HomePage Prof May Home Page

Hope for Healing: Miscarriage and the Dignity of the Human Body

Andrew J. Sodergren, M.S.

Abstract

This paper examines the issue of miscarriage from the perspective of the mother-child couplet. A discussion of the psychology of motherhood and miscarriage highlights the negative impact miscarriage has on the mother. Mothers must be helped to mourn the irreplaceable child lost in miscarriage. A review of Catholic teaching on the human body and dignity of the unborn emphasizes the respect owed to pre-natal human life and the bodies of embryos and fetuses who have died. Finally, it is argued that holding a funeral/burial is the best possible way to assist the mother's grieving and to respect the deceased child. Current practices and attitudes fail to recognize either of these norms.

Hope for Healing: Miscarriage and the Dignity of the Human Body

Catholic bioethicists today are continually confronted with a number of pressing issues raised by the culture of death and new medical technologies: stem cell research,

cloning, frozen embryos, reproductive technologies, euthanasia, and the like. While it is necessary that scholars and Church officials devote their energies to responding to these many new challenges, a regrettable consequence of this is that less controverted, more mundane issues are sometimes overlooked. When this happens, people are left without sound ethical guidance and support for dealing with situations in their lives. This is precisely the case with miscarriage, a very common and morally delicate event that has received little attention.

Central to the issue of miscarriage is the care due to the two people most affected by it: the mother and her unborn child. This paper will thus examine the proper care due to the mother-child couplet. **[1]** To begin, I examine the psychology of motherhood and miscarriage to provide a human context from which to evaluate any interventions aimed at the mother. Following this, I review Catholic teaching on the human body, care of human corpses, and the dignity of the unborn. Finally, these two lines of thought are integrated, showing that the good of the deceased child and the good of the mother converge. I argue that in light of the substantial grief experienced by the mother and Catholic teaching on the human body, holding a funeral and dignified burial for a miscarried child is the best possible response to such a tragedy. Obstacles preventing the implementation of this response to miscarriage are also discussed.

Motherhood and the Psychology of Miscarriage

Defined in the professional literature as "the spontaneous termination of an intrauterine pregnancy prior to 28 weeks of gestation resulting in fetal death,"

miscarriage "is fairly common, occurring in 10-20% of clinically recognized pregnancies" (Geller, Kerns, & Klier, 2004, p. 35). **[2]** Researchers have noted, "In the United States in the 1990s, approximately half a million women miscarry annually" (Neugebauer, Kline, Shrout, Skodol, O'Connor, Geller, Stein, & Susser, 1997, p. 383). Approximately 80% of these deaths occur in the first trimester, i.e., conception to 13 weeks (Maker & Ogden, 2003). Thus, miscarriage (also known as "spontaneous abortion") occurs much more frequently than most people realize, especially in the early phase of pregnancy.

The primary medical treatment for miscarriage is dilation and curettage (D&C) (Geyman, Oliver, & Sullivan, 1999). This involves the dilation of the cervix and the surgical removal of the deceased baby and associated structures. This procedure is utilized to ensure that that none of the child's tissue remains in the uterus increasing the risk of infection and blood loss (McCartney & van der Meer, 1990). It is a quick, outpatient procedure (Kohn & Moffit, 2000) with a high success rate—though not without risks such as damage to or perforation of the uterus. However, it should be noted that Geyman et al. (1999) reviewed the extant literature on treatment of first trimester miscarriage and found that expectant therapy (waiting for the miscarriage to resolve itself naturally) had a success rate approximately equal to D&C. They recommend this treatment in conjunction with transvaginal sonography to ensure that all fetal tissue has been passed. Likewise, Kippley & Kippley (1996) argue from their consultations with experts that D&C is often not medically necessary. Nonetheless, elective D&C has remained the typical manner of treating early miscarriage.

Despite the relative brevity of most pregnancies ending in miscarriage noted above, these losses can be devastating for the women who experience them. Before discussing the research illustrating this pain, it is helpful to explore why miscarriage is a particularly painful event for women. This question is best answered by reviewing the Christian vision of motherhood Pope John Paul II offers in his apostolic letter *Mulieris Dignitatem* and elsewhere. In his discussions of motherhood, the Pope never fails to provide a proper anthropological grounding:

> The human being - both male and female - is the only being in the world which God willed for its own sake. The human being is a person, a subject who decides for himself. At the same time, man "cannot fully find himself except through a sincere gift of self"…. This definition of the person corresponds to the fundamental biblical truth about the creation of the human being - man and woman - in the image and likeness of God. This is not a purely theoretical interpretation, nor an abstract definition, for it *gives an essential indication of what it means to be human,* while emphasizing *the value of the gift of self, the gift of the person* (John Paul II, 1988, p. 62).

For the Pope, a crucial aspect of human nature is that it is given to us as a gift and bears the structure of gift within it such that the fulfillment of the human being is to give himself to another in love. This "other" is most principally God, but as Christ teaches, love of God and love of neighbor cannot be separated (Mk 12:30-31, Jn 13:34, 1 Jn 4:21). Moreover, human nature is an embodied nature, one that always exists in the duality of the sexes. The human being is either a man or a woman, and this difference is irreducible. The two sexes constitute two fundamentally different ways of being human. This sexual difference does not merely affect the physical features of the body but conditions the human person in the deepest way, thereby affecting his entire body-

soul composite. However, it does not follow from this that one sex is superior to the other. Rather, they are complementary. The sexual difference enables man and woman to give themselves totally to each other and receive each other as gift in marriage. This self-giving love is a fruitful love that opens to the blessing of children. Through this communion made possible by man's sexual body, the human family bears an image of the communion of the Father, Son, and Holy Spirit in the one ineffable divinity.

