage (trauma). It has focussed on lament as a source of comfort and support for the people of the Old Testament; a resource which was drawn upon by the people of the New Testament. However, the Christian church has neglected the value of lament over the years and often ignores its role within public (and private) worship. I advocate that lament is a resource we should turn to at times of personal trauma and loss. Conducting this research has also afforded me the opportunity to reflect theologically about the issues I continue to confront as a pastoral practitioner. I have a greater understanding of miscarriage as trauma which, as a minister, I must engage with. I have also described how my own understanding and practice as a parish minister has changed as a result of my reflection and learning.

## Chapter 6 - The Story Continues …

In this final chapter, I outline the continuation of the story presented thus far. I have argued that the story of early miscarriage has been largely ignored and that the women who participated in my study felt unsupported. That, however, is not the end of my research journey. Having come full circle within the action research paradigm, I am anxious that the circle is not viewed as complete. Just as the story continues in the lives of so many, so must our search for understanding and improved practice.

One way of ensuring the story continues would be to conduct further studies. I am conscious that this project has only begun to scratch the surface and so commend it as a catalyst for future research. In doing so, it is important to acknowledge and address this study's numerous limitations.

The chapter also makes recommendations for institutional change within the church as well as highlighting issues that require a societal change. This is followed by a note of what this thesis has achieved in relation to the purpose and intended outcomes of my research, before offering a conclusion.

### 6.1 Limitations

I have already acknowledged that my gender has had a role in the research process. However, I believe that this research is long overdue and is justified by need. Another major limitation is that only women were interviewed. The next step on my research journey would be to interview partners. They too have experienced a loss and they too may require support.[78]

[78] My opinion is supported by a recent Australian study reported that the support that was most wanted by men was to be shown some acknowledgement, understanding and sensitivity around their loss (Miller, Temple-Smith and Bilardi 2019, 12). The authors add: "Men felt additional professional support, including psychologists, telephone counsellors, pastors and life coaches was often needed due to a lack of hospital follow up and no formal supports offered or referred to them individually" (2019, 13).

Even with a reflexive approach, the reliability of my findings is still subject to researcher bias (Guba and Lincoln 1981, 125-127). It is also argued by some that the level of the researcher's empathy influences the authenticity of the findings (Cutliffe and McKenna 1999, 378). However, others point out that all research is influenced by the researcher's adoption of particular epistemological and methodological perspectives and that it is best to acknowledge these rather than to deny them. Certainly, my own personal quest to have a better understanding of miscarriage and my desire to improve my own ministerial practice will have influenced my conduct of the research process throughout. It is difficult to imagine, however, how this could have been otherwise. Conducting a pilot study helped to minimise this as a limitation. However, my inexperience became particularly apparent within the educational intervention sessions which also functioned as focus groups. In future research projects, I would also carry out a pilot for the focus group interviews.

As has already been noted, convenience sampling was utilised which means that the interview and fraternal participants may have been atypical of their respective populations. Therefore, the findings of this study cannot be generalised (Burnard 1995, 1168). It may be that women who experienced less of a sense of bereavement after miscarriage would have been less likely to volunteer to take part in a study of this kind. This is a definite possibility. However, it does not mean that the experience of those women who do experience miscarriage as loss of a longed-for child should not be acknowledged and responded to. Furthermore, knowledge of me as a minister (even if not their minister) may have had an influence in the participants' decision to take part. It would have been possible to mitigate this limitation through the use of questionnaires via which women could have responded anonymously. However, these would not have provided the richness of data these interviews provided, and would not have led to the production of the I-Poems.

The interviewees had their miscarriages in the West of Scotland (bar one, who miscarried while living in England) and so the findings may be contextually limited and reflect the particularity of a relatively small geographical location. Family and cultural traditions may also have influenced how these women were

treated, and so a larger study is required with a wider geographical base, to ensure that the findings can speak to wider contexts.

Further studies using a greater number of participants, both interviewees and groups of ministers (not only in fraternals), should also be carried out to ensure that the findings are transferable to other settings. That said, sufficient information has been given to enable readers of this study to determine the importance of the findings (Lincoln and Guba 1985, 120). Furthermore, as stated in Chapter 2 on interpreting qualitative data, the question of the insight it generates rather than its transferability and generalisability, emerge as paramount.

Another limitation of the research was of the minimum ten year gap since the miscarriage occurred. In obtaining ethical approval, it was agreed that since this research involved sensitive and emotional events a significant lapse of time was essential to ensure that participants were in less danger of 'undue harm', and were more likely to be able to make a decision about the potential risk of talking about their experiences. However, approaches to sensitive issues are subject to rapid cultural change as evidenced recently by the impact of the 'Me Too' movement.[79] It is possible that women discussing the same topic after a more recent loss might have recorded rather different experiences.

### 6.2 Proposals for Institutional Change in The Church

As I reflect further upon all stages of my research process, I am increasingly conscious of how complicit the church has been in the silence following early pregnancy loss. This has perhaps been an historical and cultural failing but it does not make it right. Just as it was not right that the church did not speak out against issues such as slavery and apartheid because it had once been seen as normal practice. Regardless of the past, the church and those involved in pastoral care need to acknowledge the issues around early miscarriage and create an environment where all affected can speak out and receive the support they need. In the 21st Century, the church strives to be inclusive and to become

[79] The 'Me Too' movement is a movement against sexual harassment and sexual assault.

a place where no-one feels excluded or marginalised. In carrying out this research I have come to believe that the very people I sought to invite to become participants are marginalised. In the words of Puneet Singh, Kearsley Stewart and Scott Moses, "the silence around pregnancy loss is pervasive" (2004, 52). Silence has also been described in Anshu Chaudhary's moving autoethnographic account of her own early pregnancy perinatal loss as 'silent suffering'. She argues for the necessity of challenging the prevailing trend of silent suffering after miscarriages to promote the mental health and well-being of women (2019, 1). In fact, as both my anecdotal experience and research show, the wall of silence around the subject of early pregnancy loss has been built into a dam holding back a plethora of emotions and feelings. Hopefully, this research will play a part in helping the flood gates open!

Having considered how my own practice has changed, I believe that the church also needs to reflect on current practice and change accordingly. To this end, I make five recommendations which I hope will prove a stimulus for future action:

1. The church should repent of the marginalisation (or, in many cases, the total disregard) of those who have experienced pregnancy loss.

   One quarter of pregnancies end in miscarriage. It is quite shocking that such a demographic has not been attended to by the church. If any group of similar proportions had been marginalised, abused or victimised the church would be at the forefront of establishing and developing programmes of care. Yet, in the case of miscarriage, it remains silent. The church has to address this failing as it has others in the past.[80] Similarly, I argue that pregnancy loss has been marginalised (rather than discriminated against). Therefore, it is time the church faced up to its neglect of care in this area.

[80] For example, at the 2017 General Assembly of the Church of Scotland, the Church offered an apology to gay people for the history of discrimination they have faced.

To do so would require more than words, and I suggest that consideration be given to commissioning an appropriate memorial (for example, stained glass or sculpture) dedicated as a focus for remembrance. This would serve as a very visible statement that the church does care. In addition, by acting on the following, the church would be sending a clear message that it wishes to learn from its past and ensure that everyone who seeks support will find an appropriate pastoral response.

2. The church should invest in resources to incorporate the findings of this and other relevant research into the training programme for ministers, both pre and post ordination. The evidence for this need came from ministers fraternals and is further supported by the work of Singh, Stewart and Moses who advocate that clergy can help create a comfortable forum for parents to talk about their pain, and an environment in which the silence surrounding pregnancy loss is no longer acceptable (2004, 53). I offer the educational intervention as a first step resource in this process.

3. The Church should initiate a theological discussion on miscarriage, similar to a working group or commission (as it has for other issues, such as baptism and same-sex matters). This to include consideration of an appropriate means to record the existence of people's babies lost by miscarriage when this is desired.

In my analysis I noted that there was no great desire for a funeral service per se. However, as I reflected in Chapter 5 lament is a resource that has historically been used by the faithful yet largely ignored by the Christian church. The church must reclaim the benefits of lament and incorporate it into its life and witness. Liturgical resources should be created which enable grieving parents to move closer to God as they cope with the traumas they experience in life.

In Appendix 20 I have included liturgical resources which I have drawn together to assist me in worship and pastoral care. I offer these as a stimulus to others in the hope that they might serve as a catalyst for

change as I encourage the church to re-envision the benefits of lament. By utilising lament, grieving parents might discover a means to voice their experiences to God.

4. The church should encourage congregations to create space for discussion and reflection on how they might become a supportive resource for those experiencing early pregnancy loss. I concur with Denzin and Lincoln who argue: "Telling the stories of marginalised people can help to create a public space requiring others to hear what they do not want to hear" (2008, 46). We may not think of people who have miscarried as being marginalised, but their experiences inform us differently.

5. The church should make available a public on-line resource which people can easily locate when experiencing personal grief or when seeking to help others who have suffered miscarriage. This might contain a synopsis of its theological discussions, and contact details of ministers, congregations and organisations which are seeking to offer support. It might also be a place where spiritual resources could be shared and online conversations take place.

By adopting my recommendations, the church would not only be addressing the lack of support currently available but would also be sending out a clear message that it cares about this issue.

### 6.3 Proposals for Societal Change.

I have referred to the need to break the silence surrounding miscarriage throughout this thesis. However, great care needs to be exercised to ensure that what is said and how it is said does not add to the upset already being experienced. It is quite clear that the women who participated in my research project were sensitive to the language and terminology used in relation to their miscarriage. I have highlighted this in Chapter 4, where I also note that (according to self-reported experiences printed in the Guardian newspaper in January of 2020) this is still a matter of concern. There needs to be a cultural shift, a societal change in the way miscarriage is spoken about. I advocate that

miscarriage should be normalised in discussion, and in doing so we need to name things and do so honestly. The use of medical descriptions requires careful consideration. The impact of terms like products of conception, Evac, D&C, abortion, uterine aspiration can be hurtful and long lasting. Therefore, there is a need to steer language in a new direction. Such a change needs to be embraced by the medical and nursing community. However, society as a whole must take responsibility for actively encouraging a new and more sensitive terminology. The church (institutionally and as the whole people of God) also has a role to play in societal change and it must not be afraid to challenge the status quo. By doing so, the church would be viewed as not only responding to a pastoral need but as a proponent for change.

### 6.4 What This Thesis Has Achieved.

Having presented my findings, actions taken and recommendations to the national church, this section addresses what this thesis has achieved.

In chapter 5, I described how my own understanding and ministerial practice has changed as a result of my research. This is a significant achievement in itself. However, having framed my question within the Introduction, and set out the purpose and intended outcomes of my research, I now present an answer by noting how ministers (and all called upon to offer pastoral care) might offer better and more appropriate support following early miscarriage.

The purpose of the research has been addressed. Women were interviewed and, through analysis of their transcripts, four recommendations were identified. These being that ministers should make contact, acknowledge the loss, listen and respond appropriately. In order to present my findings in an accessible way, I-Poems were constructed as a means of sharing the experiences recorded with others. These, together with the recommendations, formed part of an educational intervention with groups of ministers, which also served as focus groups, allowing for a reflection on their practice.

At the outset, I identified three outcomes that I hoped would be achieved. These being that:

1. The gap in published literature concerning pastoral support after early miscarriage will begin to be addressed.
2. Awareness will be raised within the church (and beyond) concerning the effects of miscarriage.
3. Those who are called upon to offer pastoral support might be better equipped to do so.

This thesis does raise awareness of early miscarriage support and it serves to highlight the need for further work. However, on its own, it does not fill the gap in published literature. To do so, my findings require to be prepared for publication as a contribution to developing conversations on this important topic.

By carrying out this research and making recommendations to the church, the issues identified have been raised within my denomination. Trialling the educational intervention also served as a first step in raising the awareness of groups within the church. This intervention can be used and adapted for others – both within and outwith the church.

My work sought to equip those who are called upon to offer pastoral support and it offers resources through which to do so. With the I-Poems, ministers are presented with actual recalled experiences which convey a deep-rooted emotion and hurt as well as a call for better support. The I-Poems serve as motivation for ministers to respond pastorally. In addition, the four recommendations, coming from the women interviewed, provide not so much a toolkit but a foundation upon which ministers can construct an appropriate response in each situation.

However, I am fully aware that the story continues!

## 6.5 Conclusion

This thesis sought to identify how I and other pastoral care givers might offer better and more appropriate support following early miscarriage. My interviews with women who had experienced early pregnancy loss generated two significant resources that contributed to this quest. The first was the I-Poems which speak for themselves or, more accurately, provide a voice for the women's stories to

be heard and shared. The second is the four recommendations for the improvement of pastoral care.[81] However, to continue the story metaphor that I have throughout, this thesis does not conclude with the words, 'THE END'. The stories that I have been privileged to hear and share continue in the lives of their tellers; and new stories are being made every day. This is something we must all be aware of.

The I-Poems play a pivotal role in conveying the necessity for ministers to review and reflect on their current practice. I found these transforming. They provided a means to lift words off the page and convey a sense of what the women had experienced. Each is different and, in turn, will be different from the experiences of others, yet they share a similarity in conveying a sense of suffering and trauma that I argue is largely hidden from society. As one of the ministers in encouraging her colleagues to be active in offering support reminded her focus group, miscarriage happens in one out of every four pregnancies. It is not a rare event but often remains private and unacknowledged by others. This thesis argues that there is a need for support, and that ministers, and other pastoral care givers, must be prepared to offer an appropriate pastoral response irrespective of their own uncertainties.

For the women who shared with me their experiences, miscarriage was a significant, life changing event. However, every situation is unique and the recommendations coming out of this study may not be appropriate for everyone. Each parent will have their own parameters of loss. This must be recognised by all involved in pastoral care, Nevertheless the women whose stories have been told, heard and shared through this research journey wanted people to make contact, acknowledge their loss, listen and respond appropriately. This cannot be done in silence. Indeed, I argue that my research has given a voice to individuals who have lived with silence for too long. These women have a story that voices never share. In presenting the I Poems contained in this Thesis, I do so in the hope that they serve as the opening stanzas of sharing stories, stories

[81] Make contact, Acknowledge the Loss, Listen, and Respond Appropriately.

that some of the participants viewed as a taboo subject. Everything possible needs to be done to disturb the silence.

I have already stated that it was in the creation of the I-Poems that my data came alive to me. How ironic, when the data was generated by the descriptions of women whose longed-for babies did not live. I conclude with a poem which recounts a miscarriage experience and commend it to my colleagues in ministry as a reminder of why we need to offer appropriate support:[82]

> My body aches and weeps for the life that we have lost.
> My heart yearns for the baby I never had the chance to welcome into this world.
> My mind races wildly trying to find meaning in this loss.
> My arms long for the baby I never had the chance to hold close and say I love you.
> My soul grieves for the many dreams I had for this beautiful child.
> My spirit grounds me in hopes for blessings to come.
>
> Kimberly Crawford Kohl (2012)

[82] Poem published in 2012 by the freelance writer Kimberly Crawford Kohl as she vividly recounted her own miscarriage experience – see: Remembering Your Faith through the Grief: Experiencing a Miscarriage (2012, 2).

## List of Appendices

**Appendix 1 – <u>Reflection Pro forma</u> – adapted from John's Model**

- *Description of situation/incident*
- *Why did I intervene as I did?*
- *What were the consequences of my actions for: myself, patient/family, people I work with?*
- *How did I feel about this experience when it was happening?*
- *How did the 'person' feel about it?*
- *What knowledge influenced my decisions and actions?*
- *What other choices did I have? And what would have been their consequences*
- *How do I feel now about this experience?*
- *Could I have dealt better the situation?*
- *Where was/is God in relation to the situation?*
- *What have I learned from this experience?*

## Appendix 2 – Framework for Evaluating Qualitative Studies

The Cabinet Office of the British Government (2003) has developed a useful framework for evaluating qualitative studies. The framework suggests 18 questions that can be applied to any piece of qualitative research in order to check its reliability. Not all 18 questions have to be answered positively, but the more that can be, the more likely the research is to be reliable, and accepted by others as such. The list is as follows:

1. *How credible are the findings?*
2. *How has knowledge or understanding been extended by the research?*
3. *How well does the evaluation address its original aims and purpose?*
4. *How well is the scope for drawing wider inference explained?*
5. *How clear is the basis of evaluative appraisal?*
6. *How defensible is the research design?*
7. *How well defended are the sample design/target selection of cases/documents?*
8. *How well is the eventual sample composition and coverage described?*
9. *How well was the data collection carried out?*
10. *How well has the approach to and formulation of analysis been conveyed?*
11. *How well are the contexts of data sources retained and portrayed?*
12. *How well has diversity of perspective and content been explored?*
13. *How well has detail, depth and complexity (i.e. richness) of the data been conveyed?*
14. *How clear are the links between data, interpretation and conclusions - i.e., how well can the route to any conclusions be seen?*
15. *How clear and coherent is the reporting?*
16. *How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?*
17. *What evidence is there of attention to ethical issues?*
18. *How adequately has the research process been documented?*

**Appendix 3 – Ethical Approval**

11 Nov 2016

Dear Shaw

**Ethics Application 100160049: Ethics Approval**

Ethical approval is given for your research. Please note that an end of project report is required by the Ethics Committee. A brief report should be provided within one month of the completion of the research, giving details of any ethical issues which have arisen (a copy of the report to the funder, or a paragraph or two will usually be sufficient). This is a condition of approval and in line with the committee's need to monitor research. Further, it is your responsibility to inform, as appropriate, your supervisor, advisor or funding body of the outcome of your Ethics application. You should also indicate successful receipt of ethics clearance on the acknowledgements page of the approved project.

In addition, any unforeseen events which might affect the ethical conduct of the research, or which might provide grounds for discontinuing the study, must be reported immediately in writing to the Ethics Committee. The Committee will examine the circumstances and advise you of its decision, which may include referral of the matter to the central University Ethics Committee or a requirement that the research be terminated.

Information on the College of Arts Ethics policy and procedures is at http://www.gla.ac.uk/colleges/arts/research/ethics.

Yours sincerely

Iain

Dr Iain Banks

College of Arts Ethics Officer
School of Humanities/An Sgoil Daonnachdan
10 University Gdns
University of Glasgow
Glasgow
G12 8QQ
0141 330 2420

**Appendix 4**

## PARTICIPANT INFORMATION SHEET

**You are invited to take part, voluntarily, in the following research study:**

*Title:*

How might parish ministers (and other pastoral care givers) better support women

who have experienced an early miscarriage?