Because of the constitutive nature of the sexual difference and man's vocation to be a gift for another, man and woman reach their fulfillment in and through fatherhood and motherhood. Therefore, the Pope states,

> This truth about the person also opens up *the path to a full understanding of women's motherhood*. Motherhood is the fruit of the marriage union of a man and woman, of that biblical "knowledge" which corresponds to the "union of the two in one flesh" (cf. *Gen* 2:24). This brings about - on the woman's part - a special "gift of self", as an expression of that spousal love whereby the two are united to each other so closely that they become "one flesh"…. This *mutual gift of the person in marriage* opens to the gift of a new life, *a new human being,* who is also a person in the likeness of his parents. Motherhood implies from the beginning a special openness to the new person: and this is precisely the woman's "part". In this openness, in conceiving and giving birth to a child, the woman "discovers herself through a sincere gift of self". The gift of interior readiness to accept the child and bring it into the world is linked to the marriage union, which - as mentioned earlier - should constitute a special moment in the mutual self-giving both by the woman and the man. According to the Bible, the conception and birth of a new human being are accompanied by the following words of the woman: *"I have brought a man into being with the help of the Lord"* (Gen 4:1). This exclamation of Eve, the "mother of all the living" is repeated every time a new human being comes into the world. It expresses the woman's joy and

> awareness that she is sharing in the great mystery of eternal generation (John Paul II, 1988, p. 63, underline added).

Motherhood, then, has a special importance for the woman because it is inscribed in her very being and flows out of her mutual self-giving with her husband. Her femininity makes her apt to receive her husband's self-gift and also to receive the new life that God may give as the fruit of their loving communion. The woman's call thus entails giving herself in a bodily way not only to her husband but to their children as well. Her fulfillment as a human being is always tied in some way to motherhood. **[3]**

Because of the woman's special aptitude to receive new life and her calling to give herself in a bodily way to this life, there forms an intense bond between mother and child from the very moment of conception.

> Motherhood involves a special communion with the mystery of life, as it develops in the woman's womb. The mother is filled with wonder at this mystery of life, and "understands" with unique intuition what is happening inside her. In the light of the "beginning", the mother accepts and loves as a person the child she is carrying in her womb (John Paul II, 1988, p. 66).

Thus, in becoming pregnant, i.e. welcoming a new child into her womb, the mother enters into a special type of relationship with her new son or daughter. This relationship plays an enormously formative role in both the child's development and the maturation of the mother who accepts the new life and must then give herself in return to this delicate new human being.

> The first months of the child's presence in the mother's womb bring about a particular bond which already possesses an educational significance of its own. The *mother,* even before giving birth, *does not only give shape to the*

> *child's body, but also, in an indirect way, to the child's whole personality*. Even though we are speaking about a process in which the mother primarily affects the child, we should not overlook the unique influence that the unborn child has on its mother. In this *mutual influence* which will be revealed to the outside world following the birth of the child, the father does not have a direct part to play. But he should be responsibly committed to providing attention and support throughout the pregnancy and, if possible, at the moment of birth (John Paul II, 1994, p. 54).

Empirical research has demonstrated that these observations are undoubtedly correct (see Verny, 1988). From conception forward, the new child and his mother are in constant dialogue on both physical and bio-chemical levels. They are in continual contact and share every experience together. The mother's body and personality clearly change as a result of the child's presence, and her behavior and emotions in turn have vast effects on the physical and psychological make-up of her child in utero. Psychologists speak of this bond in terms of attachment, which has been extensively researched in recent years. It is now clear that the quality of the mother-child attachment, the foundation for which is laid during pregnancy, is linked with numerous psychosocial variables during childhood and even into adulthood (see Cassidy & Shaver, 1999).

The Pope does not fail to recognize the many sacrifices that this special relationship entails for women (especially during pregnancy), and he desires to ensure that their needs and rights are recognized.

> The woman's motherhood in the period between the baby's conception and birth is a bio-physiological and psychological process which is better understood in our days than in the past, and is the subject of many detailed

> studies. Scientific analysis fully confirms that the very physical constitution of women is naturally disposed to motherhood - conception, pregnancy and giving birth - which is a consequence of the marriage union with the man. At the same time, this also corresponds to the psycho-physical structure of women…. Although both [spouses] together are parents of their child, *the woman's motherhood constitutes a special "part" in this shared parenthood,* and the most demanding part. Parenthood - even though it belongs to both - is realized much more fully in the woman, especially in the prenatal period. It is the woman who "pays" directly for this shared generation, which literally absorbs the energies of her body and soul. It is therefore necessary that *the man* be fully aware that in their shared parenthood he owes *a special debt to the woman*. No program of "equal rights" between women and men is valid unless it takes this fact fully into account… (John Paul II, 1988, p. 64-65, underline added).

It is through the various sacrifices associated with maternity that the mother expresses self-giving love for her child, and in this, she must be supported by her husband whom the Pope encourages to be present at the very moment of birth. Nonetheless, because of her special aptitude to receive and nurture new life in her womb, "the mother's contribution is decisive in laying the foundation for a new human personality" (John Paul II, 1988, p. 66). Thus, the Pope wonders, "On the human level, can there be any other '*communion*' comparable to that *between a mother and a child* whom she has carried in her womb and then brought to birth?" (John Paul II, 1994, p. 16-17).

In light of this analysis of motherhood, one can easily see why miscarriage can be a definite source of suffering for women. The death of an unborn child strikes right at the heart of the mother's femininity and dashes her hopes and aspirations. Most importantly, it means the loss of a family member with whom she had been intimately

relating. As some experts have noted, "Our capacity to bond or affiliate with others is precisely what leaves us vulnerable to grief when a relationship is abruptly ended" (Kay, Roman, & Schulte, 1997, p. 9). For this reason, the anguish experienced by mothers following miscarriage is best understood as a grieving process similar to the bereavement of any lost loved one. Though there are significant individual differences, this process can be characterized by three phases: protest, disorganization, and reorganization (Kay, 1987).

During the initial protest phase, the mother often experiences a sense of shock in response to the unexpected trauma of miscarriage. There may be disbelief and denial as she comes to terms with the sad reality of her situation. She "may cry uncontrollably at first then experience emotional shock and denial, feeling numb and detached, unable to believe that [her] baby has died" (Kohn & Moffit, 2000, p. 6). Disorganization is the second phase, during which "emotions become explicitly painful and are accompanied by profound sadness and deep yearning in search of the lost person. Feelings of intense loneliness, isolation, and meaninglessness predominate" (Kay et al., 1997, p. 9). Women during this stage tend to withdraw from the outside world and are preoccupied with thoughts of the lost child. These thoughts may contribute to somatic expressions of grief such as "decreased appetite, difficulty in sleeping, weakness, tightening of the throat, empty feeling in the stomach, choking sensations, sighing, lethargy, and anergy" (Kay, 1987, p. 8). During the final phase of mourning, called reorganization, "the bereaved person slowly reinvests interest in the world" (Kay, 1987, p. 8). Though negative emotions still occasionally arise, as do thoughts of her lost child, these will be

less frequent, and the mother may renew previous pursuits or perhaps take up new ones.

This understanding of the bereavement process is based on studies of those who have lost a post-natal loved one. However, there are additional psychological hurtles that are peculiar to miscarriage.

> These include loss of being pregnant and of the sense of oneness with the fetus, loss of anticipated motherhood, loss of special attention and care frequently accorded a pregnant woman, and loss of prenatal medical care. In addition, there is a crucial loss of self-esteem resulting from the woman's inability to rely on her body and successfully give birth (Kay et al., 1997), p. 11).

As described above, motherhood is a constitutive element of a woman's self-realization. Therefore, miscarriage is a setback for her sense of self and well-being. Indeed, researchers have found that in the aftermath of miscarriage "lowered self-concept may occur because of the woman's feeling that her body cannot function properly in pregnancy" (Stirzinger, Robinson, Stewart, & Ralevski, 1999, p. 237). The following account describes one woman's sense of failure and disappointment when she experienced a miscarriage:

> A few hours earlier I had been carrying a baby, doing what I wanted to do and winning everyone's approval. Now, suddenly, I was reduced, cut down. I had become a source of disappointment to myself, to Mark, my family and friends, and others. For probably the first time in my life I felt like a loser…. This surely was a failure. A very personal, direct kind of failure. There was no one else to tie it to—the pregnancy was mine, in *my* body, and it didn't work! (Pizer & Palinski, 1980, p. 108).

This sense of failure is often coupled with feelings of guilt, that the mother did something to cause the miscarriage. She may blame herself for not being more careful, for engaging in various activities thought to have caused the miscarriage, though in reality these may have had no connection to the loss. Nonetheless, her feelings of guilt are real and distressing.

In recent years, psychological researchers have begun to investigate systematically the severity of these experiences. For example, Klier, Geller, & Ritsher (2002) conducted a comprehensive review of the scientific literature regarding affective disorders in the wake of miscarriage. The findings of the published research "consistently show an increase in affective symptomatology in women who have experienced a miscarriage in comparison to the particular control groups employed" (Klier et al., 2002, p. 136). For instance, Neugebauer et al. (1997) found that women who miscarried were 2.5 times as likely to experience an episode of Major Depressive Disorder compared to a control group. Based on this and many other studies, Klier et al. (2002) state,

> Since 1992, a body of research investigating psychiatric and psychological distress and disorder following miscarriage has been conducted in a rigorous way using control groups of pregnant and/or community women. The results of these studies allow us to conclude the following: In the first six months after the loss event, women are at elevated risk for depressive symptoms, subthreshold depression and depressive disorders (p. 145).

Geller et al. (2004) likewise reviewed the empirical literature regarding symptoms of anxiety following miscarriage. They conclude "that miscarrying women are at

increased risk for anxiety symptoms immediately following miscarriage and continuing until approximately 4 months after the loss" (p. 42). These anxiety symptoms are detectable as an increased risk for Obsessive Compulsive Disorder, Acute Stress Disorder, and Post-Traumatic Stress Disorder.

These increased rates of psychiatric symptoms and disorders have been noted very early after the miscarriage. As Neugebauer (2003) found, "Among miscarrying women first interviewed at 6-8 weeks after loss, depressive symptom levels were significantly elevated over those in a comparable community sample…" (p. 158). In a prior study, 72% of the "cases of major depressive disorder commenced within the first month following reproductive loss" (Neugebauer et al., 1997, p. 386). These symptoms and disorders can likewise persist well into the future as research "shows that depressive symptoms are common in women up to one year after miscarriage" (Stirtzinger, Robinson, Stewart, & Ralevski, 1999, p. 244). Psychological morbidity has also been found regardless of whether the miscarriage happened suddenly or was precipitated by warning signs (Walker & Davidson, 2001). This points out that it is not the sudden and traumatic nature of the events surrounding the miscarriage that underlie these psychological sequelae, but rather the loss of an unborn child. As discussed above, the bond between a mother and her unborn child is real and substantial.

> Research has shown that women have detailed mental images of their unborn child and his/her personality which correlate positively with their later perception of the child in infancy. A survey of ninety-one women… showed that women, even years after miscarriage, continue to fantasize about the sex of the child and to imagine what he/she would have been like.

> Our study supports the finding that having other children does not make up for the loss of a particular pregnancy (Stirtzinger et al., 1999, p. 244-245).