This study is being carried out as part of a postgraduate thesis towards the award of D.P.T. (Doctor of Practical Theology) based within the School of Critical Studies, The University of Glasgow.

Miscarriage is a very sensitive and emotional issue which is not often spoken about. This study seeks to gain an understanding of what people actually experience, so that those who are called upon to offer support are better equipped. If you have experienced a miscarriage between ten and twenty years ago, and would like more information about this study please contact the researcher by e-mail (or snail mail) who will be happy to meet, discuss and allow you to ask questions about the research. Should you wish further information my supervisor's details are noted below.

### Research Aim

This research seeks to identify the support needs of women who have experienced an early miscarriage and to engender better informed and more adequate pastoral responses.

### Research Objectives

- To understand the lived experiences of women who have experienced early miscarriage by analysing their stories.
- To identify common experiences of the support they received during and following the miscarriage.
- To understand what support would have been of value to those involved and highlight this for the benefit of pastoral professionals.
- To present the findings to clergy in groups, as anonymised, and fictionalised, case studies, and determine how their practice might change.
- To develop an educational resource for ministers other pastoral care givers.

If you are willing to participate in a one-off interview (lasting approximately one hour), which will be audio recorded at a place and time to suit yourself, please contact me to arrange a mutually convenient time.

The interviews will be transcribed (a copy of the transcript will be provided to allow you to comment or modify) and analysed. Thereafter, anonymised, and fictionalised, case studies will be presented to focus groups of ministers who will

be asked to reflect on their current practice and how it might change in the future to offer more appropriate support. The responses from these focus groups will be transcribed and analysed in order to prepare a training module which will be offered to those involved in pastoral care.

The results of this study will be made available on-line and you will be provided with the appropriate link at the end of the study.

You can withdraw from this research at any time and any material gathered will be destroyed.

Confidentiality is assured. All names will be changed. Tapes and transcripts will be stored in a locked filing cabinet within the researcher's own home, and subsequently destroyed upon completion of the research.

In recognising that this is a difficult topic for people to talk about, a retired colleague has agreed to make himself available to offer pastoral support should you wish. His contact details are: the Rev Norman B McKee, e-mail: normanmckee946@btinternet.com.

Thank you for considering to help with this research.

*Signed* *Date*

**Researcher's name, address and email contact: Shaw J Paterson;**

**15 Lethame Road, Strathaven ML10 6AD e-mail s.paterson195@btinternet.com**

**Supervisor's name and email contact: Prof Heather Walton**

**Department address: No 4 The Square, The University of Glasgow, Glasgow.**

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How might parish ministers (and other pastoral care givers) better support women

who have experienced an early miscarriage?

Individual's Name Contact Telephone No.

Preferred place for interview: e-mail:

Times when available:

**Appendix 5**

**Research Ethics Risk Assessment and Management - Interviews**

[1] Physical Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Travel | Low | Car accident | Pay due care and attention. | Experienced driver – over 35 years experience. |
| Physical harm to researcher when in a one to one situation. | Low | Physical & psychological distress | Ensure researcher's whereabouts are known by others. | |
| Health and Safety | Low | Physical harm | Researcher to be aware of any relevant H&S procedures pertaining to place of interview. | |

[2] Psychological Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| The discussion of a sensitive topic has the potential to cause distress to the participants. | Medium | Participants – psychological stress | Remind participants can refuse to answer the questions and can withdraw from the research at any time.<br>Signpost participants to appropriate support services. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. |
| Discussion of a sensitive topic has the potential to cause distress to the participant through fear of lack of confidentiality | Medium | Participant – psychological stress | Clear confidentiality and anonymity stated in Participation Information Sheet which will be distributed in advance.<br>This will be highlighted before commencement of interview.<br>. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. |
| Participant might disclose details of a professional colleague to researcher eg another minister with whom they have an on-going pastoral relationship. | Medium | Participant – emotional and psychological distress | Remind participants of confidentiality in Participation Information Sheet.<br>Offer to cease the interview. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Disclosure of unmet mental health needs | Low | Participant - psychological distress immediate, prompt or urgent response might be required | Participation Information Sheet has contact details of support.<br>Offer to stop the interview.<br>Signpost participants to appropriate support services. | |
| Research participant in danger of harm to self or others | Low | Immediate, response might be required | Ensure Participation Information Letter indicates possible researcher response to disclosure or fear of harm<br>Offer to cease the focus group<br>Signpost participants to appropriate internal and external support services | |
| Researcher insensitivity | Low | Participants might be suffered from emotional or | Pilot the process in advance | Previous experience in carrying out interviews for research at masters level. |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| | | psychological stress | | |
| Participants may be known to the researcher | Medium | Participants - Psychological stress through fear of identification or breach of confidentiality | Ensure participants are fully informed the nature of the research and who is conducting the research before they agree to participate.<br>Participant Information Sheet highlights confidentiality and the anonymising of data.<br>Stress confidentiality at every stage. | |

[3] Risks due to invasion of Privacy and/or Breach of Confidentiality

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Respondents might be identified | Medium | Participants - Emotional and psychological stress | All data will be coded.<br>All identifier codes will be destroyed.<br>Standard guidelines for storage of codes and data will be observed at all times. | |
| Participants may be known to the researcher | Medium | Participants - Psychological stress through fear of identification or breach of confidentiality | Ensure participants are fully informed of the purposes of the research before they agree to participate.<br>Clear confidentiality agreement in the participants information sheet before their participation.<br>Remind participants of the confidentiality agreement at the start of the interview. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. |

**Appendix 6**

**CONSENT TO THE USE OF DATA**
University of Glasgow, College of Arts Research Ethics Committee

I understand that Shaw J Paterson is collecting data in the form of taped interviews for use in an academic research project at the University of Glasgow.

This study is being carried out as part of a postgraduate doctoral research degree, leading to the award of Doctor of Practical Theology (DPT) under the supervision of the School of Critical Studies, The University of Glasgow.
This short practical theology project uses a variety of qualitative methods loosely framed within an action research approach. The aim of this research is to determine the support needs that exist following early miscarriage and seeks to identify the support needs of women who have experienced an early miscarriage and to engender better informed and more adequate pastoral responses.
The purpose of this research study is:

1) To interview women who have experienced early miscarriage to ascertain what support they received and what support they think might have been helpful.
2) To present the findings to parish ministers as anonymised, and fictionalised, case studies and determine if, and how, they might change their practice.
3) To design a training module as an educational resource for those called upon to offer support following early miscarriage.

By carrying out this study, the gap in published literature will begin to be bridged, church (and society) will become more aware of the effects of miscarriage, and that those who are called upon for pastoral support might be better equipped.

**I give my consent to the use of data for this purpose on the understanding that:**

- All names and other material likely to identify individuals will be anonymised.
- The material will be treated as confidential and kept in secure storage at all times.
- The material will be destroyed once the project is complete.
- The findings may be used in future publications, both print and online.

Signed by the contributor:_____ Date:

**Researcher's name and email contact: Shaw J Paterson;**
s.paterson195@btinternet.com

**Supervisor's name and email contact: Prof Heather Walton**
**Department address: No 4 The Square, The University of Glasgow, Glasgow.**

**Appendix 7**

## Interview Prompt Schedule – for Pilot Study

### Questions

- How long ago was your miscarriage?
- Tell me what happened – tell me your story?
- Tell me about the care you received?
- Did you receive any religious or spiritual support?

### Further Prompt Questions

- Was it your first pregnancy?
- Do you have any other children?
- Were you admitted to hospital?
- Who did you tell about your loss?
- Did you have a funeral (or other ritual) for your baby?
- Did you give your baby a name?
- Where do you feel God was during all this?
- Where do you feel God is now?
- Looking back, what would have helped?

**Appendix 8**

Interview Prompt Schedule for use in main study

**Stage 1**

Questions - for those who have experienced early miscarriage

Why did you volunteer to participate in this study?

How long ago was your miscarriage?

Please tell me about what happened – tell me your story?

Please tell me about the care you received?

Did you receive any religious or spiritual support?

What from your experience might be used to help others in the future?

What follow-up support was offered? In hindsight what do you think might have been helpful to you?

Have you spoken with others about your loss – either at the time or in the years following?

**Stage 2**

Draft Questions - for focus groups (these will be further shaped following analysis of stage 1 interviews.

Please tell me about any support you offer for those who have experienced early miscarriage?

Having heard the analysed responses from women about their support needs, what would you think, should (or could) be offered by ministers?

In what ways do you think you may alter your practice?

What training and resources would be useful to you?

**Appendix 9 – comments on observation field notes**

**F1**

Contacted by phone following parish magazine article. Visited her home to discuss the purpose of the research and left the participant information sheet. Further phone call to arrange interview. Met at door by husband who had a cup of tea with us then left before the interview.
Had six miscarriages. Didn't know of anyone who had a miscarriage up to this point. Interestingly that she could name the attending doctor by name and that he was a bachelor. Baby delivered at home and disposed of at home. Home was in England and no family within a few hundred miles.
Would like to know what happened to her babies.
Always viewed reaching mid point of pregnancy was a milestone.
Never had 'children of her own' but adopted twins. Found comments about the twins not 'being hers' very hurtful.
Spoke very positively about her husband & his support.
Had to prompt quite a bit referring to initial discussion.
Only near end of interview did the more sensitive issues come up.

**F2**

Welcomed with cup of tea and home baking.
Workmen were elsewhere in house.
Friendly dog in room, but put out for interview (during interview had to be taken from outside door and locked away elsewhere).
Very open talking about family.
She didn't drink much of her coffee and ate only half a piece of home-made cake.
Lots of informal chat – good rapport.
Had her hands clasped in front of her chest for most of the interview. A sign of tenseness, uncomfortableness perhaps?
Very much maintained eye contact throughout.
Very smiley when talking about what had happened.
No lasting silences. Could almost think 'I have a story to tell and here it is'.
Visit lasted one and a half hours, though interview lasted 30mins.
No wish to see transcript.
Once tape switched off she went on to say that she compartmentalised miscarriage and moved on. She also said she would probably not have moved on if it were not for her following successful pregnancies.

**F3**

Interview arranged via e-mail, following intimation being put out at a Presbytery meeting. Couldn't be in her own home due to having three dogs which would bark, and F3 suggested/offered her local church for the interview.
On arrival, there was tea and biscuits sitting on a table in a small room, together with a lit candle in the middle of the table. Very reflective atmosphere and almost worshipful.
Mostly sat with hand folded across her chest, but hands moved to her mouth when things started to become a bit emotional.
She kept good eye contact throughout. Not veering off into space. However, starting wringing her hands when talking about emotional matters.
Three miscarriages, then three successful pregnancies.
Eye contact reduced as interview went on.

She didn't finish eating her biscuit.
Same as but different from any other bereavement – became very red face/neck at this time.
Wasn't for volunteering comments that nurses said – ie platitudes etc.
Hates phrase 'spontaneous abortion'. Prefers term miscarriage
GP has abortion in her notes – word spontaneous is missing.
Will never forget it happened
No transcript.

**F4**
Interview arranged via e-mail, following intimation being put out at a Presbytery meeting. Met in her own home (living room) and was welcomed with tea and homemade pancakes which she insisted she put butter and homemade jam on for me. I think this was an effort to make me feel welcomed, and/or to give me a sense of this being a 'real' home.
We spoke face to face to describe what the research was about. She had recently undertaken Masters research into youth work and so was completely OK with idea of needing consent etc.
I noticed that her diary was open on the couch (where neither of us sat) and her knitting was sitting on a stool. This was obviously a room in which she felt very comfortable and relaxed in.
23 years since miscarriage & never spoken about it.
Volunteered as this was an opportunity to talk.
When talking about her miscarriage her hand headed to her mouth.
Lessened eye contact when she reflected on painful matters.
There was often prolonged silence before answering question.
I was aware that there was someone else in the house (turned out to be her daughter who is a university student and I was introduced to her as I was leaving).
Turns out I know F4's brother as he is a minister.
After exhausting my questions, I kept the interview going & kept tape on. We just sat in a kind of respectful silence. This then led to another 10 mins (approx) of extra material being spoken.
Lots of silence before she would speak.
I came away feeling very satisfied. Someone who had apparently dealt with her miscarriage admitting that things came up that she had never thought of before. She was anxious to learn what I had found out so far. I spent a few minutes highlighting the work I had done in terms of the literature review and what my findings were from the pilot study.
I e-mailed a few days later to ensure she was OK and she replied that she was and asked to see a copy of the transcript.

**F5**
Arranged by e-mail. Wasn't bothered about the location. I gave her several options and her response was 'wherever you want'. Eventually, I said that due to the Ethics Committee regulations she needed to choose a venue. She chose to come to my church hall and meet me for interview.
At due time, I went looking for her. She was sitting in her car ostensibly on the phone?? She said she was arranging for a locksmith to open her front door as it had broken somehow. We had a forty plus minute conversation about her life

and family and job and her role in her own church. Turns out she was diagnosed last year with ischemic heart disease after collapsing at work (in a surgical theatre). If she had taken ill anywhere else she may not have survived.
Very open & easy rapport.
Hands crossed across lap.
Good eye contact.
Straight to the heart of the matter.
Seven miscarriages in total – now eyes moving to ceiling and breaking eye contact.
Tears began to well up in her eyes when talking about what happened to her baby.
Crying when talking about what I could do.
As miscarriages went on they got harder. Having had normal pregnancies then losing one was more difficult. Fortunate that she learned why she was having miscarriage.
No wish to see transcript.

**F6**
Arranged by e-mail. In her own home.
Husband was ushered elsewhere in house to give us some privacy. Was 8pm.
Talked in dining room. Offered tea/coffee but declined. Spent 15 mins on chat about the research and word 'taboo' came up three times.
No transcript requested.
One miscarriage between 1st and second child.
Husband entered room to pass through and acknowledged my presence.
Uses word mother to refer to someone who had miscarriages but no children.
I worried about introducing the word acknowledge – didn't want it to be a leading statement, but felt I wanted to ensure that what she was alluding to was an acknowledgement.

<u>After tape switched off</u>
Shopping delivery arrived just at end of tape. Delivery man and husband were walking past the open dining room door. After shopping was delivered – it still needed to be put away. Husband had obviously wanted to leave it so as not to disturb us anymore, but in a way while we were not physically interrupted, it was an interruption to the discussion. Glad taped interview had come to a conclusion otherwise it may have brought about a premature end.
Talked about what I had found out from my pilot study for a brief time, then left her to put shopping away.
No wish to see transcript.

**F7**
Had only suggested coming to me because of her dog but it was in the kitchen sleeping.
She was alone in the house.
Talked in living room.
Wanted to help me in my research so I would have more experience and knowledge.
16 weeks pregnant with 2nd child.
Had baby in toilet at home.
I wonder why she felt the need to apologise for losing husband's son.

Very quickly reached the emotional stage. Hand covered mouth when talking about putting baby in newspaper in back of fire.
Tears in her eyes.
Real struggle to keep interview going.
When asked if she ever found out what went wrong – she welled up with tears again.
Quite emotional when talking about de-personalising next pregnancy
Really felt for husband having to put baby on back of the fire.
When is a child not a child?
When does a soul develop?
Do babies which are stillborn go to heaven and develop there?
Looked like a sausage with arms and legs but still a baby. That's why she gave it a name. Still thinks about 'name' and wonders what he would be like all grown up.
Because she saw it and gave birth to it, it was a baby.
She felt doctors were heartless in a kind of way.
After second child had coil inserted. Immediately fell pregnant (coil didn't work); went to hospital and they offered a termination and she felt horrified.
Back to speaking about feeling very very lucky. She had a child & looking after her kept her mind form thinking about baby she had lost – so felt very lucky.
Even [more] lucky - went on to have two more children. Been lucky all life long.
Wants others who have miscarried to feel they have gone through the same experience.
Gave baby a name so it would develop in heaven and become something. Even to this day wonders what he would look like and what he's doing. Thought it good to give him name. Comforting. But everybody's different.
No wish to see transcript.

**F8**

F8 is a member of my congregation who first spoke to me at the church door after everyone else had gone. Miscarriage was between her two children. On asking me about study she mentioned that she was taken into a maternity ward surrounded by new mums & was asked 'what did you have?' and she said to me (though not to the enquirer, in these words) 'I had an abortion... because that's what it was... not that I was wanting one'
On day of interview I was welcomed into her home with a cup of tea. We sat in a formal front room.
In discussion before tape she mentioned that her body let her down. She talked of being diagnosed that morning (out of the blue) with osteoporosis and again her body had let her down.
Important research. To make people aware of the grief of losing a baby – even though it was just a clutch of cells.
Middle pregnancy of three – other two successful. Miscarriage at 13/14 weeks
Spoke a lot with her hands. Lost eye contact when talking about losing a baby.
Talking about cleaning windows – uses hands in cleaning windows motion. Same with hoovering. Then would hold hands and rub her thumbs together.
Wants a sharing of grief + reassurance that she was not making a fuss about nothing.
Annoyed with herself for not remembering date of miscarriage. Hands clasped and started shaking.
Kept saying: 'As you say'. I had not said – check to tape to verify.

Quite light hearted throughout.
Would play a record over and over again to make herself cry. This went on for 3-4 weeks. Felt quite sorry for herself. Hands to mouth & pinkies over her lips.
On about not remembering – covers mouth with hand.
Mentioned about what would be the psychological effect of the miscarriage. Acknowledgment is one of the main things.
Went on to talk for quite a while.
On mentioning to her Simon & Garfunkel's 'Sound of Silence' – she thought that was the song she played.
No transcript.