During a miscarriage, the mother intuitively knows that a unique member of her family with whom she had an intimate bond has died. Thus, in order for healing to take place, mothers must be encouraged to mourn the loss of this unique, irreplaceable child.

Though there has been less systematic research into the question, some data suggest that fathers of miscarried children likewise experience measurable psychological distress. Puddifoot & Johnson (1999) found that the level of grief experienced by the 323 men in their study were "very high, not dissimilar overall to the raised levels reported for women in previous comparable research" (p. 92). Grief scores were especially high among "those men who had seen an ultrasound scan" of their child (p. 92). Thus, as ultrasound technology becomes more advanced and more widely available, the bonding process of parents and siblings with the unborn child is likely to be intensified and the pain felt in the event of a miscarriage may become even more acute.

Respect Due to the Human Body and the Unborn

The *Catechism of the Catholic Church* states, "Being in the image of God the human individual possesses the dignity of a person, who is not just something, but someone" (CCC, 1997, no. 357, p. 92). This concise statement shows that Catholic teaching holds the human person in high esteem because he has been created in God's image. He stands out from all the rest of creation because of this dignity. Each human

person is an utterly unique, free, rational being who has been loved into existence and destined for eternal loving communion with God.

> God created man in His own image and likeness: calling him to existence through love, He called him at the same time for love. God is love and in Himself He lives a mystery of personal loving communion. Creating the human race in His own image and continually keeping it in being, God inscribed in the humanity of man and woman the vocation, and thus the capacity and responsibility of love and communion. Love is therefore the fundamental and innate vocation of every human being. As an incarnate spirit, that is a soul which expresses itself in a body and a body informed by an immortal spirit, man is called to love in his unified totality. Love includes the human body, and the body is made a sharer in spiritual love (John Paul II, 1981, p. 22).

Thus, man's dignity arises from the fact that he has God as his source and as his destiny. Moreover, as the Pope says in this passage, he is an "incarnate spirit, that is a soul which expresses itself in a body and a body informed by an immortal spirit." This reflects an ancient tradition based in Scripture and supported by philosophy that man is both a spiritual and bodily being. The human person is not solely identified with either his soul or his body but is a substantial unity of the two. The human body, then, though inferior to man's spiritual soul, is an essential part of who he is and is part of his lofty vocation to divine communion. This is why the Second Vatican Council taught, "Man, though made of body and soul, is a unity…. Man may not despise his bodily life. Rather he is obliged to regard his body as good and to hold it in honor since God has created it and will raise it up on the last day" (Vatican II, 1965). Similarly the *Catechism* states,

> The human body shares in the dignity of "the image of God": it is a human body precisely because it is animated by a spiritual soul, and it is the whole human person that is intended to become, in the body of Christ, a temple of the Spirit (CCC, 1997, no. 364, p. 93).

Because of original sin, the human person must experience death, i.e., the separation of soul and body. However, the deceased human body, though subject to decay, is destined to be resurrected and reunited with the soul at the end of time. In Jesus Christ, the incarnate Word, we have our hope of resurrection, "for by His incarnation the Son of God has united Himself in some fashion with every man" (Vatican II, 1965, no. 22). Through his own bodily resurrection, Christ has conquered death and opened the way to eternal life. In the Scriptures, we see that in his resurrected body Christ is no longer subject to death. Though still human, his body has now been perfected and glorified and has certain extraordinary properties to it. Those who have been baptized into Christ likewise yearn for this redemption of the body. Thus, the incarnation and resurrection of Jesus reveal the dignity and purpose of the human body: to be divinized and participate eternally in Trinitarian communion.

> The spiritual and immortal soul is the principle of unity of the human being, whereby it exists as a whole — *corpore et anima unus* — as a person. These definitions… point out that the body, which has been promised the resurrection, will also share in glory (John Paul II, 1993, p. 66).

This lofty view of the human body forms the basis of many ethical norms, which are especially pertinent today. For instance, the Congregation for the Doctrine of the Faith (CDF) instructs,

> By virtue of its substantial union with a spiritual soul, the human body cannot be considered as a mere complex of tissues, organs and functions, nor can it be evaluated in the same way as the body of animals; rather it is a constitutive part of the person who manifests and expresses himself through it. (CDF, 1987, p. 21).

The Vatican's *Charter for Health Care Workers* reiterates the same teaching:

> The body, indivisibly with the spirit, shares in the dignity and human worth of the human person: *body-subject* not body-object, and as such is indisposable and inviolable. The body cannot be treated as a belonging. It cannot be dealt with as a thing or an object of which one is the owner and arbiter (PCPAHCW, 1995, p. 50-51).

Because of the inherent value of the human body, it must be respected and not regarded as mere matter. Even at death, i.e. the separation of soul and body, the human body is to be treated with respect. Because of a firm belief and hope in the resurrection of the body, Catholic Tradition places great emphasis on the proper care and burial of deceased human bodies. Hence, the *Catechism* states,

> The bodies of the dead must be treated with respect and charity, in faith and hope of the Resurrection. The burial of the dead is a corporal work of mercy; it honors the children of God, who are temples of the Holy Spirit (CCC, 1997, no. 2300, p. 554).

More precise norms for dealing with human corpses based on this teaching can be found in the *Order of Christian Funerals*, which states,

> Any customs associated with the preparation of the body of the deceased should always be marked with dignity and reverence… For the final disposition of the body, it is the ancient Christian custom to bury or entomb the bodies of the dead… (USCC, 1989, p. 13).

An important passage of the *Code of Canon Law* likewise instructs,

> The Christian faithful are to be given ecclesiastical funeral rites according to the norm of law. Through ecclesiastical funeral rites the Church asks spiritual assistance for the departed, *honors their bodies*, and at the same time brings the solace of hope to the living…. *The Church earnestly recommends that the pious custom of burying the bodies of the dead be observed*… (Can. 1176, §1-§3, p. 425, emphasis added).

In light of the Church's teachings discussed above, some may wonder why the *Code of Canon Law* here only "recommends" the burial of the deceased bodies rather than forthrightly mandating the practice. It is important to note that this passage of the Code goes on to speak of cremation, which was first permitted by the Church in the 1963 document of the Holy Office *Piam et Constantem*. Though cremation is now permitted, the norm of the Church for dealing with human corpses remains burial. This is what the Code is emphasizing by recommending burial over against cremation. The overall theme of this text, however, seems to imply that human remains of whatever sort must be treated respectfully and interred in some way. This is made explicit in other magisterial documents. For instance, the bishops of the United States in an appendix to the *Order of Christian Funerals* state, "The cremated remains of a body should be treated with the same respect given to the human body from which they come" (no. 417, cited in Cunningham, 1998). Thus, cremated remains should be dealt with in the same manner as other human remains, which is precisely what the Congregation for Divine Worship and the Discipline of the Sacraments recently instructed, "The faithful should be exhorted not to keep the ashes of the dead in their homes, *but to bury them in*

the usual manner, until God shall raise up those who rest in the earth, and until the sea gives up its dead" (CDWDS, 2001, no. 254, emphasis added).

These ethical teachings pertain to the care owed to the human body in life and in death. Essential to the present considerations is that these teachings apply to the body at any stage of development, including the pre-natal period. The inestimable value of human life, and therefore the body, is present from the first moment of existence, as the CDF reiterated in 1974:

> In reality, respect for human life is called for from the time that the process of generation begins. From the time that the ovum is fertilized, a life is begun which is neither that of the father nor of the mother, it is rather the life of a new human being with his own growth. It would never be made human if it were not human already…. Right from fertilization is begun the adventure of human life.

When the nuclei of the spermatozoon and ovum fuse in the process known as conception, a genetically distinct entity comes into being who has never existed before. Its unique genetic make up is that of the species *homo sapiens* and is distinct from the father, mother, and every other member of the species. It has its own internal dynamisms of growth, differentiation, movement, orientation in space, and the like.

> Thus the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life. This

> doctrinal reminder provides the fundamental criterion for the solution of the various problems posed by the development of the biomedical sciences in this field: since the embryo must be treated as a person, it must also be defended in its integrity, tended and cared for, to the extent possible, in the same way as any other human being as far as medical assistance is concerned (CDF, 1987, p. 24-25).

Unborn human beings are human beings nonetheless and therefore are owed the utmost respect from the moment of conception. "Prenatal life is fully human in every phase of its development. Hence health care workers owe it the same respect, the same protection and the same care as that given to a human person" (PCPAHCW, 1995, p.46). This teaching has important implications for how to deal with the deceased bodies of unborn human beings as well. The CDF has clearly specified these implications by declaring, "The corpses of human embryos and fetuses, whether they have been deliberately aborted or not, must be respected just as the remains of other human beings" (CDF, 1987, p. 35).

Respectful Care of the Couplet During Miscarriage

As the evidence shows, miscarriage is beyond any doubt a psychologically painful experience for mothers. As mentioned above, it is essential to the mother's healing that she be encouraged to mourn the loss of her distinct, irreplaceable child. Despite this, "Many professionals and the lay community perpetuate the belief that miscarriage is an insignificant event" (Stirtzinger et al., 1999, p. 236). Authors have noted that it is often treated as a "'silent event' that [is] not discussed within the wider community" (Maker & Ogden, 2003, p. 405). "In addition, clinicians and the young women's community

tend to discredit one loss giving advice such as 'you're young' or 'you will have other children,' leading to a denial of the emotional impact of the miscarriage, thus impeding mourning" (Stirtzinger et al., 1999, p. 244). As Kohn and Moffit (2000) note,

> Well-intentioned people may utter platitudes such as "It was only an early loss" or "It happened for the best" in an attempt to reassure both [the mother] and themselves. They may also assume that because the loss occurred so early, [the mother] should recover quickly and have another child right away. But pregnancy losses should be acknowledged and mourned, and these comments only make [her] feel [her] sadness is inappropriate because the pregnancy was so brief (p. 49).

Even religiously motivated individuals can make these mistakes. Cunningham (1997) remarks, "In my bereaved-parent support group survey which I conducted years ago, fewer than 50% of parents felt that their clergy were understanding and supportive. Fewer than 30% felt that their faith congregations were understanding and supportive" (p. 491).

Despite these obstacles, a major source of healing for the parents of a miscarried child is to formally say good-bye to their little one through a public ritual such as a funeral and/or burial.

> The funeral gives parents the means to set aside the general societal perception of and response to a baby's death as a "nonevent". It also recognizes a *person* (the baby) as having lived and shared in a love relationship rather than the general societal definition of a dead baby as a "nonperson"…. Focusing our attention on the death (event) and the baby's life (person) through a funeral ceremony is now recognized as therapeutic and helpful in most cases (Troyer, 1987, p. 154).

Holding a funeral, then, can be a tremendous source of healing for mothers who miscarry. Recall the words from Canon Law above: "Through ecclesiastical funeral rites the Church asks spiritual assistance for the departed, honors their bodies, and at the same time *brings the solace of hope to the living*…" (Can. 1176, §2, p. 425, emphasis added). Stirtzinger et al. (1999) likewise state,

> Rituals and rites that identify the loss and initiate the process of grief can provide powerful therapeutic experiences. Anthropologists note that all cultures have made uses of rituals to acknowledge and accept a major life event such as the death of someone loved. The absence of rituals and rites for miscarriage loss denies women the opportunity to mourn within the comfort and support of others (p. 236).