**F9**
Contacted by e-mail by husband who said his wife had read that I was doing research etc and said his wife had a blighted ovum at 10 weeks (turns out to have been 12 weeks) into her second pregnancy. I sent an information sheet and he replied that she was happy to take part and asked me to phone her to make an appointment. This I did.
Met at her home in the afternoon. No one else at home. We sat in the front room. Very convivial. General conversation and I went over the purpose behind the research etc.
At 12 week scan. Blighted ovum.
Very positive individual.
Talks rapidly.
This was like a general conversation – not something that was getting emotional in any way. No silences. No tears. No thoughtful or reflective pauses.
<u>After tape switched off</u>
Offered tea/coffee at this point – declined.
Thinking back – not sure husband knew how to handle it. Very supportive but not sure what to do.
Need to speak about things – get things out in the open.
Father-in-law referred to her as being unwell when she was pregnant – even when all was well.
2nd child was born – 7 weeks early. Never found out why. Baby was in IT unit, and the sister of the ward handed F9 a baby picture and when asked 'what's this', replied, 'just in case'. In retrospect she thought this was a thoughtful this to do but terminology could have been better.
She mentioned that there were women at the support group (which she only attended once) who were sitting weeping. However, some women had been much further on in their pregnancy.
Never desperate to be a mother.
One of her daughters (the eldest) knew about the interview - both may have known, but the eldest sent a text at lunch time to her wishing her well.
No wish to see transcript.

**F10**
I was approached in person by F10 who spoke about the study and could mention to the exact day, when her miscarriage took place. We arranged date and location for interview via e-mail and met in the vestry at my church.
Easy conversation before tape. However, as soon as tape was switched on, she became visibly nervous. Hands started wringing and focussed eye contact on me. She did seem to relax as the interview went on.

Miscarried at home at 14.5 weeks
Didn't know if it was a boy or girl.
Would often 'tut' at the end of a sentence as a sport of 'Ah well... that's what happened.'
Check tape – but contradicted herself about minister responding. Earlier she had said she wouldn't have wanted a visit; later on, she said a visit would be OK because she went to church.
Clasped hands together, rubbing thumbs when talking emotionally.
After tape – not a lot of conversation – mainly wishing me every success in my studies. But did go on to say that she and her husband never really saw the miscarriage as a bereavement. It was something that happened. Baby wasn't fully formed – so just have to get on with it.
No wish to see transcript.

**F11**
I was contacted by e-mail and in a very straightforward way offered to participate and suggested we meet up. Arranged to interview in a few days' time.
Arrived at F11's home. Sat in a separate lounge – elderly relative was in living room. Tea & shortbread was prepared for my arrival. Real sense that room was separated off from rest of house. Very private & relaxed.
Was a nurse. We spoke at length about the roles she had over the years and the places she worked + how its all different nowadays.
F11 sat legs crossed with hands clasped under legs – very much a relaxed ready for a blether type pose.
Miscarriage was at 13/14 weeks.
Recording device made the noise warning that the batteries were about to die. Turns out that the machine was switching itself off. Batteries changed. Same thing happened again. Batteries changed. Used mobile phone as a back-up recording device.
Changed tenor of voice when mentioning what was unsupportive – almost angry sounding.
At what should I do as a minister? She reached for a tissue.
Became very emotional as we neared end of interview. Could feel a failure because of miscarriage.
Conversation moved away from miscarriage. General chit chat.
No wish to see transcript.

**F12**
First contact was from her mother, at the church door. Mother a member, but F12 not. Mother then got her daughter to contact me via e-mail. We corresponded and set up interview date. Met in church vestry – so as not to be 'hassled' by her children.
Arrived with mother which was a surprise. Said she may have backed out if mother didn't come. Mother very involved in conversation before tape. I explained what the study was about and allowed time for questions – there were none.
Seemed to have issues as to why her miscarriages were not of 'a baby' but products of conception.
Mother stayed with her through interview.

Two normal pregnancies, then 3 miscarriages. One an ectopic pregnancy, the other two had no issues until bleeding, then miscarried at home (at 7 & 11 weeks). Mother had been present with her during the medical procedures/checks etc.
Hands started shaking when she began to talk in detail about miscarriage. Obvious this was very emotional for her.
Kept looking at mother for reassurance.
Mother hinted that she thinks she may have had a miscarriage but that was the time before pregnancy test kits.
We spoke at length about her husband's gran's funeral. This was raised in relation to speaking to her children about the miscarriages – she will tell them when they are older – feels they are too young. This was reason she didn't take them to their great-gran's funeral. However, I think her personal bereavement from the miscarriages was compounded by this relative's death. It had been a humanist service and she was left feeling cold + was that it? She believed in life after death and in Christianity. Mother a church member but she wasn't.
No wish to see transcript.

## Appendix 10 – Demographics of Interview Participants

| | Approximate age at time of miscarriage | Years since miscarriage | Number of miscarriages | Miscarriage occured at: | Geographical location | Other Children | Interview setting | Occupation (self described) | Cultural/ Religious background |
|---|---|---|---|---|---|---|---|---|---|
| **F1** | Late 20's to early 30's | 25 to 27 | 6 | At home, taken to hospital | Larnarkshire x1 Middleborough x4 Derby x1 | Subsequently adopted twins | Own home tea, coffee and biscuits | Homeworker | White Christian practicing |
| **F2** | Early 30's | 12 | 1 | Started at work, taken to hospital | Lanarkshire | 1 before and 1 after | Own home tea, coffee and biscuits | Professional | White Christian non-practicing |
| **F3** | Late 20's to early 30's | 20 to 23 | 3 | At home and in hospital | Glasgow | 3 subsequent children | Participant's church vestry | Professional | White Christian practicing |
| **F4** | Late 20's | 21 | 1 | In hospital | Glasgow | 2 subsequent children | Own home tea, coffee and biscuits | Youth Development | White Christian practicing |
| **F5** | End of 20's to late 30's | 9 to 18 | 7 | At home and in hospital | Lanarkshire | 2 children after and between | Interviewer's church vestry | Professional | White Christian practicing |
| **F6** | Mid 20's | 11 | 1 | At work | Lanarkshire | Between 1st and 2nd child | Own home | Professional | White Christian practicing |
| **F7** | Late 20's | 23 | 1 | At home, taken to hospital | Lanarkshire | 2nd pregnancy of 4 (3 children) | Own home | Professional | White Christian practicing |
| **F8** | Late 20's | 22 | 1 | In hospital | Lanarkshire | 2 children. 1 before and 1 after | Own home tea, coffee and biscuits | Professional | White Christian practicing |
| **F9** | Mid 30's | 25 | 1 | In hospital | Glasgow | 2 children. 1 before and 1 after | Own home tea, coffee and biscuits | Professional | White Christian practicing |
| **F10** | Late 30's | 25 | 1 | At home, taken to hospital | Lanarkshire | 2 before, 1 after | Interviewer's church vestry | Service Sector | White Christian practicing |
| **F11** | Late 20's | 21 | 1 | In hospital | Glasgow | 2 children. 1 before and 1 after | Own home tea, coffee and biscuits | Professional | White Christian practicing |
| **F12** | Early 20's | 9 to 11 | 3 | In hospital | Lanarkshire | 2 children followed by 3 miscarriages | Interviewer's church vestry | Manager | White Christian non-practicing |

**Appendix 11 Research Ethics Risk Assessment and Management – Fraternals/Focus Groups**

[1] Physical Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Travel | Low | Car accident | Pay due care and attention. | Experienced driver – over 35 years experience. |
| Health and Safety | Low | Physical harm | Researcher to be aware of any relevant H&S procedures pertaining to place of interview. | Health and Safety |

[2] Psychological Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| The discussion of a sensitive topic in a focus group has the potential to cause distress to the participants should any of the participants have experienced an early pregnancy loss. | Medium | Participants – psychological stress | Remind participants can refuse to answer the questions or withdraw from the process at any time. Signpost participants to appropriate support services. | Researcher has over 25 years experience of pastoral care. |
| Discussion of a sensitive topic in a focus group has the potential to cause distress to the participant through fear of lack of confidentiality | Medium | Participant – psychological stress | Clear confidentiality and anonymity stated in Letter will be distributed in advance before participants agree to take part. Confidentiality highlighted in the Participation Information Sheet. The need to adhere to confidentiality stressed to all participants. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. Participants are all pastoral care professionals and are used to working within the confines of confidentiality. |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Disclosure of unmet mental health needs | Low | Participant - psychological distress immediate, prompt or urgent response might be required | Offer to cease the focus group. Permit participants to withdraw from the group at any point. Signpost participants to appropriate support services. | |
| Research participant in danger of harm to self or others | Low | Immediate response might be required | Offer to cease the focus group. Signpost participants to appropriate support services | |
| Researcher insensitivity | Low | Participants might be suffered from | Ensure, as a researcher that I am properly prepared for each stage of the research process. | Researcher has over 25 years of experience in ministry and pastoral care. |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| | | emotional or psychological stress | | |
| Participants may be known to the researcher | Medium | Participants - Psychological stress through fear of identification or breach of confidentiality | Ensure participants are fully informed of the nature of the research before they agree to participate.<br>Remind participants of the confidentiality agreement before each stage in the process. | Researcher has over 25 years of experience in ministry with the inherent need for (and experience of) confidentiality. |

[3] Risks due to invasion of Privacy and/or Breach of Confidentiality

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Respondents might be identified | Medium | Participants - Emotional and psychological stress | All data will be coded.<br>All identifier codes will be destroyed.<br>Standard guidelines for storage of codes and data will be observed at all times. | |
| Participants may be known to the researcher | Medium | Participants - Psychological stress through fear of identification or breach of confidentiality | Ensure participants are fully informed of the purposes of the research before they agree to participate.<br>Clear confidentiality agreement in the participants information sheet before their participation.<br>Remind participants of the confidentiality agreement at the start of the interview. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality. |

**Appendix 12**

## FRATERNAL/FOCUS GROUP SESSION PLAN

**Title: How might parish ministers (and other pastoral care givers) better support women who have experienced an early miscarriage?**

Date:

Time:

Venue:

Number of pastoral care givers (PCG's) –

**Aim** – To learn of current practice, educate about the need for support and learn as to how current practice may now change.

**Learning Outcomes** –

- PCG's should be more aware of the frequency of early miscarriage.
- PCG's should be more aware of the support needed following early miscarriage.
- PCG's to reflect on their practice in light of what has been learned.

**Material** Introduction – facts and figures
Pictures and sayings sheet
Permission forms
'I' poems
Recommendations
Evaluation forms

**Resources Required** – recording device

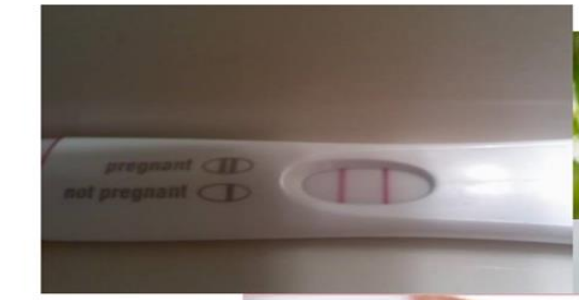
**Appendix 12 (continued)**

**TIMINGS**

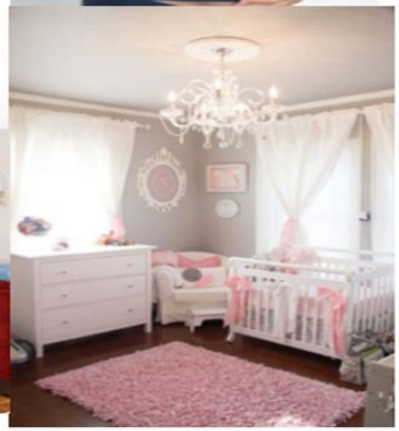
| | |
|---|---|
| 0-10 mins | **Introduction** by me of the purposes of the research including permission forms (to be signed and returned) and stressing the need for confidentiality. Issue pictures and saying sheet. |
| 10-15 mins | **General questions** on my research |
| 15-25 mins | **Discussion** on their current practice. |
| 25-30 mins | **'I' poems** – Two 'I' poems issued to be read in private with time for reflection. |
| 30-55 mins | **Discussion of four recommendations** on how their practice might change |
| 55-60 mins | **Any Questions & Hand out Evaluation Forms** |
| 60 mins | **Finish** |

*Initial self-evaluation*:

## Appendix 13- Picture Sayings Sheet (Information Leaflet)







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**Appendix 13 – Picture Sayings Sheet: overleaf**

## *How might we better support women who have experienced an early miscarriage?*

*This session has been developed following a doctoral research project with the aim to identify the needs of women who have experienced an early miscarriage and to engender netter informed and more adequate pastoral responses.*

One in four of all pregnancies end in a loss, of which 80% are early miscarriages

Ainsworth-Smith and Speck (1988; p44) comment that "The experience of losing a child early on in its life has been described by one parent as 'death before life' and it is against all the normal established order."

"It is time to face up to the reality of pregnancy loss" Layne, L. (2003) Unhappy endings: A feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science and Medicine*, 56, p.1889.

And in the naked light I saw
Ten thousand people, maybe more
People talking without speaking
People hearing without listening
People writing songs that voices never share
And no one dared
Disturb the sound of silence

*'The Sound of Silence' (vs 3), written in 1964 by the American music duo, Simon and Garfunkel. The third verse is particularly poignant!*

"He became our baby from the moment we knew he was there..."
Kelly E (2007) *Marking Short Lives. Constructing and Sharing Rituals Following Pregnancy Loss.* Bern Peter Lang p11.

**Miscarriage is unexpected and unplanned; its significance is often minimised by family, friends and the community, leaving grieving parents with unmet support needs.**
Gold KJ, Boggs ME, Mugisha E & Palladina CL (2012) Internet Message Boards for Pregnancy Loss: Who's On-Line and Why? *Women's Health Issues*, Vol. 22, Issue 1, p67-72

## Appendix 14 – Example of I-Poem Construction

This Appendix serves as an example of how an I Poem was constructed, using excerpts from the Interview with F8.

After transcribing the interviews, each I statement was highlighted and given a numerical code (as per Figure 6 below).

F8 … 12 weeks you could tell people cause it was quite safe then to say you were pregnant. So, I'd really only been telling people, you know, it'd be only couple of weeks and that was it. All over. I remember coming home and just crying all the time and I had [Child 1 male] and I'm thinking why am I crying, I've got this lovely boy and, you know, if I don't have any others, so what but I just felt bereft. I really did feel hollow, I felt my body had let me down that I'd let I'd let my body down. But there was no reason for it. It just was obviously a foetus that hadn't developed normally and it pro…. See, they didn't really say oh well, you're your your baby maybe stopped developing at six weeks or something. I mean, I don't know whether if a if a foetus stops developing how long it takes then for it to abort. I don't know these things.

These were then extracted and given codes so that the different themes from the interviews

could be grouped together as can be seen below:

I thought you won't be interested in me 1

I thought it was important that erm other people suffering, not suffering, cause I wasn't really suffering but other people having the experience that I had could be helped by the likes of yourself and you know, other ministers hopefully to make them feel a wee bit better about themselves. 1+6

I think to make people aware that erm the grief that there is involved in lose… losing a baby 1

and I suddenly felt cramping pains in my tummy and went to the toilet and there was some blood 2

that I was miscarrying but lay there, trying not to move. 2

I had gone to the toilet again and there was quite a lot of clots had come away and I kind of knew myself 2

I literally just had a D&C. That was it. It was all over. 3

I was panicking because I realised that I was losing the baby and there was nothing I could do to stop it. 2

## Appendix 14 (Continued) - Example of I-Poem Construction

I had a DNC and that was it. Cleaned out 2

I just thought I've just lost a baby, I don't want another baby. I wanted this one. 3

I went to the day room or something and somebody said, oh what did you have and I thought I have just lost a baby I had a D&C. You know, I didn't have a baby. 2-3

I remember coming home and just crying all the time 3i

I just felt bereft. I really did feel hollow, 3ii

I felt my body had let me down that I'd let I'd let my body down 4

I think they don't think about the dads very much.3iii

, it wasn't like a death to other people but it was like a death to me.5

I cried a lot and I just felt I felt quite empty and numb3iv

I was still quite sad when I realised that this baby wasn't going to come to term. 2-3

I thought I believed I would have another baby 3

… I just believe it was, you know, something that just happened that God didn't mean it to be 6

I blamed my body more than God 6

well I think that was what that was the thing that I think really upset me most of all was the sort of clinical way I was treated 1

I felt there was no empathy given 2-3

I know that I lost just a lump of cells, bloody, you know 2

I thought to myself have I done something. 4

I think probably most of it was away by the time I got to the hospital 2

but I think it's just reassurance and listening erm and just being sympathetic, empathetic. 5

there was a record I used to I played over and over again to make myself cry 3-4

I would torture myself sometimes and I think, you know, erm… just to give myself a good cry 3-4

I felt quite sorry for myself 3

I still went to church after it 6

I didn't sort of think oh, God, you let me down 6

I can remember going up there in a car and sitting there crying 2-3

## Appendix 14 (Continued) - Example of I-Poem Construction

Grouping the I statements into themes of:

1. Thought/think
2. Actual event
3. Reaction
4. Blame
5. Support
6. God

produced the following:

1. **Thought/think**
   I thought you won't be interested in me
   I think to make people aware that erm the grief that there is involved in lose… losing a baby
   I thought it was important that erm other people suffering
   I think that was what that was the thing that I think really upset me most of all was the sort of clinical way I was treated 1

2. **Actual event**
   and I suddenly felt cramping pains in my tummy and went to the toilet and there was some blood 2
   that I was miscarrying but lay there, trying not to move. 2
   I had gone to the toilet again and there was quite a lot of clots had come away and I kind of knew myself 2
   I was panicking because I realised that I was losing the baby and there was nothing I could do to stop it. 2
   day I had a DNS and that was it. Cleaned out 2
   well I think that was what that was the thing that I think really upset me most of all was the sort of clinical way I was treated 2b
   I think probably most of it was away by the time I got to the hospital 2
   I felt there was no empathy given 2-3
   I know that I lost just a lump of cells, bloody, you know 2
   I went to the day room or something and somebody said, oh what did you have and I thought I have just lost a baby I had a D&C. You know, I didn't have a baby. 2-3
   I was still quite sad when I realised that this baby wasn't going to come to term. 2-3
   I can remember going up there in a car and sitting there crying 2-3

3. **Reaction**
   I literally just had a D&C. That was it. It was all over. 3
   I just thought I've just lost a baby, I don't want another baby. I wanted this one. 3
   I remember coming home and just crying all the time 3i
   I just felt bereft. I really did feel hollow, 3ii
   I think they don't think about the dads very much.3iii
   I cried a lot and I just felt I felt quite empty and numb3iv
   I thought I believed I would have another baby 3
   I felt quite sorry for myself 3
   there was a record I used to I played over and over again to make myself cry 3-4
   I would torture myself sometimes and I think, you know, erm… just to give myself a good cry 3-4

4. **Blame**
   I thought to myself have I done something. 4
   I felt my body had let me down that I'd let I'd let my body down 4

5. **Support**
   it wasn't like a death to other people but it was like a death to me.5
   but I think it's just reassurance and listening erm and just being sympathetic, empathetic. 5

6. **God**
   I just believe it was, you know, something that just happened that God didn't mean it to be 6
   I blamed my body more than God 6
   I still went to church after it 6
   I didn't sort of think oh, God, you let me down 6

## Appendix 14 Continued) - Example of I-Poem Construction

Reflecting on these categories, I would re-number them and put category one as the last one. This resulted in the first draft of I Poem 8.

I suddenly felt cramping pains in my tummy and went to the toilet and there was some blood
I was miscarrying but lay there, trying not to move
I kind of knew myself
I was panicking
I realised that I was losing the baby and there was nothing I could do to stop it.

I think probably most of it was away by the time I got to the hospital
I had a D&C and that was it. Cleaned out
I went to the day room and somebody said 'what did you have'
I have just lost a baby, I had a D&C. You know,
I didn't have a baby.

I literally just had a D&C. That was it. It was all over.
I remember coming home and just crying all the time
I just felt bereft.
I really did feel hollow,
I felt my body had let me down that I'd let my body down

I think they don't think about the dads very much.
I cried a lot and I felt quite empty and numb
I felt quite sorry for myself
I used to play a record over and over again to make myself cry
I would torture myself sometimes … just to give myself a good cry

I know that I lost a lump of cells, bloody, you know
I thought I've just lost a baby,
I thought I believed I would have another baby
I don't want another baby.
I wanted this one.

I thought to myself have I done something.
I felt my body had let me down
that I'd let my body down
I blamed my body more than God
I didn't sort of think oh, God, you let me down

I believe God didn't mean it to be
I still went to church after it
I was still quite sad when
I realised that this baby wasn't going to come to term.
I felt there was no empathy given

I thought you won't be interested in me
I thought it was important for other people suffering

## Appendix 14 (Continued) - Example of I-Poem Construction

I think to make people aware of the grief in losing a baby
it wasn't like a death to other people but it was like a death to me.
it's just reassurance and listening; being sympathetic, empathetic.

This process was repeated for each of the twelve interviews and created the twelve I Poems that are presented in Chapter 3.

**APPENDIX 15 – Development of Coding Process**

As noted in the text, four broad themes were identified:

- Recognition that it 'was a baby' & acknowledgment of loss
- Mother's emotions
- Response of others
- Comments by medical/nursing staff

These, I was soon to discover were not ideal. Since I am looking at the support received, I identified two main themes and I quickly adapted the above which led to the development of:

- Acknowledgement of loss
- Having a baby (incl personalising baby)
- Phraseology of medical/nursing staff & were these supportive or not
- Response of others (family of friends) & were these supportive or not
- Feelings of guilt (incl letting partner down)
- Feelings of shame

These led, in turn, to the following codes being developed:

- Support a – by immediate family
- Support b - others
- Support c – from medical/nursing staff
- Support d – how they would support others
- Support – religious
- Personal Reflection (what might have been & acknowledgment of loss)
- Memory Making
- Emotion – guilt
- Emotion – shame
- Emotion - fortunate
- Striking Story – a significant event that made me stop and reflect (and has remained with me)

A coding diagram was created (Figure 6 – Coding diagram a) to illustrate the process.

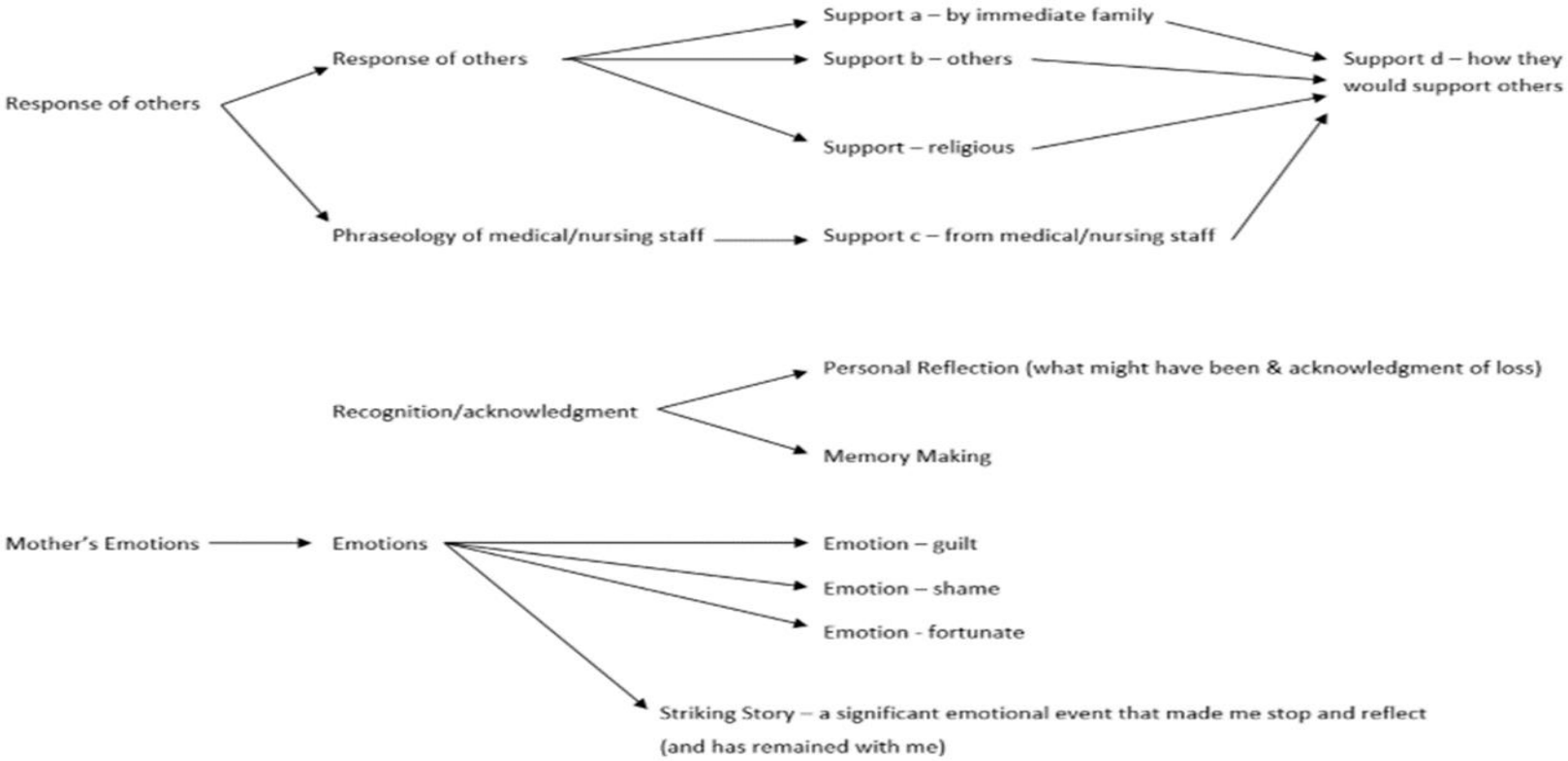


Figure 6 - Coding diagram a

After coding two interviews it became apparent that the codes above did not capture the richness of the women's stories. Using the review feature in MS Office, all of the above codes were highlighted and marked in the margins. On reading through the un-highlighted text, there were other significant pieces of text that had not been identified. Words, which were more than a combination of letters on a page, such as sadness, grief, hopelessness and loss were not coded. The actual physical event had been passed over and yet this contained a meaningful insight into what the women had experienced and which, in turn, would have influenced their reaction/emotions/feelings that followed. It also became clear that my own reaction to the interviews and to the text was missing which, in order to be reflexive, adds another layer to words on a page and needed to be included. It was only on reflecting about my own role in the process that I was able to identify the code 'striking stories' as belonging to my reaction, not that of the mother.[83] Each of the women had told me their story, but it was how I heard these stories that made them striking – to me they were such a significant emotional event that they have been a constant area for personal reflection that I have carried them with me ever since.

This led me to revisit my coding and construct a new coding diagram (Figure 7 - Diagram b).

[83] See Appendix 16 for a note of the Striking Stories.

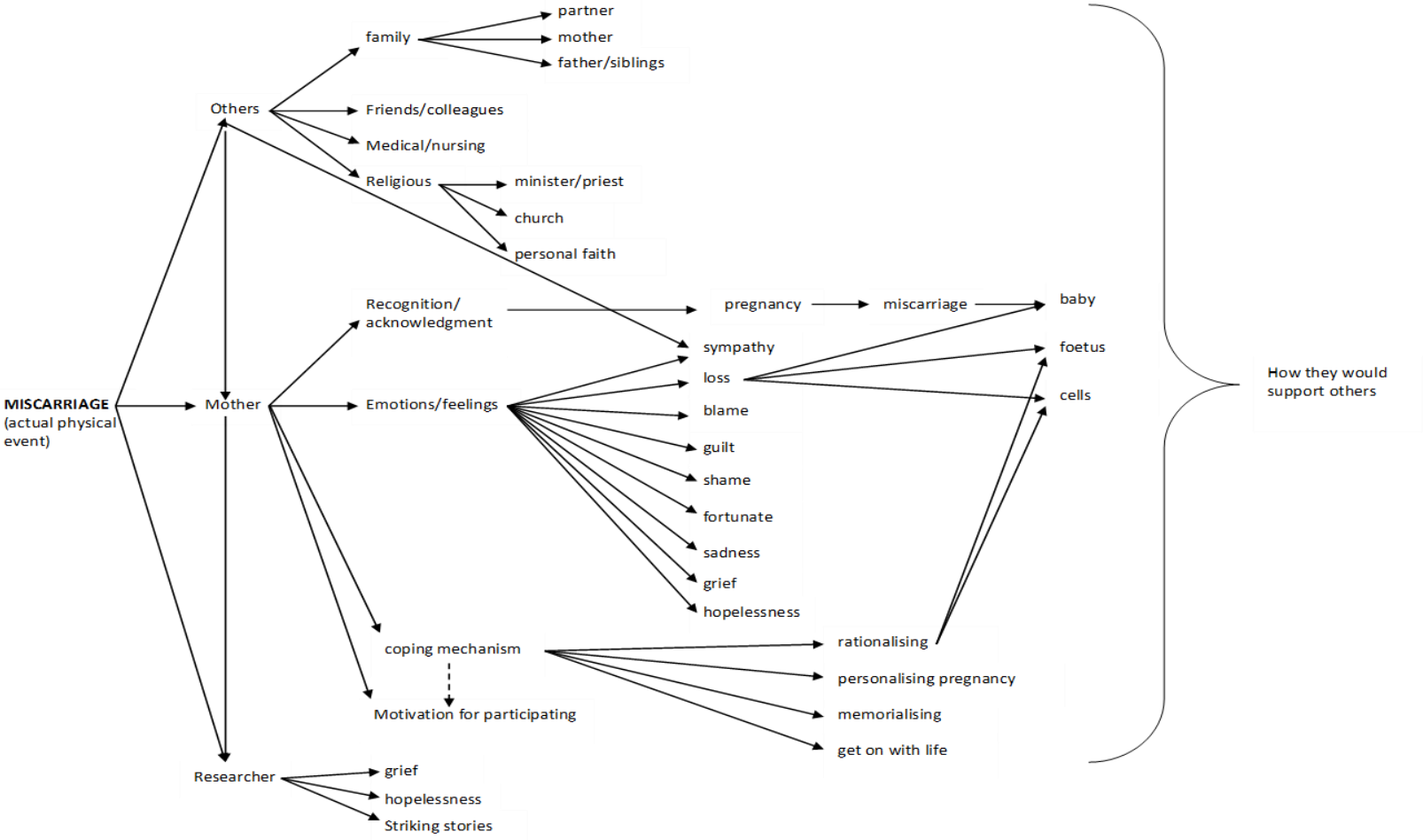


Figure 7 – Coding Diagram b

Taking this approach, I viewed the miscarriage as having an effect on the mother, others and myself (as researcher). Others, including family, friends, and professionals, also have an effect on the mother which would play a role in the mother's emotion and need for recognition and coping mechanisms. I have added another category here (with dotted line) as I do not see a coping mechanism as being something at a fixed point in history (for example, at the time of the miscarriage). Coping mechanism is long term, or perhaps this should be rephrased as the need for a coping mechanism is long term. Even those mothers who expressed a very clear sense of 'getting on with life' (for example, F2), did so in a way that that was their way of coping. The dotted line referred to a question raised when doing my analysis. Was the motivation for taking part in this research project a coping mechanism in itself? For some it was. Participant F12 (who was accompanied by her mother) showed this most clearly right at the beginning of the interview.[84]

SP So, why did you agree to participate in this study?

F12 Erm I did find it interesting purely because when I went through it all I didn't have the support there really. Erm and I had…

Mother You had the medical and family but that was it.

F12 Yeah, I had the medi… aha, the medical and family but there isn't really a wider support for people who go through this and it's the most common thing having to go through. Erm I also felt as if I could get a wee bit of closure from it as well. So…

SP Okay and to understand that I mean in a sense this is this is not a counselling session.

Participant F12 stated "I also felt as if I could get a wee bit of closure from it as well." She was still seeking closure; she was still trying to find a means to cope with her loss. This issue was brought to the surface in my last interview prompting me to re-read all the transcripts again and to code specifically for motivation to participate.

[84] SP is used to identify me as the researcher.

One of the significant omissions from this second attempt at coding was the word ‘support’.

A third category is also included in the final version of the diagram included in the main text which I refer to as ‘Researcher’s Input’. It may appear that I have offered little input, but by being reflexive I acknowledge my role in the research process and how I may have influenced not just the data gathering but also the analysis. I have been affected by some moving and emotional testimonies which must be acknowledged as having had bearing on the analysis of the data.

**Appendix 16 - Striking Stories**

In this appendix, I present certain events that I have been honoured and privileged to hear at interview. I have used the title 'Striking Stories' simply because I found them striking. They have stuck with me since the interviews and perhaps will forever. It would have been easy to set these stories aside as atypical and thus not suitable for generalisation. However, these stories belong to real people. These stories are real experiences. Therefore, they deserve to be heard and acknowledged.

During the interview stage of the research process, there were some experiences shared which I found particularly striking. These events have lived with me ever since. They are unique to each individual and convey a deep sense of the trauma that some people go through. I found it difficult to move beyond these accounts. I had to consciously avoid focusing on these events and remind myself that the purpose of the research was to determine what support can be offered rather than simply describing experiences. That said, the events related to me deserve to be heard. They serve to convey a real sense of what people have lived with. They may be one-off events but as one of the aims of the research was to make the issue of early miscarriage more widely known, I am of the opinion that along with the I-Poems they help to do just that.

I was conscious of allowing such stories to become the focus of the research. It was tempting to mention the events recorded below for the impact and knowing that they would certainly have got the attention of those involved in pastoral care. To do so would have resulted in a change of focus away from the participants own story to my (the researcher's) story, as it has been difficult to move beyond these emotive recollections. Yet, what I am asking pastoral carers to reflect upon is not my perception of early miscarriage but the recalled experiences of those who have volunteered to share their stories, and how they might be better supported.

The events related below are offered without any commentary. They are brief but have had a lasting effect on those who shared them – and also with me.

- Two of the participants had seven miscarriages (F1, F5)

- Following one miscarriage, F1's husband was asked by the doctor "Do you want to burn it or bin it?"
- In one instance a General Practitioner advised the father to wrap what had been miscarried (i.e. his baby) in newspaper and put it on the back of the fire.
- As already noted, one mother (F11) after a stressful live birth and on being very ill herself had what is sometimes described as a near-death experience, wanted to die to be with her dead baby.

**APPENDIX 17 – Educational Principles**

The objective was to design an educational resource for those called upon to offer support following early miscarriage. The difficulty, for me, was to identify and meet the learners' need and not fall into the trap of meeting my objectives at the expense of their expectations (Clark 1999, 23). The focus is on an audience who will be in attendance to learn more about early miscarriage and how to better support those who are going through this experience.

Malcolm Knowles makes five fundamental assumptions about adult learners:

1. They have an independent self-concept and can direct his/her learning.

2. They have accumulated a reservoir of life experiences that is a rich resource for learning.

3. They have learning needs closely related to changing social roles.

4. They are problem centred and interested in immediate application of knowledge.

5. They are motivated to learn by internal rather than external factors. (1970, 12)

Teaching in a one-off situation is difficult. There is little time to get to know the learners, develop trust and identify their needs. It is tempting then to use a didactic style of teaching, especially to large numbers. Whatever their reputation, lectures are an efficient means of transferring knowledge and concepts to large groups (Cantillon 2003, 437). However, they are not an effective means through which to teach skills, change attitudes, or encourage higher-order thinking. The one who lectures hopes that knowledge is in some osmotic way being absorbed by the students. In a lecture situation there is an understandable tendency for students to sit back, be entertained, and 'soak up' the learning (Cantillon 2003, 438).

Learning is about change, whether developing a new skill, understanding a scientific law or changing an attitude (Reece and Walker 2007, 53). Robert Gagne sees learning as being mainly under the control of the environmental influences that interact with the individual (1985, 17). Taking this further, Kolb sees learning as a core process of human development and makes a distinction between development and simple readjustment to change.

Development comes from learning that has occurred through experience and can be shown in diagrammatic form as follows:

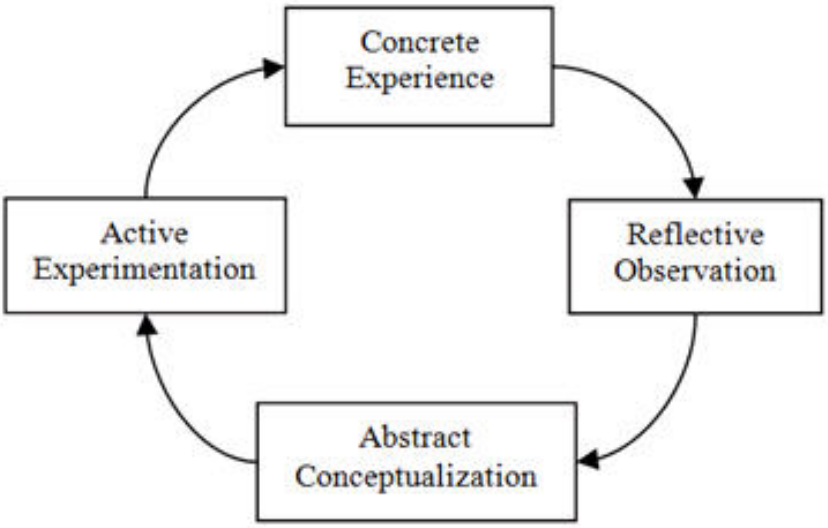


Figure 8 Kolb's Cycle

Following some sort of concrete experience, observations are gathered and the learner reflects on it over and over again until certain insights begin to emerge in the form of a 'theory' about that experience (Kolb 1984, 38). From that theory implications arise which can then be used to modify existing practice.