While these quotations clearly testify to the value of mourning the child lost in miscarriage via a funeral/burial, the last alludes to the fact that this opportunity is rarely extended to the affected mothers. Others have written similarly:

> "From my perspective, every family whose baby dies should be offered a funeral or memorial service. Often, nothing is offered or there may be only a minimal service" (Cunningham, 1997, p. 491).

"A funeral and burial are preferable, but not always possible" (Klein, 1987, p. 141).

The main reason that burial is not often possible in the case of miscarriage is that the remains of the child are either lost via the toilet or are taken into the custody of the hospital and later destroyed with other biological waste. In either scenario, parents are not usually encouraged to obtain their child's remains and give him/her a ritualized farewell. In fact, frequently the parents never even see their child's remains. Doctors routinely tell their miscarrying patients that they will not want to see the contents of the

uterus because these will be disturbing to them. On the contrary several authors claim this can be very healing for parents:

> In *Coping with a Miscarriage*, the contributor Rothchild encourages parents to look at what the woman has passed. In [another] study, almost a third of the patients said that they would like to have seen the products of conception. Very often, though, the woman has difficulty articulating this need, or she may not think of it herself, but would be eager to see her "baby" (Hager & Owens, 1987, p. 35).

Additionally, in a study of parents who had experienced a miscarriage or stillbirth, "85% indicated they would have appreciated additional opportunities to see their baby" (Heiman, Yankowitz, & Wilkins, 1997, p. 587).

The fact that parents are so abruptly and permanently separated from their child's remains, which are discarded, is a very unfortunate state of affairs both from the point of the view of the mother and the deceased child. As Kohn and Moffit (2000) observe, this "lack of tangible reminders of your pregnancy can keep… you from grieving properly" (p. 48). Moreover, in light of Catholic teaching on the dignity of the body and of the unborn discussed above, the burial of a miscarried child is not only a privilege that brings solace to the mother and family, but approximates a moral duty. Because of the inherent value of every human life from the moment of conception, the corpses of unborn babies "must be respected just as the remains of other human beings" (CDF, 1987, p. 35). This is simply an application of the perennial teaching of the Catholic faith on the human body and the hope of future resurrection. In practice, it means that every possible step should be taken to ensure that the bodies of children who

die in utero are treated with the same respect as adult corpses. This implies holding a dignified funeral and burying the remains in a suitable place. Indeed, the *Charter for Health Care Workers* makes this explicit:

> Health care workers have special obligations with regard to aborted fetuses. An aborted fetus, if it is still alive should be baptized if at all possible. ***A dead aborted fetus must be given the same respect as a human corpse. This means that it cannot be disposed of as just another item of rubbish. If at all possible it should be appropriately interred*** (PCPAHCW, 1995, p.125, emphasis added). **[4]**

Thus, medical professionals, support personnel, clergy, and parents should do everything in their ability to retain the miscarried child's remains, treat them with respect, and give them a burial worthy of a human being. This may raise the question in some minds of whether an unbaptized, miscarried child can be given a Christian funeral. If the parents intended to baptize their child, the answer is "yes" as the *Code of Canon Law* makes clear: "As regards funeral rites catechumens are to be considered members of the Christian faithful. The local ordinary can permit children to be given ecclesiastical funeral rites if their parents intended to baptize them but they died before their baptism" (Can. 1183, §1-§2, p. 427).

Though the Catholic Tradition has numerous resources for recognizing and honoring the personhood of the deceased unborn and for comforting the mourning family, these are not being utilized because of carelessness and silence. It is, however, important to recognize that because of the frequently devastating nature of miscarriage, the parents are clearly under duress and therefore their culpability in this matter is

greatly reduced or perhaps eliminated all together. It is those who treat, comfort, and advise the parents of a miscarried child who are to be held most responsible for the manner in which the child's remains are handled and therefore the extent to which the mourning process is helped or hindered. The grieving parents are at the mercy of others and have little ability to stand up for themselves or for their deceased child. For instance, Lovell (1983) notes that when a miscarrying woman is sent to the hospital for a D&C "the dead baby is usually whisked away and the bereaved woman sent back to the community with what feels like indecent haste" (p. 755). In the hospital setting, the issue of the baby's remains is rarely discussed as was seen in a study of women who experienced first trimester miscarriages, in which the researchers note, "Some aspects of medical care were reported as unsatisfactory. Little consultation was evident concerning decisions about viewing or disposing of remains following miscarriage" (Jackman, McGee, & Turner, 1991, p. 108). In a subsequent study of early miscarriage by the same researchers, "Results indicate that most [mothers] neither saw the miscarried fetus nor knew of burial details. Regardless of stated preference for viewing and burial, all [mothers] indicated that they wanted to be involved in making these decisions" (Jackman et al., 1994, p. 93). Despite her desire to be informed and involved, these important issues are simply not discussed with the miscarrying mother who is shocked and distressed and unsure of what to say or do. Even if she is strong enough to ask about these issues, she may not get a clear answer about her baby's remains. As Matthews (1987) notes, "Unfortunately, in a busy obstetric practice it is not unusual to have confusion arise as to where a stillborn or a dead neonate was taken" (p. 146).

This was sadly the case with Cecelia McGregor who suffered an early miscarriage in 2000. McGregor, a Catholic, went to Provena Saint Joseph Medical Center in Joliet, Illinois for a D&C. Though greatly saddened by her loss, she mustered enough courage to ask "a nurse in outpatient surgery about the miscarriage remains, how they would be disposed of, and whether there should be a funeral. The nurse wasn't able to answer [her] questions" and McGregor "was in too much psychological distress to think clearly or pursue the answer more aggressively" (Velasco, 2000). After the procedure, she "went home wanting to know what they [the hospital staff] had done—'they made me feel that I did not have the right to ask the question'" (Velasco, 2000).