Reflecting on personal experience, then, is a central element of learning. According to Quinn (2007, 444), it was only in the 1980's, through the work of Donald Schon, that it became part of the professional practice in both the teaching and the nursing professions. It was even later that this concept was adopted by my own profession. In a report to the General Assembly of the Church of Scotland in 2000 titled *'Ministers of the Gospel: A Policy Statement*

*for the Board of Ministry'* reflective practice was made central to the training and continuing professional development of ministers (Reports to the General Assembly, 2000).

I was aware that some of those who attended may have themselves experienced miscarriage and find the session extremely emotional. To address this concern, I asked those responsible for organizing the session to include in their notices information that would ensure the participants were fully aware of what the session entailed.

As per the interviews and focus group stages, I prepared a risk assessment (see Appendix 19). I believed this to be necessary as there may have been people in attendance for whom the sessions might bring to the surface memories and emotions from their own personal experience that had been suppressed. This was a particular concern knowing that one in four pregnancies end in miscarriage and therefore the likelihood of someone in attendance having experience of miscarriage was very high.

The main difficulty was trying to present the session in only one hour.

## APPENDIX 18 – Fraternal/Focus Group Evaluation Form

**EVALUATION FORM**

***How might parish ministers (and other pastoral care givers) better support women who have experienced an early miscarriage?***

**Date:** **Venue:**

---

*In what ways did you find the material presented helpful?*

*How useful were the images in helping you to identify with the emotions accompanying miscarriage?*

*How useful were the 'I' Poems in conveying the actual experience of someone who had experienced as miscarriage?*

*In what ways did the group discussion aid your understanding of miscarriage?*

*What was the most thought-provoking aspect of this session?*

*What one thing will you take away from this session?*

*What was the least useful aspect of this session?*

*How significant was this session to your ministry?*

*How might you envisage your practice changing when you hear of miscarriage?*

---

*Please add any comments overleaf that you feel would be useful for the planning and delivery of this session as an educational resource for those involved in pastoral care:*

**Appendix 19 Research Ethics Risk Assessment and Management – Educational Intervention**

[1] Physical Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Travel | Low | Car accident | Pay due care and attention. | Experienced driver – over 35 years experience. |
| Health and Safety | Low | Physical harm | Researcher to be aware of any relevant H&S procedures pertaining to location. | Health and Safety |

[2] Psychological Risks

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| The discussion of a sensitive topic in an 'open' group has the potential to cause distress to the participants should any of the participants have experienced an early pregnancy loss. | Medium | Participants – psychological stress | Remind participants of what the teaching session is about. Inform them that they can leave at any time. Offer to meet, in private, any individual the end of the session. Signpost participants to appropriate support services. | Researcher has over 25 years experience of pastoral care. |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Discussion of a sensitive topic in an open group has the potential to cause distress to the participant through fear of lack of confidentiality | Medium | Participant – psychological stress | Remind those who attend that this is a voluntary session which will be discussing the support needs of those who have experienced early miscarriage and as such it will touch on sensitive issues.<br>Clearly state that no one need reveal any personal information and stress that all present should respect the confidentiality of others.<br>Should anyone begin to reveal personal experiences during the session, provide an opportunity to remind them that they do not need to do so. | Researcher has over 25 years experience in ministry with the inherent need for (and experience of) confidentiality and of leading groups in a variety of settings. |
| Disclosure of unmet mental health needs | Low | Participant - psychological distress immediate, prompt or urgent response might be required | Offer to stop the session.<br>Permit participants to leave the session at any point.<br>Signpost participants to appropriate support services. | |

| Identified Risks | Likelihood High/ Medium/ Low | Potential Impact/Outcome Who might be harmed and how | Risk Management | Mitigating Factors |
|---|---|---|---|---|
| Researcher insensitivity | Low | Those present might be suffered from emotional or psychological stress | Ensure, that I am properly prepared for each session. | Researcher has over 25 years of experience in ministry and pastoral care. |
| Participants may be known to the researcher | Medium | Participants - Psychological stress through fear of identification or breach of confidentiality | Ensure participants are fully informed of the nature of the research before they agree to participate.<br>Remind participants of the confidentiality agreement before each stage in the process. | Researcher has over 25 years of experience in ministry with the inherent need for (and experience of) confidentiality. |

**Appendix 20 - Liturgical Resources**

In offering these resources to all involved in pastoral care, I do so with the request that thoughtful reflection be given as to which readings and prayers are best suited in each individual situation. They can be adapted and modified, as appropriate, in discussion with grieving parents. This also applies to any ritual that might be offered. I simply list rituals that can be considered together with grieving parents should that be their wish.

Finally, I urge caution. Please listen carefully to the needs of those who grieve. Listening and acknowledging are central to our role as carers. We may feel the need to 'do' something but must be mindful that the appropriate thing to do is to 'do' nothing other than simply being there. This, I have discovered, should be our primary response.

**Useful Scripture Passages** These are from the Good News Translation which is the pew Bible used in my own congregations and the version issued to all our young folk as they progress through the youth organisations. Therefore, in my context, it is the version of scriptures that my parishioners are most familiar with.

Psalm 6: 6-9

6 I am worn out with grief; every night my bed is damp from my weeping;
my pillow is soaked with tears.
7 I can hardly see; my eyes are so swollen from the weeping caused by my
enemies.
8 Keep away from me, you evil people! The Lord hears my weeping;
9 he listens to my cry for help and will answer my prayer.

Psalm 22: 1-5

1 My God, my God, why have you abandoned me? I have cried desperately for help, but still it does not come.
2 During the day I call to you, my God, but you do not answer; I call at night, but get no rest.
3 But you are enthroned as the Holy One, the one whom Israel praises.
4 Our ancestors put their trust in you; they trusted you, and you saved them.
5 They called to you and escaped from danger; they trusted you and were not disappointed

Psalm 23: 1-4

1 The Lord is my shepherd; I have everything I need.
2 He lets me rest in fields of green grass and leads me to quiet pools of fresh water.
3 He gives me new strength. He guides me in the right paths, as he has promised.
4 Even if I go through the deepest darkness, I will not be afraid, Lord, for you are with me. Your shepherd's rod and staff protect me

Psalm 34: 18

18 The Lord is near to those who are discouraged; he saves those who have lost all hope.

Psalm 77: 1-3 & 11-12

1 I cry aloud to God; I cry aloud, and he hears me.
2 In times of trouble I pray to the Lord; all night long I lift my hands in prayer, but I cannot find comfort.
3 When I think of God, I sigh; when I meditate, I feel discouraged
11 I will remember your great deeds, Lord; I will recall the wonders you did in the past.
12 I will think about all that you have done; I will meditate on all your mighty acts.

Psalm 121

1 I look to the mountains; where will my help come from?
2 My help will come from the Lord, who made heaven and earth.
3 He will not let you fall; your protector is always awake.
4 The protector of Israel never dozes or sleeps.
5 The Lord will guard you; he is by your side to protect you.
6 The sun will not hurt you during the day, nor the moon during the night.
7 The Lord will protect you from all danger; he will keep you safe.
8 He will protect you as you come and go now and forever.

Lamentations 3: 19-24

19 The thought of my pain, my homelessness, is bitter poison.
20 I think of it constantly, and my spirit is depressed.
21 Yet hope returns when I remember this one thing:
22 The Lord's unfailing love and mercy still continue,
23 Fresh as the morning, as sure as the sunrise.
24 The Lord is all I have, and so in him I put my hope.

Matthew 11: 28

28 Come to me, all of you who are tired from carrying heavy loads, and I will give you rest.

Matthew 27: 45

45 At noon the whole country was covered with darkness, which lasted for three hours.

Luke 18: 16b-17

16 Let the children come to me and do not stop them, because the Kingdom of God belongs to such as these.
17 Remember this! Whoever does not receive the Kingdom of God like a child will never enter it.

2 Corinthians 1: 3-5

3 Let us give thanks to the God and Father of our Lord Jesus Christ, the merciful Father, the God from whom all help comes!
4 He helps us in all our troubles, so that we are able to help others who have all kinds of troubles, using the same help that we ourselves have received from God.
5 Just as we have a share in Christ's many sufferings, so also through Christ we share in God's great help.

1 Thessalonians 4: 14

14 We believe that Jesus died and rose again, and so we believe that God will take back with Jesus those who have died believing in him.

Revelation 21: 3-4

3 I heard a loud voice speaking from the throne: "Now God's home is with people! He will live with them, and they shall be his people. God himself will be with them, and he will be their God.
4 He will wipe away all tears from their eyes. There will be no more death, no more grief or crying or pain. The old things have disappeared.

**Useful Prayers**

There are lots of useful prayers that can be accessed through the Internet. Like the readings mentioned above, these should be selected thoughtfully and prayerfully with regard to each individual that you pray with. Also, if there is a group of people present, the wording will need to be adapted to suit.

Please take care! Do not use words like heal or cure. I also advocate that you do not give unrealistic assurances for the future or false hope. Do not offer platitudes. My research has taught me the importance of being honest and not feeling the need to have the answer to every question. Be with others in their loss and ensure your prayer reflects this. It is not our job to make things right, how can we?

One difficulty with suggesting prayer is that it is often in response to an immediate need as opposed to prepared as part of a liturgy. Therefore, I offer this template as a place from which to start.

Prayer Template:

- Acknowledge the struggle to find the right words to express our feelings.
- Acknowledge that God loves us.
- Ask that we might know God's presence with us.
- Help us to know that God shares our pain.
- Give us an inner peace.
- Reassure us of our baby's 'safe keeping'.

For example:

> Almighty God,
>
> I do not know the words to say; I do not know how to articulate my feelings; but we [I] pray to you now knowing that you know us, that you love us and that you are with us. You know what is in our hearts and minds, you know the deep sense of loss that we [I] feel; the despair, the anguish; the grief of losing our baby. You know of our [my] broken dreams and lost hopes for the future.
>
> Help us [me] to know that you are with us in our [my] pain; that you share our [my] sense of grief. Strengthen us as we [I] try to find meaning; as we [I] learn to adjust to a new reality.
>
> Give us an inner peace, knowing that our [my] baby is in your safe keeping; that they have a place in your eternal kingdom; and remind us of your eternal hope that one day we will all be united with those whom we have loved and there will be no more tears and no more partings.
>
> In the Name of Jesus Christ we pray; Amen.

Conscious that hymns are a significant contributor to worship which allow a faithful expression of our faith, this next resource draws on the familiarity of hymns (words and tunes) and how they can be a resource following miscarriage. I have selected some of the most frequently sung hymns at funerals (garnered from my own ministry) as an aid to parents to help them express their thoughts and feelings in prayer. This is not an exhaustive list and is offered as an example.

When parents express their desire to pray but are at a loss, I suggest the following as a template which can be changed, amended or adapted as each scenario and each situation dictates. Within the familiar words of familiar hymns, they can say what is in italics or (preferably) re-write to express their own thoughts and feelings. This can be used as part of a service thereafter, if desired.

**Let us pray:**

> **In heavenly love abiding,**
>
> *Almighty God help us to know that we are surrounded by Your love. We come to you struggling to find the right words, unable to articulate our thoughts and feelings. Yet, we know that you care, that you are there for us when the storms of life surround us.*
>
> The storm may roar without me
>
> My heart may low be laid;
>
> But God is round about me
>
> **Abide with me: fast falls the eventide;**
>
> The darkness deepens; Lord, with me abide.
>
> *Almighty God, the darkness threatens to overwhelm us. We cannot envisage that the morning light will ever again shine for us.*

Hold thou thy cross before my closing eyes,

Shine through the gloom and point me to the skies.

**Great is thy faithfulness, O God my father,**

There is no shadow of turning with thee;

*Almighty God, remind us of your faithfulness. Remind us that you are with us and will continue to journey with us as we try to make sense of our loss.*

Thou changest not, thy compassions they fail not,

As thou hast been thou for ever wilt be.

**Will your anchor hold in the storms of life,**

When the clouds unfold their wings of strife.

*Almighty God we come to you in the midst of a storm in our lives. We are devasted, we cannot contemplate the present and fear for the future. Help us to know that through our faith we have a strong anchor which will help us through our loss. Help us to know that death is not the end, that our baby is with you in heaven.*

Will your anchor safe by the heavenly shore,

When life's storms are past for ever more.

**Guide me O thou great Jehovah,**

*Almighty God, our hymn talks about being pilgrims in a foreign land. That is exactly how we feel. Bewildered. Lost. Uncertain. Anxious. Afraid. We seek strength as we try to cope with the loss of our baby.*

I am weak, but thou art mighty;

Hold me with thy powerful hand.

**All things bright and beautiful,**

All creatures great and small,

*Almighty God, as we grieve over the loss of our baby. Our baby was so small but to us bright and beautiful and wise and wonderful. We acknowledge that you are our heavenly Father and the heavenly Father of our children also. You have made us all.*

All things wise and wonderful,

The Lord God made them all.

**Thine be the glory, risen, conquering Son**

Lo Jesus greets us, risen from the tomb;

*Almighty God, in the resurrection of Jesus Christ we have the assurance that he will meet us and our loved ones, our baby, and bring us safely into the Kingdom of Heaven.*

Bring us safe through Jordan to thy home above.

**In Jesus Name we pray; Amen.**

**Useful Rituals**

A service. This may take the form of a more traditional memorial or thanksgiving service. However, my own experience suggests otherwise. I suggest the role of the pastoral care giver is to listen and if the parents speak about wanting to 'do something?' or 'what should we do?' then a we can suggest what others have found useful. However, we must be mindful that individual needs vary considerably, and we must avoid giving the impression that some kind of ritual must be carried out. If we do so, we will leave people who do not wish for any ritual (or are not yet ready to do so) feeling that somehow they have not honoured their baby.

The following are also useful to consider both within a religious service context or as quite distinct activities:

- Prayers and poems (whether found elsewhere or written especially for the occasion);
- Writing a letter (which can be private or shared);
- Blessing ceremony and/or Naming ceremony;
- Lighting a candle;
- Plant a tree or bush.

**Useful Christmas Activity**

Throughout Advent and Christmas everything is very children centred. The Nativity story is often retold by children on the Sunday before Christmas. This is a time of year when many will have thoughts of 'what might have been'. Therefore, we must be conscious of those who find this season of the year personally upsetting. I place a pair of baby booties on the Church's Christmas Tree. These may interrupt the coordinated decoration, but they serve as a reminder of those babies which are not with us, while reassuring those who have experienced a loss that our thoughts and prayers are very much with them.

**Useful Reminder about Mothering Sunday and Father's Day**

Please be sensitive on these days. We can only imagine the emotions parents who have lost a longed-for child go through on that day. Give some thought about how a worship service might be constructed which avoids excluding those who have lost their babies (and indeed those who have lost their parents). Giving, for example, a flower to every mother on Mothering Sunday does just that. Consider giving a flower to every woman. Encourage everyone to give thanks for their own parents.

Create a space or a locus for those who wish to reflect on their own experience. Ensure that the sanctuary is available outside the normal worship hours so that it

can be accessed. Make it known that a flower can be left on the chancel or on a window sill as a means of remembering and honouring their baby. By doing so, it helps to encourage grieving parents to know that all are welcome in God's House and alleviates the thought that they should stay away thinking 'this is not a day for us'.

## Bibliography

Ackermann, Denise M., and Riet Bons-Storm. 1998. *Liberating Faith Practices: Feminist Practical Theology in Context*. Leuven: Peeters.

Aho, Anna Liisa, Jaana Malmisuo and Marja Kaunonen. 2018. "The effects of peer support on post-traumatic stress reactions in bereaved parents." *Scandinavian Journal of Caring Sciences* 32: 326–334.

Ainsworth-Smith, Ian, and Peter Speck. 1988. *Letting Go, Caring for the Dying and Bereaved.* New Library of Pastoral Care. London: SPCK.

Allen, Leslie C. 2011. *A Liturgy of Grief: A Pastoral Commentary on Lamentations.* Grand Rapids: Baker Publishing Group.

Alvesson, Mats, and Kaj Sköldberg. 2009. *Reflexive Methodology: New Vistas for Qualitative Research* (second edition). London: Sage.

Angell, Charles Roy. 1965. *Shields of Brass.* Nashville: Broadman Press.

Angiolini, Dame Elish. 2014. *Mortonhall Investigation Report*. Online at: http://www.edinburgh.gov.uk/info/20004/council_and_democracy/957/mortonhall_investigation_report/2; accessed 1 May2014.

Antze, Paul, and Michael Lambeck. 1996. *Tense Past: Essays in Trauma and Memory*. London: Routledge.

Aristotle. 2009. *The Nicomachean Ethics.* Oxford: Oxford University Press.

Atkins, Sue, and Kathy Murphy. 1995. "Reflective Practice." *Nursing Standard* 9: 31-37.

Atran, Scott, Douglas L. Medin and Norbert O. Ross. 2005. "The cultural mind: Environmental decision making and cultural modelling within and across populations." *Psychological Review* 112: 744-776.

Baker, Therese L. 1999. *Doing Social Research.* Boston: McGraw-Hill.

Barbour, Rosaline S. 2005. "Making Sense of Focus Groups." *Medical Education* 39: 742-750.

Barker, Philip J. 1991. "Interview." In *The Research Process in Nursing*, edited by D. Cormmack, 207-214. Oxford: Blackwell.

Battaglia, Mike. 2008. "*Convenience Sampling,*" in *Encyclopedia of Survey Research Methods*, edited by Paul J. Lavrakas, 645-647. Thousand Oaks: Sage. Online at: https://dx.doi.org/10.4135/9781412963947; accessed 2 July 2019.

Bauckham, Richard. 2008 *Jesus and the God of Israel: God Crucified and Other Studies on the New Testament's Christology of Divine Identity*. Grand Rapids: Eerdmans.

Beauchamp, Tom L., and James F. Childress. 2009. *Principles of Biomedical Ethics*. Oxford: Oxford University Press.

Becker, Howard S. 1998. *Tricks of the Trade: How to Think about Your Research while Doing It*. Chicago and London: University of Chicago Press.

Bennett, Zoë, Elaine Graham, Stephen Pattison, and Heather Walton. 2018. *Invitation to Research in Practical Theology*. New York: Routledge.

Berliner, David, and Douglas Fallen. 2008. "Introduction to Special Action on Men Doing Anthropology of Women." *Men & Masculinities* 11: 135-144.

Beste, Jennifer. (2007). *God and the victim: Traumatic intrusions on grace and freedom* (American Association of Religion Academy Series). New York: Oxford University Press.

Bleyen, Jan. 2006. "Hiding babies: Making Sense of Death and Grief." Unpublished paper presented at the , 4th Global Conference on Making Sense of Death and Dying, Mansfield College, Oxford. 12-14 July 2006.

Bluff, Rosalind, and Immy Holloway. 1994. "'They know best': women's perceptions of midwifery care during labour and childbirth." *Midwifery* 10: 157-164.

Bogdan, Richard, and Sari K. Biklen. 1998. *Qualitative Research for Education: An Introduction to Theory and Method*. Boston: Allyn & Bacon.

Bolton, Gillian. 2005. *Reflective Practice: Writing and Professional Development* (second edition). London: Sage.

Bonomy, Lord Iain. 2014. Report of the Infant Cremation Commission. Online at: https://www.gov.scot/publications/report-infant-cremation-commission/; accessed 8 July 2015.

Bowlby, John. 1979. *The Making and Breaking of Affectional Bonds*. London: Tavistock.

Brady, Ivan. 2009. "Foreword." In *Poetic Inquiry. Vibrant Voices in the Social Sciences,* edited by M. Prendergast, C. Leggo and P. Sameshima, xi-xvi. Rotterdam: Sense Publishers.

Brink, Pamela J. 1989. "Issues of Reliability and Validity." In: *Qualitative Nursing Research. A Contemporary Dialogue*, edited by Janice M. Morse, 164-187. London: Sage.

Browning, Don S. 1983. *Religious Ethics and Pastoral Care*. Philadelphia: Fortress Press.

Brueggemann, Walter. 1977. “Formfulness of Grief.” *Interpretation* 31: 263-75.

—. 1986. “The Costly Loss of Lament.” *Journal for the Study of the Old Testament* 36: 57-71.

—. 1991. *Abiding Astonishment: Psalms, Modernity, and the Making of History*. Louisville: Westminster John Knox Press.

— (ed.). 1992. *Old Testament Theology. Essays on Structure, Theme and Text*. PD Miller. Minneapolis: Fortress Press.

—. 1997. *Theology of the Old Testament: Testimony, Dispute, Advocacy*. Minneapolis: Fortress Press.

—. 2008. “Lament as Wake-Up Call (Class Analysis and Historical Possibility).” In *Lamentations in Ancient and Contemporary Cultural Contexts*, edited by Nancy C. Lee and Carleen Mandolfo, 221-36. Atlanta: Society of Biblical Literature.

Broyles, Craig C. 1989. *The Conflict of Faith and Experience in the Psalms: A Form - Critical and Theological Study*. Sheffield: JSOT Press.

Bullock, C. Hassel 2001. *Encountering the Book of Psalms*. Grand Rapids: Baker Books.

Brydon-Miller, Mary, Davydd Greenwood, and Patricia Maguire. 2003. *Why Action Research?* Thousand Oaks: Sage Publications.

Bryman, Alan. 1984. "The Debate about Quantitative and Qualitative Research: A Question of Method or Epistemology?" *The British Journal of Sociology* 35: 75-92.

—. 1988. *Quantity and Quality in Social Research*. London: Unwin Hyman.

Burnard, Philip. 1991. *“*A method of analysing interview transcripts in qualitative research.*” Nurse Education Today* 11: 461–466.

—. 1995. "Nurse educators’ perceptions of reflection and reflective practice: a report of a descriptive study." *Journal of Advanced Nursing* 21: 1167-1174.

Burns, Nancy, and Susan K. Grove. 2005. *The Practice of Nursing Research; Conduct, Critique and Utilisation*. London: W. B. Saunders.

Buttitta, Peter K. 1995. "Theological Reflection in Health Ministry: A Strategy for Parish Nurses." In *Method in Ministry: Theological Reflection and Christian Ministry*, edited by J. D. Whitehead and E. E. Whitehead, 112-123. Kansas City: Sheed and Ward.

Cabinet Office of the British Government [Liz Spencer, Jane Ritchie, Jane Lewis and Lucy Dillon, National Centre for Social Research]. 2003. *Quality in Qualitative Evaluation: A framework for assessing research evidence*. United Kingdom: Government Chief Social Researcher's Office.

Cacciatore, Joanne, Jeffrey R. Lacasse, Cynthia A. Lietz, and Jane McPherson. 2013-2014. "A parent's TEARS: Primary results from the Traumatic Experiences and Resiliency Study." *Omega (Westport)* 63: 183-205.

Cacciatore, Joanne, and Kara Thieleman. 2019. **"**Normal Complications and Abnormal Assumptions After Perinatal Death." *MCN: The American Journal of Maternal/Child Nursing* 44: 6.

Cahnmann-Taylor, Melisa. 2009. "The Craft, Practice, and Possibility of Poetry in Educational Research." In *Poetic Inquiry: Vibrant Voices in the Social Sciences*, edited by M. Prendergast, C. Leggo and P. Sameshima, 13-29. Rotterdam: Sense Publishers.

Cameron, Helen, John Reader, Victoria Slater, and Chris Rowland. 2012. *Theological Reflection for Human Flourishing: Pastoral Practice and Public Theology*. London: SCM Press.

Cantillon, Peter. 2003. "Teaching Large Groups." *British Medical Journal* 326: 437.

Capron, Alexander M. 1998. "Human experimentation." In *Medical Ethics* (second edition), edited by R.M. Veatch, 135-184. Sudbury: Jones and Bartlett Publishers.

Carlson, Nathaniel A. 2015. "Lament: The Biblical Language of Trauma." *A Journal for the Theology of Culture* 11: 50-68.

Carroll, Penelope, Kevin Dew and Philippa Howden-Chapman. 2011. "The Heart of the Matter: Using Poetry as a Method of Ethnographic Inquiry to Represent and Present Experiences of the Informally Housed in Aotearoa/New Zealand." *Qualitative Inquiry* 17: 623-630.

Charmaz, Kathy. 2006. *Constructing Grounded Theory*. Los Angeles: Sage.

Chaudhary, Anshu. 2019. "Living Through an Early Pregnancy Loss: an Autoethnographic Account." *Research Gate*. Online at: https://www.researchgate.net/publication/332197473_Living_Through_an_Early_Pregnancy_Loss_an_Autoethnographic_Account; accessed 11 April 2019.

Church Hymnary. 1973. *The Church Hymnary*. Oxford University Press: Oxford.

Church of Scotland Panel on Worship. 1994. *The Book of Common Order*. Edinburgh: Saint Andrews Press.

Clark, Victoria B. 1999. “The ABCs of highly effective presentations: A customer-centered approach.” *Journal for Nurses in Staff Development* 15: 23-26.

Cobb, Mark. 2001. *The Dying Soul: Spiritual Care At The End Of Life*. Buckingham: Open University Press.

Coffey, Amanda, and Paul Atkinson. 1996. *Making Sense of Qualitative Data: Complementary Research Strategies.* Thousand Oaks: Sage.

Coleman, Gerald D. 1986. “Baptising Dying Infants Not Always Required.” *Health Progress* 67: 46-49.

Collier, Judith, Murray Longmore and Keith Amarakone (eds). 2013. *Oxford Handbook of Clinical Specialities* (ninth edition). Oxford: Oxford University Press.

Constas, Mark A. 1992. “Qualitative Analysis as a Public Event: The Documentation of Category Development Proceudres.” *American Educational Research Journal* 29: 253-266.

Cooke, Deryck. 1959. *The Language of Music*. London and New York: Oxford University Press.

Cooper-White, Pamela. 2012. “Suffering.” In: *The Wiley Blackwell Companion to Practical Theology*, edited by Bonnie J. Miller-McLemore, 23-31. Malden: Wiley Publishing.

Crawley, Rosalind, Samantha Lomax, and Susan Ayres. 2013. “Recovering from Stillbirth: The Effects of Making and Sharing Memories on Maternal Mental Health.” *Journal of Reproductive and Infant Psychology* 31: 195-207.

Creswell, John W. 1998. *Qualitative Inquiry and Research Design Choosing among Five Traditions.* Thousand Oaks: Sage.

Crombie, Ian K., and Huw T. O. Davies. 1996. *Research in Health Care Design: Conduct and Interpretation of Health Services Research.* Chichester: Wiley and Sons.

Cutcliffe, John R., and Hugh Patrick Mckenna. 1999. “Establishing the credibility of qualitative research findings: the plot thickens.” *Journal of Advanced Nursing* 30: 374-380.

Daniel, Terry. 2014. *Turning the Corner on Grief Street: Loss and Bereavement as a Journey of Awakening.* N.pl.: First House Press.

Davies, Martin Brett, and Nathan Hughes. 2014. *Doing a Successful Research Project: Using Qualitative or Quantitative Methods* (second edition). Basingstoke: Palgrave McMillan.

Denzin, Norman K., and Yvonna S. Lincoln. 2008. *Strategies of Qualitative Inquiry* (third edition). Thousand Oaks: Sage.

Davies, Sally C. 2012. *Chief Medical Officer Annual Report 2012: children and young people's health*. Online at: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays; accessed 12 July 2015.

De Beer, Marlene. 2003. "A seventh moment bricoleurship and narrative turn to poetics in educational research." Unpublished paper presented at the British Educational Research Association Annual Student Conference, Heriot-Watt University. Student Conference, Edinburgh. 10 September 2003.

Denzin, Norman K. 2014. *Interpretive Autoethnography* (second edition). Los Angeles: Sage.

Denzin, Norman K., and Yvonna S. Lincoln. 1994. "Introduction: Entering the field of qualitative research." In: *Handbook of Qualitative Research*, edited by Norman K. Denzin and Yvonna S. Lincoln, 1-18. Thousand Oaks: Sage.

Devine, Fiona, and Sue Heath. 1999. *Sociological Research Methods in Context*. New York: Palgrave.

Dickie, June F. 2019. "The importance of lament in pastoral ministry: Biblical basis and some applications." *Verbum et Ecclesia* 40. Online at: https://doi.org/10.4102/ve.v40i1.2002; accessed 9 February 2020.

Doka, Kenneth. 1989. *Disenfranchised Grief: Recognizing Hidden Sorrow*. Lexington: Lexington Books.

Doyal, Len, and Ian Gough. 1991. *A Theory of Human Need*. London: MacMillan.

Downer, K. 1996. "Assessment of parental competence to consent to treatment for their child." *Nursing in Critical Care* 1: 6-8.

Drew, N. C., P. Salmon, and L. Webb. 1989. "Mothers', midwives' and obstetricians' views on the features of obstetric care which influence satisfaction with childbirth." *British Journal of Obstetrics & Gynaecology* 96: 1084-1088.

Driscoll, Joseph J. 1996. "The Sound of Spirit Blowing." *Vision* 6: 14-16.

Du Bois, Barbara. 1983. "Passionate Scholarship: Notes on values, knowing and method in feminist social science." In *Theories of Women's Studies*, edited by G. Bowles and R. D. Klein, 105-116. London: Routledge.

Dyregrov, Kari, Dag Nordanger, and Atle Dyregrov. 2003. "Predictors of psychosocial distress after suicide, SIDS and accidents." *Death Studies*. 27: 143–165.

Easton, Kirsten, Judith F. McComish, and Riwka Greenberg. 2000. “Avoid Common Pitfalls in Qualitative Data Collection and Transcription.” *Qualitative Health Research* 10: 703-708.

Ebner, Martin. 2001. “Klage und Auferweckungshoffnung im Neuen Testament.” In *Klage*, edited by Martin Ebner et al., 1673-87. Neukirchen-Vluyn: Neukirchener Verlag.

Edwards, Rosalind. and Susie Weller. 2012. “Shifting Analytic Ontology: Using I-Poems in Qualitative Longitudinal Research.” *Qualitative Research.* 12: 202-217.

Edwards, Steven D. 1996. *Nursing Ethics: A Principle-Based Approach*. London: MacMillan.

Elliott, John. 2000. *Images of Educational Change*. Buckingham: Open University Press.

Ely, Margot, Diane Garner, and Margaret Anzul. 1991. *Doing Qualitative Research: Circles within Circles.* London: The Falmer Press.

Ely, Margot, Ruth Vinz, Maryann Downing and Margaret Anzul. 1997. *On writing qualitative research: Living by words*. London: The Falmer Press.

Emanuel, Ezekiel J., David Wendler, and Christine Grady. 2000. “What Makes Clinical Research Ethical?” *The Journal of the American Medical Association* 283: 2701-2711.

Emery, Michele. 2000. "Informed consent: keeping parents in the picture." *Journal of Neonatal Nursing* 6: 90-92.

Estes, Daniel J. 2005. *Handbook on the Wisdom Books and Psalms*. Grand Rapids: Baker Academic.

Eva, Willmore D. 1998. “Embracing the Role of Pastoral Theology,” *Ministry*. Online at: https://cdn.ministrymagazine.org/issues/1998/issues/MIN1998-10.pdf; accessed 10 February 2020.

Fahie, Declan. 2014. “Doing Sensitive Research Sensitively: Ethical and Methodological Issues in Researching Workplace Bullying.” *International Journal of Qualitative Methods* 13: 19–36.

Farren, Jessica, Maria Jalmbrant, Lieveke Ameye, Karen Joash, Nicola Mitchell-Jones, Sophie Tapp, Dirk Timmerman, and Tom Bourne. 2016. “Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: a prospective cohort study.” Online at: *BMJ Open* 2016;6:e011864; accessed 14 July 2019.

—. 2019. “Posttraumatic stress, anxiety and depression following miscarriage and ectopic pregnancy: a multicenter, prospective, cohort study.” *American*

*Journal of Obstetrics and Gynaecology* 222. Online at: https://doi.org/10.1016/j.ajog.2019.10.102; accessed 18 Jan 2020.

Fielding, Nigel, and Jane Fielding. 1986. *Linking Data*. London: Sage.

Flanagan, Mark. *What is poetry?* Online at http://contemporarylit.about.com/cs/literaryterms/g/poetry.htm; accessed 23 July 2017.

Fontana, Andrea, and James Frey. 2005. "The interview: From neutral stance to political involvement." In: *The Sage handbook of qualitative research*, edited by N. K. Denzin and Y. S. Lincoln, 695–727. London: Sage.

Ford, David. 1999. *Theology: A Very Short Introduction*. Oxford; New York: Oxford University Press.

Forrester, Duncan B. 2000. *Truthful Action: Explorations in Practical Theology*. Edinburgh: T&T Clark.

Freud, Sigmund. 1913. *Mourning and Melancholia*. London: Pelican.

Gagne, Robert. 1985. *The Conditions of Learning and Theory of Instruction* (fourth edition). New York: Holt, Rinehart and Winston.

Ganzevoort, R. Ruard. 2008a. "Teaching that Matters: A Course on Trauma and Theology." *Journal of Adult Theological Education* 5: 8-19.

—. 2008b. "Scars and Stigmata: Trauma, identity and theology." *Practical Theology* 1: 19-31.

Gerber-Epstein, Paula, Ronit D Leichtentritt, and Yael Benyamini. 2009. "The Experience of Miscarriage in First Pregnancy: The Women's Voices." *Death Studies* 33: 1-29.

Gerrish, Brian Albert. 1984. *A Prince of the Church: Schleiermacher and the Beginnings of Modern Theology*. Philadelphia: Fortress Press.

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

Gillis, Angela, and Winston Jackson. 2002. *Research for nurses: methods and interpretation*. Philadelphia: F.A. Davis Company.

Glaser, Barney G. 1992. *Emergence vs Forcing: Basics of Grounded Theory*. California: The Sociology Press.

Glesne, Corrine. 1997. "That Rare Feeling: Re-Presenting Research Through Poetic Transcription." *Qualitative Inquiry* 3: 202-221.

Glesne, Corrine, and Alan Peshkin. 1992. *Becoming Qualitative Researchers: An Introduction*. White Plains: Longman.

Gold, Katherine, Martha Boggs, Emeline Mugisha, and Christie Palladino. 2012. "Internet Message Boards for Pregnancy Loss: Who's On-Line and Why?" *Women's Health Issues* 22: 67-72.

Goldingay, John. 2006. *Psalms*, Volume 1: *Psalms 1–41*. Baker commentary on the Old Testament Wisdom and Psalms, 1. Grand Rapids: Baker Academic.

Graham, Elaine, Heather Walton, and Francis Ward. 2005. *Theological Reflections: Methods.* London: SCM Press.

Graham, Elaine. 2013. "Is Practical Theology a form of 'Action Research'?" *International Journal of Practical Theology* 17: 148-178.

—. 2017 "On becoming a practical theologian: Past, present and future tenses." *HTS Teologiese Studies/Theological Studies* 73. Online at: a4634. https://doi.org/10.4102/hts.v73i4.4634; accessed 6 August 2019.

Grant, Jacquelyn. 1989. *White Women's Christ and Black Women's Jesus: Feminist Christology and Womanist Response*. Atlanta: Scholars Press.

Gravensteen, I.K., L.B. Helgadóttir, E-M. Jacobsen, I. Rådestad, P. M. Sandset, and O. Ekeberg. 2013. "Women's experiences in relation to stillbirth and risk factors for long-term post-traumatic stress symptoms: a retrospective study." *British Medical Journal*. Online at: *BMJ Open* 2013;3:e003323. doi: 10.1136/bmjopen-2013-003323; accessed 7 August 2015.

Green, Judith, and Nicki Thorogood. 2009. *Qualitative Methods for Health Research*. Thousand Oaks: Sage.

Greenwood, Davydd J., and Morten Levin. 1998. *Introduction to Action Research: Social Research for Social Change*. Thousand Oaks: Sage.