In time, she joined a support group to help cope with her loss. There, it was suggested that she hold a memorial service for her lost child. Being a Catholic and desiring to celebrate a Catholic funeral and burial, McGregor decided to contact the hospital to inquire about her child's remains. On her first attempt at locating her child's remains, she was lead to believe they had already been buried and that "it was just a bunch of blood clots anyway" (Velasco, 2000). In subsequent attempts to find out where the remains were buried so that she could pay her respects, she was informed by the hospital's CEO that her child's remains had been incinerated with other biological waste. He reiterated the hospital's policy that parents are given a grace period of 4 weeks (later lengthened to 6 weeks) after the procedure to claim their child's remains. If the remains are still in the hospital's custody after that time, they are incinerated. He attempted to reassure McGregor by informing her that all five Catholic hospitals at which he had previously worked operated in this manner.

At this point, McGregor began investigating the legal issues involved and discovered that "in the majority of states, contents of the womb prior to 20 weeks of gestation would be handled like medical waste. Hospitals incinerate the material as they would tumors or gallstones" (Eisner, 2000). In other words, "parents have no legal rights to the remains when the death occurs during the first 20 weeks of pregnancy" (Velasco, 2000). In most states, it is left to the hospital's discretion. Despite such legal laxity, one would hope that a Catholic hospital like the one where McGregor was treated would enact a policy that fully respects the bodily dignity of unborn human life. It is unclear why all Catholic hospitals do not enforce a policy similar to St. Mary's Hospital in Kankakee, IL. There, if the parents refuse custody of their child's remains, the hospital sends them, regardless of gestational age or weight, to a funeral home that provides a dignified burial in a local cemetery. The parents are then notified of the location of their child's grave in case they wish to pay their respects (Velasco, 2000). This seems to be the most ideal policy because it ensures that the child's body will be treated with the utmost respect even if the parents fail to claim it as well as giving them ample opportunity to take custody of the remains and knowledge of their final resting place. Unfortunately, this sort of policy is uncommon among Catholic hospitals and therefore even more so among hospitals in general.

What about those women who miscarry at home? Are these children destined to a watery tomb? Although this may often be the case, it does not have to be. It may take courage and support from her spouse, family, clergy, and doctor, but a woman who miscarries at home can take certain steps to ensure that her child's body is retained and

then buried. This may at first sound like heroism, but it is not substantially different from what the following authors recommend for the sake of pathological testing. They recommend that women experiencing an early miscarriage

> be advised to collect any pregnancy tissue that she may pass at home, to be examined later. For this purpose, she might be given a specimen container with a lid…, which saves her from having to rummage through her kitchen for a suitable container. Frequently, tissue and blood clots are passed into the toilet. A small kitchen strainer can be used to transfer them from the toilet bowl to the container. Because distinguishing between clots and tissue would place an unnecessary burden on the woman, she should be instructed to collect everything (Hager & Owens, 1987, p. 31).

Again, these recommendations are purely to obtain tissue to test for abnormalities. Those who adhere to the Catholic view of the dignity of the body and of unborn human life should be *even more motivated* to take such actions to honor their child, thus facilitating their own mourning process as well. However, as mentioned above, women in this situation will only be able to do this when they are adequately supported and encouraged by those around them and those in a position to offer guidance. Unfortunately, women are not normally instructed to do this, nor are they even enabled to talk about such things freely. Thus, most women in this scenario succumb to the awkwardness and distress of the situation and miss the chance to retrieve and honor their child's remains. Yet, it can be done as is illustrated by the following real life vignette.

> Annette was 6 weeks pregnant when she began spotting while on vacation. A few days later, she went to see an OBGYN who was unable to find a heartbeat. Hoping that the child was still alive, she and her husband decided

> to proceed cautiously. Subsequent HCG tests and ultrasounds continued to point in the direction, though not conclusively, that the child had died. Annette and her husband returned to their home and contacted their midwife who arranged for another HCG test and encouraged Annette to let nature take its course rather than rush to a doctor for a D&C. After being home a few days, Annette's bleeding began to increase and she began passing clots. She did not want to lose her baby, so every time she used the toilet she tried to pay close attention to any material she passed. On a few occasions, when she passed blood clots, she retrieved them from the toilet bowl using a large spoon and gently rinsed them off to make sure that this was not her baby. After a couple days of this, her bleeding began to decrease, and she started to wonder if she wasn't miscarrying after all because she hadn't passed anything like what she expected based on various pictures of a child this age. Then, during one of her bathroom visits, she passed a substantial something that felt and looked different from everything else. She gently retrieved the material from the toilet with the spoon and rinsed it. This was her baby. It was still sealed inside the chorion and was mostly trophoblastic tissue. The whole mass was smaller than the palm of her hand. Yet, she new this was her baby. She sealed him in a plastic bag, set him on the family bible, and called her husband. They named the child, and about a week later, had a funeral with family and friends, burying his tiny remains at the foot of Annette's grandfather's grave. **[5]**

Conclusion

I was once in an abortion debate with a relative who posed an unusual but challenging criticism. He argued that those who hold the pro-life position, despite their statements to the contrary, clearly do not believe that the unborn are persons. His support for this assertion was to say,

> Look at how you pro-lifers deal with miscarriage. If you really maintain that the unborn are human persons, you would not be so careless and nonchalant about miscarriages. When a woman miscarries, why is the body not

> retained? Why is the mother not allowed to mourn? Why is there no funeral or burial? These omissions prove the unreasonableness and inconsistency of the pro-life position.

This is a serious objection, one that in many cases cannot be answered with a clear conscience.