Groenewald, Thomas. 2004. "A Phenomoelogical Research Design Illustrated." *International Journal of Qualitative Methods* 3: 1-26.

Guba, Egon G., and Yvonna S. Lincoln. 1981. *Effective Evaluation*. San Fransisco: Jossey-Bass.

—. 1989. *Fourth Generation Evaluation*. California: Sage.

Guest, Greg, Arwen Bunce, and Laura Johnson. 2006. "How Many Interviews are Enough? An Experiment with Data Saturation and Variability." *Field Methods* 18: 59-82.

Hamann, Jaco J. 2005. *When Steeples cry: Leading congregations through loss and change*. Cleveland: The Pilgrim Press.

Hammersley, Martyn. 1992. *What's Wrong with Ethnography? Methodological Explorations*. London: Routledge.

Hand, Helen. 2003. "The mentor's tale: a reflexive account of semi-structured interviews." *Nurse Researcher* 10: 15-27.

Haraway, Donna. 1991. "A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century." In *Simians, Cyborgs and Women: The Reinvention of Nature,* 149-181. New York: Routledge.

Harding, Sandra. 1987. "Introduction: Is There a Feminist Method?" In *Feminism & Methodology,* edited by Sandra Harding, 1-14. Milton Keynes: Open University Press.

—. 1995. "'Strong objectivity': A response to the new objectivity question." *Synthese* 104: 331-349.

Hart, David B. 2002. "No Shadow of Turning: On Divine Impassibility." *Pro Ecclesia* 11: 184-206.

Heritage, John. 1984. *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.

Herman, Judith. 1992. *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*. New York: Basic Books.

Hesse-Biber, Sharlene N. 2007. *Handbook of Feminist Research: Theory and Praxis*. Thousand Oaks: Sage.

Hesse-Biber, Sharlene N., and Patricia Leavy. 2005. *The Practice of Qualitative Research*. Thousand Oaks: Sage.

Hollingsworth, A. 2013. "Simone Weil and the Theo-Politics of Compassion." *Modern Theology* 29: 203-229.

Holloway, Immy. 1997. *Basic concepts for Qualitative Research*. Oxford: Blackwell Science.

—. 2005. *Qualitative Research in Health Care*. Maidenhead: Open University Press.

Holloway, Immy, and Stephanie Wheeler. 1996. *Qualitative Research for Nurses.* Cambridge: Blackwell Science.

Hollway, Wendy, and Tony Jefferson. 2000. *Doing qualitative research differently: free association, narrative and the interview method.* London: Sage.

Holmes, Colin A. 1990. "Alternatives to Natural Science Foundations for Nursing." *International Journal of Nursing Studies* 27: 187-198.

Human, Melanie, Sulina Green, Coen Groenewald, Richard D. Goldstein, Hannah C. Kinney, and Hein J. Odendaal. 2014. "Psychosocial implications of stillbirth for the mother and her family: a crisis support approach." *Social Work* 50: 392.

Irion, Paul E. 1991. “Changing patterns of ritual response to death.” *Omega: Journal of Death and Dying* 22: 159–172.

Jayaratne, Toby. 1983. “The value of quantitative methodology for feminist research.” In *Theories of women's studies*, edited by Gloria Bowles and Renate Duelli Klein, 140-162. London: Routledge and Kegan Paul.

Johns, Christopher. 1995. “Framing learning through reflection within Carper’s fundamental ways of knowing in nursing.” *Journal of Advanced Nursing* 22: 226-234.

Jones, Serene. 2003. “Soul Anatomy: Calvin’s commentary on the Psalms.” In *Psalms in community. Jewish and Christian textual, liturgical, and artistic traditions*, edited by H.W. Attridge & M.E. Fassler, 265–284. Atlanta: Society of Biblical Literature.

—. 2009. *Trauma and Grace: Theology in a Ruptured World.* Louisville: Westminster John Knox Press.

Kara, Helen. 2015. *Creative Research Methods in the Social Sciences: A practical guide*. Bristol: Policy Press.

Kavanaugh, Karen, Darcie Trier, and Michelle Korzec. 2004. “Social Support Following Perinatal Loss.” *Journal of Family Nursing* 10: 70-92.

Kelly, Ewan R. 2007. *Marking Short Lives. Constructing and Sharing Rituals Following Pregnancy Loss.* Bern: Peter Lang.

Kemmis, Stephen. 2009. “Action research as a practice-based practice.” *Educational Action Research* 17: 463-474.

Kemmis, Stephen, and Robin McTaggart. 1988. *The Action research planner* (fourth edition). Geelong: Deakin University Press.

Kitzinger, Jenny. 1995. “Qualitative Research: Introducing focus groups.” *British Medical Journal* 311: 299-302.

Knowles, Malcolm. S. 1970. *The Modern Practice of Adult Education: Andragogy versus Pedagogy*. New York: Association Press.

Koch, Tina. 1998. “Storytelling: is it really research?” *Journal of Advanced Nursing* 28: 1182-1190.

Kock, Ned. 2004. “The three threats of action research: a discussion of methodological antidotes in the context of an information systems study.” *Decision Support Systems* 37: 265–286.

Kohl, Kimberly Crawford. 2012. “Remembering Your Faith through the Grief: Experiencing a Miscarriage.” *The journal of pastoral care & counselling* 8: 1-2.

Kolata, Gina. 1998. “Scientific Myths That Are Too Good to Die.” *New York Times*, 6 December, 1998. Online at: https://archive.nytimes.com/www.nytimes.com/library/review/120698science-myths-review.html; accesssed 14 May 2014.

Kolb, David A. 1984. *Experiential Learning: Experience as the Source of Learning and Development*. Inglewood Cliffs: Prentice-Hall.

Komaromy, Carol, Sarah Earle, Cathy Lloyd, and Pam Foley. 2007. “A social insight into bereavement and reproductive loss.” *Practising Midwife*. Online at: https://www.researchgate.net/publication/42796536_A_social_insight_into_bereavement_and_reproductive_loss; accessed 1 July 2019.

Kreicbergs, Ulrika, Unnur Valdimarsdottir, Erik Onelov, Jan-Inge Henter, and Gunnar Steineck. 2004. “Anxiety and depression in parents 4-9 years after the loss of a child owing to a malignancy: a population-based follow-up.” *The New England Journal of Medicine* 34: 1431-1441.

Krueger, Richard A. 1994. *Focus Groups: A Practical Guide for Applied Research* (second edition). Thousand Oaks: Sage.

Kvale, Steinar. (1996). *InterViews—An introduction to qualitative research interviewing*. Thousand Oaks: Sage.

—. 2002. "Dialogue as Oppression and Interview Research." Paper presented at the Nordic Educational Research Association Conference. Tallinn. 7 – 9 March 2002. Online at: https://psy.au.dk/fileadmin/Psykologi/Forskning/Kvalitativ_metodeudvikling/NB32/dialogueopptallinnNB.pdf; accessed 2 May 2019.

—. 2006. “Dominance Through Interviews and Dialogues.” *Qualitative Inquiry* 12: 480-500.

Lamb, Jane Marie. 1992. "Parent’s Needs and Rights when a Baby Dies." *Health Progress* 47: 52-57. Online at: https://www.chausa.org/docs/default-source/health-progress/pastoral-care---parents_-needs-and-rights-when-a-baby-dies-pdf.pdf?sfvrsn=2; accessed 3 July 2017.

Lammert, Cathi. 2000. "The Obstetrics Patient." In: *Health Care and Spirituality: Listening, Assessing, Caring*, edited by Richard B. Gilbert, 211-234. New York: Baywood Publications.

Landsberger, Henry A. 1958. *Hawthorne Revisited*. Ithaca: Cornell University Press.

Lang, Ariella, Céline Goulet, Marilyn Aita, Victoire Lamarre, Hélène Giguère, and Elaine Perreault. 2001. "Weathering the storm of perinatal bereavement via hardiness." *Death Studies* 25: 497-512.

Lang, Ariella, Andrea R. Fleiszer, Fabie Duhamel, Wendy Sword, Kathleen R. Gilbert, and Serena Corsini-Munt. 2011. "Perinatal loss and parental grief: The challenge of ambiguity and disenfranchised grief." *Omega: Journal of Death and Dying* 62: 186-196.

Lather, Patti. 1993. "Fertile Obsession: Validity after Poststructuralism." *Sociological Quarterly* 34: 673-693.

Layne, Linda L. 2003. "Unhappy endings: A feminist reappraisal of the women's health movement from the vantage of pregnancy loss." *Social Science and Medicine* 56: 1881-1891.

Lee, Nancy C. 2010. *Lyrics of Lament: From Tragedy to Transformation*. Minneapolis: Fortress Press.

Levin, Morten. 2012. "Academic integrity in action research." *Action Research* 17: 463-474.

Lewin, Kurt. 1951. *Field Theory in Social Science*. New York: Harper.

Lewis, H. 1978. "Nothing was said sympathy-wise." *Social Work Today* 110: 2479.

Liamputtong, Pranee. 2009. *Researching the Vulnerable*. London: Sage.

Lincoln, Yvonna S., and Egon G. Guba. 1985. *Naturalistic Inquiry*. Beverly Hills: Sage.

Lofland, John, and Lyn H. Lofland. 1999. "Data Logging in Observation: Fieldnotes." In *Qualitative Research,* edited by A. Bryman and R. G. Burgess, 3: 2-7. London: Sage.

Lok, Ingrid H., and Richard Neugebauer. 2007. "Psychological morbidity following miscarriage." *Best Practice & Research Clinical Obstetrics & Gynaecology*. 21: 229-247.

Lovell, Alice. 2002. "Death at the Beginning of Life." In *Death, Gender and Ethnicity,* edited by David Field, Jenny Hockey and Neil Small, 29-51. London: Routledge.

Lumley, L. Judith. 1979. "The development of maternal fetal bonding in the first pregnancy." In *Emotion and Reproduction: 5th International Congress of Psychsomatic Obstetrics and Gynaecology*, edited by L. Carenza and L. Zichella, 1067-1069. London: Academic.

Lundqvist, Anita, and Tore Nilstun. 1998. "Neonatal death and parents' grief." *Scandinavian Journal of Caring Sciences* 12: 246-250.

MacDonald, Cathy D. 2012. "Understanding participatory action research: A qualitative research methodology option." *Canadian Journal of Action Research* 13: 34-50.

Malterud, Kirsti. 2001. “The art and science of clinical knowledge: evidence beyond measure and numbers.” *The Lancet* 358: 397-400.

Mander, Rosemary. 2006. *Loss and Bereavement in Childbearing*. London: Routledge.

Manias, Elizabeth, and Annette Street. 2001. “Rethinking ethnography: reconstructing nursing relationships.” *Journal of Advanced Nursing* 33: 234-242.

Mann, Joshua R., Robert E. McKeown, Janice Bacon, Roumen Vesselinov, and Freda Bush. 2008. “Do antenatal religious and spiritual factors impact the risk of postpartum depressive symptoms?” *Journal of Women's Health* 17: 745-755.

Marshall, Catherine, and Gretchen B. Rossman. 2006. *Designing Qualitative Research* (fourth edition). Thousand Oaks: Sage.

May, Katharyn Antle. 1991. "Interview techniques in qualitative research: concerns and challenges." In *Qualitative Nursing Research: A Contemporary Dialogue*, edited by Janice M. Morse, 188-201. Thousand Oaks: Sage.

May, Tim. 2001. *Social research: issues, methods and process*. Buckingham: Open University Press.

McGreal, Diane, Barry J. Evans, and Graham D. Burrows. 1997. “Gender differences in coping following loss of a child through miscarriage or stillbirth: A pilot study.” *Stress Medicine* 13: 159-165.

McNiff, Jean. 2002. *Action Research for Professional Development: Concise Advice for New Researchers*. Online at: http://jeanmcniff.com/ar-booklet.asp; accessed 3 May 2016.

McNiff, Jean, and Jack Whitehead. 2006. *All You Need to Know About Action Research*. London: Sage.

Merriam, Sharan B. 2009. *Qualitative research: A guide to design and implementation*. San Fransisco: Jossey-Bass.

Meyer, Julienne. 2000. “Using Qualitative Methods in Health Related Action Research.” *British Medical Journal* 320: 178-181.

Mies, Maria. 1983. “Towards a methodology for feminist research.” In: *Theories of women's studies*, edited by Gloria Bowles & Renate Duelli Klein, 117-140. London: Routledge and Kegan Paul.

Mikel Brown, L., and C. Gilligan. 1992. *Meeting at the Crossroads*. Cambridge: Harvard University Press.

Miles, Mathew, A Michael Huberman, and Johnny Saldaña. 2014. *Arizona State University Qualitative Data Analysis: A Methods Sourcebook*. Los Angeles: Sage.

Miles, Matthew B., and A. Michael Huberman. 1984. *Qualitative data analysis: A sourcebook of new methods*. Thousand Oaks: Sage.

Miller, Anna M. 2018. "Miscarriage: When Language Deepens Pain." Online at https://health.usnews.com/health-care/patient-advice/articles/2018-12-13/miscarriage-when-language-deepens-pain; accessed 19 January 2020.

Miller, Ellena J., Meredith J. Temple-Smith, and Jade E. Bilardi. 2019. "'There was just no-one there to acknowledge that it happened to me as well': A qualitative study of male partner's experience of miscarriage." Online at: https://doi.org/10.1371/journal.pone.0217395; accessed 28 May 2019.

Miller-McLemore, Bonnie J. 2014. "Introduction: The Contributions of Practical Theology." In *The Wiley-Blackwell Companion to Practical Theology*, edited by Bonnie J. Miller-McLemore, 1-20. Malden: Wiley Publishing.

Miscarriage Association. 2016. "Early Miscarriage." Online at: http://www.miscarriageassociation.org.uk/for-health-professionals/training/; accessed 15 February 2016.

Moloney, Sharon. 2011. "An experience of miscarriage from a spiritual perspective." *MIDIRS Midwifery Digest* 17: 167-169.

Moltmann, Jürgen. 1974. *The Crucified God: The Cross of Christ as the Foundation and Criticism of Christian Theology*. New York: Harper & Row.

—. 1993. *The Trinity and the Kingdom: The Doctrine of God*. Minneapolis: Fortress Press.

Monroe, Kimberly, and Philip Monroe. 2005. "The Bible and the Pain of Infertility." *The Journal of Biblical Counselling* 23: 50-58.

Morgan, David L. 1997. *The Focus Group Guide Book*. London: Sage.

Morrissey, Matthew V. 2007. "Our first child was incompatible with life; understanding miscarriage as a lived experience." *International Journal of Psychiatric Nursing Research* 12: 1415-1428.

Moschella, Mary Clark. 2008. *Ethnography as Pastoral Practice: An Introduction*. Ohio: The Pilgrim Press.

Moulder, Christine. 1990. *Miscarriage: Women's Experience and Needs*. London: Pandora Press.

Mullan, Zoë, and Richard Horton. 2011. "Bringing stillbirths out of the shadows." *The Lancet; The Management of Early Pregnancy Loss* 377: 1291-1292.

Mulvihill, Aileen, and Trish Walsh. 2014. “Pregnancy loss in rural Ireland: An experience of disenfranchised grief.” *The British Journal of Social Work* 44: 2290-2306.

Newman, Albert Henry. 1899. *A Manual of Church History*. Philadelphia: American Baptist Publication Society.

NHS Education for Scotland. 2009. *Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff*. Edinburgh: NHS Scotland.

NHS HDL. 2002. *Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland*. NHS Health Department Letter 76. Edinburgh: Scottish Executive Health Department.

NICE Clinical Guideline [CG154]. December 2012. *Ectopic pregnancy and miscarriage: diagnosis and initial management*. Online at: https://www.nice.org.uk/Guidance/CG154; accessed 15 February 2016.

NICE Guideline [NG126]. April 2019. *Ectopic pregnancy and miscarriage: diagnosis and initial management*. Online at: https://www.nice.org.uk/guidance/ng126; accessed 14 July 2019.

Nitsche, Stefan Ark. 2000 “Vor der Antwort käme die Frage: Die Psalmenrezeption im Evangelischen Gesangbuch.” In *Schweigen wäre gotteslästerlich: Die heilende Kraft der Klage*, edited by Georg Steins, 133-53. Würzburg: Echter.

Noddings, Nel. 1989. *Women and Evil*. Berkeley: University of California Press.

Nursing and Midwifery Council. 1992. *Code of professional conduct for the nurse, midwife and health visitor* (third edition). London: United Kingdom Central Council for Nursing Midwifery and Health Visiting.

Nuzum, Daniel, Sarah Meaney, and Keelin O’Donoghue. 2017. “The Spiritual and Theological Challenges of Stillbirth for Bereaved Parents.” *Journal of Religion and Health* 58: 1081-1095.

Oakley, Ann. 1981. “Interviewing women: a contradiction in terms?” In *Doing Feminist Research*, edited by H. Roberts, 30–61. London: Routledge and Kegan Paul.

—. 2016. “Interviewing Women Again: Power, Time and the Gift.” *Sociology* 50: 195-213.

O'Brien, Rory. (2001). “Um exame da abordagem metodológica da pesquisa ação” [An Overview of the Methodological Approach of Action Research]. In *Teoria e Prática da Pesquisa Ação [Theory and Practice of Action Research]*, edited by Roberto Richardson. João Pessoa, Brazil: Universidade Federal da Paraíba. (English version.) Online at: http://www.web.ca/~robrien/papers/arfinal.html; accessed 11 May 2016.

O'Connell, Jennifer. 2019. "I blamed myself for not wanting it enough – Untold tales of miscarriage." *The Irish Times, 30 November 2019*. Online at: https://www.irishtimes.com/life-and-style/health-family/i-blamed-myself-for-not-wanting-it-enough-untold-tales-of-miscarriage-1.4090751; accessed 24 January 2020.

O'Connor, Kathleen M. 2002. *Lamentations and the Tears of the World*. Maryknoll: Orbis Books.

Öhler, Markus. 2009. "To Mourn, Weep, Lament and Groan: On the Heterogeneity of the New Testament's Statements on Lament," In *Evoking Lament: A Theological Discussion*, edited by Eva Harasta and Brian Brock, 150-165. London: T&T Clark.

Packiam, Glenn. (No date). *The Place of Sadness in Contemporary Praise and Worship*. Online at: https://durham.academia.edu/GlennPackiam; accessed 8 February 2020.

Parkes, Colin Murray. 2010. "Grief: Lessons from the Past, Visions for the Future." *Psychologica Belgica* 50:7-26.

Parry, Robin A. 2010. *The Two Horizons Old Testament Commentary: Lamentations*. Grand Rapids: W. B. Eerdmans.

Paterson, Shaw James. 2004. *The Role of the Chaplain Following a Neonatal Death*. Unpublished Dissertation for the M.Sc. (Med Sci) in Palliative Care. University of Glasgow.

Pattison, Stephen. 1997. *Pastoral care and liberation theology*. London: SPCK.

—. 2000. *Shame: Theory, Therapy, Theology*. Cambridge: Cambridge University Press.

—. 2007. *The Challenge of Practical Theology: Selected Essays*. London: Jessica Kingsley.

Patton, Michael Quinn. 2002. *Qualitative research and evaluation methods*. Newbury Park: Sage.

Payne, Jacqueline. 2016. "Miscarrage." Online at: https://medical.azureedge.net/pdf/1744.pdf?v=636923258257455489; accessed 8 August 2019.

Peppers, Larry G., and Ronald J Knapp. 1980. "Maternal Reactions to Involuntary Fetal/Infant Death." *Psychiatry* 43: 155-159.

Perry, Margaret A. 2000. "Reflections on intuition and expertise." *Journal of Clinical Nursing* 9: 137-145.

Peterson, Eugene H. 1980. *Five Smooth Stones for Pastoral Work*. Grand Rapids, MI: W. B. Eerdmans.

Pillow, Wanda. 2003. “Confession, Catharsis or Cure? Rethinking the Uses of Reflexivity as Methodological Power in Qualitative Research.” *International Journal of Qualitative Studies in Education* 16: 175-196.

Plagge, Jane, and Jennifer R. Antick. 2009. “Perceptions of Perinatal Loss: Miscarriage versus Stillbirth.” *Women's Health and Urban Life* 8: 113-127.

Poliafico, Julie. 1998. “Nursing’s Gender Gap.” *RN Journal* 61: 39-42.

Polit, Denise F., and Cheryl Tatano Beck. 2009. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice* (seventh edition). Philadelphia: Lippincott Williams and Wilkins.

Polit, Denise F., and Bernadette P. Hungler. 1995. *Nursing Research: Principles and Methods* (sixth edition). Philadelphia: Lippincott, Williams & Wilkins.

Prendergast, Monica. 2009. “Introduction: The Phenomena of Poetry in Research.” In *Poetic Inquiry: Vibrant Voices in the Social Sciences*, edited by M. Prendergast, C. Leggo and P. Sameshima, xix-xlii. Rotterdam: Sense Publishers.

Prendergast, Monica, Carl Leggo and Pauline Sameshima (eds). 2009. *Poetic Inquiry: Vibrant Voices in the Social Sciences*. Rotterdam: Sense Publishers.

Quinn, Francis M., and Suzanne Hughes. 2007. *Quinn’s Principles and Practice of Nurse Education.* Cheltenham: Stanley Thornes.

Rabiee, Fatemeh. 2004. "Focus Group Interview and Data Analysis." *Proceedings of the Nutrition Society* 63: 655-660.

Rajan, Lamichhane. 1994. “Social isolation and support in pregnancy loss.” *Health Visitor* 67: 97–101.

Ramazanoğlu, Caroline, and Jannet Holland. 2002. *Feminist Methodology: Challenges and Choices.* Thousand Oaks: Sage.

Rambo, Shelly. 2017. *Resurrecting Wounds.* Waco: Baylor University Press.

—. 2010. *Spirit and Trauma: A Theology of Remaining.* Louisville: Westminster John Knox Press.

Rando, Therese A., 1993. *Treatment of Complicated Mourning*. Champaign: Research Press.

Raphael, Beverley. 1984. *The Anatomy of Bereavement: A Handbook for the Caring Professions.* London: Unwin Hyman.

Reason, Peter, and Hilary Bradbury (eds). 2008. *The Sage Handbook of Action Research: Participative Inquiry and Practice* (second edition). London: Sage.

Reece, Ian, and Stephen Walker. 2007. *Teaching Training and Learning*. Tyne and Wear: Business Education Publishers.

Research and Development Task Force. 1994. *Supporting Research and Development in the NHS*. London: HMSO.

Reinharz, Shulamit, and Lynn Davidman. 1992. *Feminist methods in social research*. New York: Oxford University Press.

Reports to the General Assembly. 2000. "Ministers of the Gospel: A policy statement for the Board of Ministry." *The Church of Scotland Board of Practice and Procedure,* 17/1-17/41. Edinburgh: The Church of Scotland Assembly Arrangements Committee.

Rice, Pranee Liamputtong, and Douglas Ezzy. 1999. *Qualitative Research Methods, a Health Focus*. Melbourne: Oxford University Press.

Rich, Deborah E. 2000. "The Impact of Postpregnancy Loss Services on Grief Outcome: Integrating Research and Practice in the Design of Perinatal Bereavement Programs." *Illness, Crisis & Loss* 8: 244-265.

Ritchie, Jane, Jane Lewis, and Gillian Elam. 2003. "Designing and selecting samples." In *Qualitative research practice. A guide for social science students and researchers, edited by* Jane Ritchie & Jane Lewis, 77-108. Thousand Oaks: Sage.

Robertson, Janet. 2000. "Ethical Issues and Researching Sensitive Topics: Mature Women and 'Bulimia'." *Feminism and Psychology* 10: 531-537.

Robinson, Gail Erlick. 2014. "Pregnancy Loss." *Best Practice & Research Clinical Obstetrics and Gynaecology* 28: 169-178.

Robson, Colin. 1993. *Real World Research*. Oxford: Blackwell.

Royal College of Obstetricians and Gynaecologist (RCOG). 2006. "Early Miscarriage." Online at: http://www.rcog.org.uk/files/rcog-corp/Early%20Miscarriage.pdf; accessed 28 Ocober 2011.

Ross, Maggie. (2007). *Pillars of flame: Power, priesthood, and spiritual maturity*. New York: Harper & Row.

Rowlands, Ingrid Jean, and Christina Lee. 2010. "'The silence was deafening': social and health service support after miscarriage." *Journal of Reproductive and Infant Psychology* 28: 274-286.

Schmuck, Richard A. 2006. *Practical Action Research for Change*. London: Sage.

Schmutzer, Andrew J. 2009. “Spiritual formation and sexual abuse: Embodiment, community, and healing.” *Journal of Spiritual Formation & Soul Care* 2: 67–86.

Schott, Judith, and Alix Henley. 2007. “Pregnancy loss and death of a baby: the new Sands Guidelines British Journal of Midwifery.” *Midwives' Training Needs* 15: 195-198.

Schutz, Susan E. 1994. “Exploring the benefits of a subjective approach in qualitative nursing research.” *Journal of Advanced Nursing* 20: 412-417.

Scottish Programme for Clinical Effectiveness in Reproductive Health. 2003. *Scottish Audit of the Management of Early Pregnancy Loss*. Aberdeen: SPCERH.

Seidl, Lawrence G. 1989. “When the bough breaks. Pastoral care of families of dying infants.” *Health Progress* 70: 50-51.

Séjourné, Natalène, Stacey Callahan, and Henri Chabrol. 2009. “Support following miscarriage: what women want.” *Journal of Reproductive and Infant Psychology* 28: 403-411.

SHARE. 1992. *Newsletter January/February*. Missouri: Pregnancy and Infant Loss Support.

Sherman, Robert R. and Rodman B. Webb. 1988. “Qualitative research in education: a focus.” In *Qualitative research in education: focus and methods*, edited by Robert R. Sherman and Rodman B. Webb, 2-21. London: The Falmer Press.

Silverman, David. 2001. *Doing Qualitative Research: A Practical Handbook*. London: Sage.

—. 2005. *Interpreting Qualitative Data: Methods for Analyzing Talk, Text and Interaction* (second edition). London: Sage.

Simmons, Rebecca K., Gita S. Singh, N. E. S. Maconochie, Pat Doyle, and Judith Green. 2006. "Study, Experience of miscarriage in the UK: Qualitative findings from the National Women’s Health." *Social Science & Medicine* 63: 1934-1946.

Simon, Paul. 1964. “The Sound of Silence.” Simon and Garfunkel Lyrics. Online at: http://www.azlyrics.com/lyrics/simongarfunkel/thesoundofsilence.html; accessed 14 February 2017.

Singh, Puneet, Kearsley Stewart and Scott Moses. 2004. “Pastoral Care Following Pregnancy Loss: The Role of Ritual.” *The Journal of Pastoral Care & Counselling* 58: 41-53.

Skjervheim, Hans.1996. “Participant and spectator.” In *Selected essays. In honour of Hans Skjervheim's 70th birthday, edited by* H. Skjervheim, 127-141. Bergen: University of Bergen.

Slee, Nicola. 1988. “The Invisible Woman in Christianity.” Online at: http://www.shapworkingparty.org.uk/journals/articles_88/3_Slee.pdf; accessed 4 August 2016.

—. 2004. *Faith and Feminism: An Introduction to Christian Feminist Theology*. London: Darton, Longman & Todd Ltd.

Smith, Anne C., and Sherry B. Borgers. 1989. "Parental Grief Response to Perinatal Death." *Omega: Journal of Death and Dying* 19: 203 - 214.

Smith, Susan Marie. 2012. *Caring Liturgies: The Pastoral Power of Christian Ritual*. Minneapolis: Fortress Press.

Snow, Kimberly N., Mark R. McMinn, Rodger K. Bufford, and Irv A. Brendlinger. 2011. “Resolving Anger toward God: Lament as an Avenue toward Attachment.” *Journal of Psychology and Theology* 39: 130-142.

Sölle, Dorothee. 1979. “Gott und das Leiden.” In *Diskussion über Jürgen Moltmanns Buch. Die Kegreuzigte Gott*, edited by Michael Welker, 111-17. München: Kaiser.

Standing, Kay. 1998. “Writing the Voices of the Less Powerful: Research on Lone Mothers.” In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*, edited by Jane Ribbens and Rosalind Edwards, 186-201. London: Sage.

Stanley, Liz. 1997. “Methodology Matters.” In *Introducing Women’s Studies*, edited by Victoria Robinson and Diane Richardson, 189-219. Basingstoke: Palgrave.

Stanley, Liz, and Wise, Sue. 1990. “Method, Methodology and Epistemology in Feminist Research Processes.” In *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology*, edited by Liz Stanley, 20-62. London: Routledge.

Steedman, Peter H. 1991. “On the relations between seeing, interpreting and knowing.” In *Research and Reflexivity*, edited by Frederick Steier, 53-62. London: Sage.

Stephenson, Jo. 2020. “Nearly third of women suffer PTSD after early pregnancy loss.” *Nursing Times*. Online at: https://www.nursingtimes.net/news/research-and-innovation/nearly-third-of-women-suffer-ptsd-after-early-pregnancy-loss-15-01-2020/; accessed 17 January 2020.

Stiernborg, M., S. B. Zaldivar, and E. G. Santiago. 1996. “Effect of didactic teaching and experiential learning on nursing students' AIDS-related knowledge and attitudes.” *AIDS Care* 8: 601-608.

Stone, Ken. 1999. “Safer Texts: Reading Biblical laments in the age of AIDS.” *Theology and Sexuality* 5: 16-27.

Strauss, Anselm, and Juliet Corbin. 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks: Sage.

Stratton, Katrina, and Libby Lloyd. 2008. “Hospital-based interventions at and following miscarriage; literature to inform a research-practice initiative.” *The Australian & New Zealand Journal of Obstetrics & Gynaecology* 48: 5-11.

Stringer, Ernie. 2004. *Action Research in Education*. Upper Saddle River: Pearson.

Sullivan, Anne. M. 2005. “Constructing data poems – how and why: A hands-on experience.” Unpublished paper presented at a pre-conference workshop at the 2002 American Educational Research Association Conference, New Orleans. 1 April 2006.

Swinton, John. 2003. “Reclaiming Mystery and Wonder: Towards a narrative based perspective on chaplaincy.” *Journal of Healthcare Chaplaincy* 6: 223-236.

Swinton, John, and Harriet Mowatt. 2006. *Practical Theology and Qualitative Research*. London: SCM.

Tesfai, Yacob. 1994. “Introduction.” In *The Scandal of a Crucified World*, edited by Yacob Tesfai, 1-16. Maryknoll: Orbis Books.

The Guardian. 2020. “Readers on the pain of Miscarriage.” *The Guardian*, 15 January 2020. Online at: https://www.theguardian.com/lifeandstyle/2020/jan/15/pain-of-miscarriage readers-share-experiences; accessed 18 January 2020.

Theological Commission. 2007. *The Hope of Salvation for Infants Who Die Without Being Baptized*. Vatican City. Online at: http://www.vatican.va/roman_curia/congregations/cfaith/cti_documents/rc_con_cfaith_doc_20070419_un-baptised-infants_en.html.; accessed 12 May 2019.

Thieleman, Kara, and Joanne Cacciatore. 2018. “‘As If Nothing Happened’: Experiences of Bereaved Parents in Romania.” *Omega: Journal of Death and Dying*: 1-21. Online at: https://www.researchgate.net/publication/327637927_As_if_Nothing_Happened_Experiences_of_Bereaved_Parents_in_Romania; accessed 30 May 2019.

Thieleman, Kara, Joanne Cacciatore, and Patricia Wonch Hill. 2014. “Traumatic Bereavementand Mindfulness: A Preliminary Study of Mental Health Outcomes Using the ATTEND Model.” *Clinical Social Work Journal* 42: 260–268.

University College London & Miscarriage Association. 2014. "RCOG statement on Miscarriage Association’s ‘Partners Too’ campaign." In *Partners Too*, by Royal College of Obstetricians and Gynaecologists. Online at: https://www.rcog.org.uk/en/news/rcog-statement-on-miscarriage-associations-partners-too-campaign/; accessed 14 May 2019.

Van, Paulina, and Afaf I. Meleis. 2002. "Coping with grief after involuntary pregnancy loss: Perspectives of African American women." *Journal of Obstetric, Gynecologic and Neonatal Nursing* 32: 28-39.

Van der Sijpt, E. 2017. "The pain and pride of 'angel mothers': Dissapointments and desires around reproductive loss in Romania." *Medical Anthropology* 37: 174-187. Online at: https://10.1080/01459740.2017.1294171; accessed 30 May 2019.

Vanderstoep, S.W., and D.D. Johnson. 2010. *Research Methods for Everyday Life: Blending Qualitative and Quantitative Approaches*. Chichester: Wiley & Sons.

Ventura, Stephanie J., Joyce C. Abma, William D. Mosher, and Stanley K. Henshaw. 2009. "Estimated pregnancy rates for the United States, 1990-2005: An Update." *National Vital Statistics Reports* 58: 1-14.

Villanueva, Federico G. 2008. *The ‘uncertainty of a hearing’. A study of the sudden change of mood in the psalms of lament*. Leiden: Brill.

—. 2017. *It's OK to Be Not OK: Preaching the Lament Psalms*. Carlisle: Langham Creative Projects.

Walter, Tony. 1996. “A new model of grief: bereavement and biography.” *Mortality* 1: 7-25.

Walton, Heather. 2002. “Speaking in Signs: Narrative and trauma in pastoral theology.” *Scottish Journal of Healthcare Chaplaincy* 5, 2-5.

—. 2015. *Not Eden: Spiritual Life Writing for this World*. London: SCM Press.

Weil, Simone. 2001. “The Love of God and Affliction.” In *Waiting for God*, edited by Simone Weil, Emma Craufurd and Leslie Fiedler, 83-142. London: Harper Perennial.

West, Gerald O. 2016. “Between text and trauma: reading Job with people living with HIV.” In *Bible through the Lens of Trauma*, edited by Elizabeth Boase and Christopher G. Frechette, 209-230. Atlanta: SBL Press.

Westermann, Claus. 1974. “Role of the Lament in the Theology of the Old Testament.” *Interpretation* 28: 20-38.

—. 1981, *Praise and lament in the Psalms*. Louisville: John Knox Press.

Wilkinson, Sue. 1988. “The Role of Reflexivity in Feminist Psychology.” *International Forum of Women’s Studies* 11: 493-502.

—. 2003. “Focus Groups in Qualitative Psychology.” In *Qualitative Psychology: A Practical Guide to Research Methods*, edited by Jonathan A. Smith, 184-204. London: Sage.

—. 2004. "Focus Group Research." In *Qualitative Research: Theory, Method, and Practice*, edited by David Silverman, 177–199. Thousand Oaks: Sage.

Wimpenny, Peter, and John Gass. 2000. "Interviewing in phenomenology and grounded theory: is there a difference?" *Journal of Advanced Nursing*. 31: 1485-1492.

Wolterstorff, Nicholas. 1987. *Lament for a Son*. Grand Rapids: Eerdmans Publishing.

Woodward, James and Stephen Pattison (eds). 2000. *The Blackwell Reader in Pastoral and Practical Theology*. Oxford: Blackwell Publishers.

Worden, William J. 1996. *Children and grief: When a parent dies*. New York: Guilford Press.

—. 2003. *Grief Counselling and Grief Therapy: A Handbook for the Health Practitioner* (third edition). New York: Routledge.

—. 2009. *Grief counselling and grief therapy: A handbook for the mental health practitioner*. London: Routledge.

World Health Organisation (WHO). 1990. “Cancer, Pain Relief and Palliative Care.” Technical Report Series 804. Online at: https://apps.who.int/iris/handle/10665/39524; accessed 3 September 2012.

Wretmark, Astrid Andersson. 1993. *Perinatal death as a pastoral problem*. (Bibliotheca Theologiae Practicae.) Sweden: Almqvist & Wiksell International.

Wright, Kathy B., and Marilee Schmelzer. 1997." “Qualitative research: exploring new frontiers.” *Gastroenterology Nursing* 20: 74-78.

Wright, H. Norman. 2011. *The Complete Guide and Trauma Counselling: What to Do and Say When it Matters Most*! Minneapolis: Bethany House.

Yeo, H. 1998. “Informed consent in the neonatal unit: the ethical and legal rights of parents.” *Journal of Neonatal Nursing* 4: 17-20.

Zambo, Ronald, and Debby Zambo. 2013. “Using I Poems to Hear the Voices and Understand the Actions of EdD Students Conducting Action Research.” *The Qualitative Report* 18: 1-17.