As we have seen, miscarriage is very often a devastating event for the mother. Medical personnel, clergy, and the community at large must recognize her grief and help her mourn the loss of her child. In addition, Catholic teaching on the dignity of the human body and unborn human life carries with it an obligation to treat pre-natal human remains with the same respect one would give an adult corpse. These two lines of reasoning lead to one and the same conclusion: ***all possible steps should be taken by all those involved to retain the remains of miscarried children, offer them a proper funeral, and respectfully bury them***. This is the best way both to help the grieved mother and to honor the deceased child. Unfortunately today, many obstacles in the form of attitudes and practices prevent this from happening. However, it is not impossible, especially if those responsible were alerted to these issues and helped to alter their approach accordingly. What great comfort and healing there would be for mothers who have lost children to miscarriage if they were at last able to acknowledge the individuality of their deceased and memorialize them. What honor these children would receive if their bodies were appropriately buried. What a greater, more consistent witness to the dignity of human life there would be if this practice was common in society. Thus, one can perceive in these recommendations not only a hope for healing the mother-child couplet, but a hope for healing a dying culture as well.

References

Carlson, B. M. (2004). *Human Embryology and Developmental Biology (3rd Ed.)* Philadelphia, PN: Mosby.

Cassidy, J. & Shaver, P. R. (1999). *Handbook of Attachment: Theory, Research, and Clinical Applications*. New York: Guilford Press.

Catechism of the Catholic Church, 2nd ed. (1997). Vatican City: Libreria Editrice Vaticana

Code of Canon Law (1983). Washington, DC: Canon Law Society of America.

Congregation for Divine Worship and the Discipline of the Sacraments (2001). *Directory on Popular Piety and the Liturgy*. Retrived from http://www.vatican.va on 1/5/05.

Congregation for the Doctrine of the Faith (1974). *Declaration on Procured Abortion*. Retrieved from http://www.vatican.va on 12/1/04.

Congregation for the Doctrine of the Faith (1987). *Donum Vitae*. Boston, MA: Pauline Books and Media.

Cunningham, J. H. (1997). Spiritual issues and care in perinatal bereavement. In J. R. Woods & J. L. Esposito (eds.), *Loss During Pregnancy or in the Newborn Period* (pp. 483-498). Pitman, NJ: Jannetti Publications, Inc.

Cunningham, M. E. (1998). Cremation in catechesis and the funeral liturgy. *Living Light, 34*(4). Retrieved from http://www.usccb.org/education/catechetics/cremation.htm on 1/4/05.

Eisner, R. (2000). “Mourning Miscarriage: A Missing Peace”. *ABCNews.com*. Retrieved from http://members.aol.com/dsangelmom/ABC.html on 12/4/04.

Geller, P. A., Kerns, D., & Klier, C. M. (2004). Anxiety following miscarriage and the subsequent pregnancy: A review of the literature and future directions. *Journal of Psychosomatic Research, 56*, 35-45.

Geyman, J. P., Oliver, L. M., & Sullivan, S. D. (1999). Management of first-trimester spontaneous abortion. *The Journal of Family Practice, 48*(5), 331-332.

Hager, A. & Owens, O. M. (1987). Early pregnancy loss: Miscarriage and ectopic pregnancy. In J. R. Woods & J. L. Esposito (eds.), *Pregnancy Loss: Medical Therapeutics and Practical Considerations* (pp. 23-50). Baltimore, MD: Williams & Wilkens.

Heiman, J., Yankowitz, J., & Wilkins, J. (1997). Grief support programs: Patients' use of services following the loss of desired pregnancy and degree of implementation in academic centers. *American Journal of Perinatology, 14*(10), 587-591.

Jackman, C., McGee, H. M., & Turner, M. (1991). The experience and psychological impact of early miscarriage. *Irish Journal of Psychology, 12*(2), 108-120.

Jackman, C., McGee, H. M., & Turner, M. (1994). Maternal views of the management of foetal remains following miscarriage. *Irish Journal of Psychological Medicine, 10*(2), 93-94.

John Paul II (1993). *Veritatis Splendor*. Boston, MA: Pauline Books and Media.

John Paul II (1981). *Familiaris Consortio*. Boston, MA: Pauline Books and Media.

John Paul II (1994). *Letter to Families*. Boston, MA: Pauline Books and Media.

John Paul II (1988). *Mulieris Dignitatem*. Boston, MA: Pauline Books and Media.

Kay, J. (1987). Pregnancy loss and the grief process. In J. R. Woods & J. L. Esposito (eds.), *Pregnancy Loss: Medical Therapeutics and Practical Considerations* (pp. 5-20). Baltimore, MD: Williams & Wilkens.

Kay, J., Roman, B., & Schulte, H. M. (1997). Pregnancy loss and the grief process. In J. R. Woods & J. L. Esposito (eds.), *Loss During Pregnancy or in the Newborn Period*

(pp. 5-36). Pitman, NJ: Jannetti Publications, Inc.

Kippley, J. F. & Kippley, S. K. (1996). *The Art of Natural Family Planning* (4th ed.). Cincinnati, OH: The Couple to Couple League International, Inc.

Klein, B. A. (1987). Chaplain's ministry when a baby dies. In J. R. Woods & J. L. Esposito (eds.), *Pregnancy Loss: Medical Therapeutics and Practical Considerations* (pp. 132-143). Baltimore, MD: Williams & Wilkens.

Klier, C. M., Geller, P. A., & Ritsher, J. B. (2002). Affective disorders in the aftermath of miscarriage: A comprehensive review. *Archives of Women's Mental Health, 5*, 129-149.

Kohn, I. & Moffit, P.-L. (with Wilkins, I. A.) (2000). *A Silent Sorrow*. New York, NY: Routledge.

Lovell, A. (1983). Some questions of identity: Late miscarriage, stillbirth and perinatal loss. *Social Science & Medicine, 17*(11), 755-761.

Maker, C. & Ogden, J. (2003). The miscarriage experience: More than just a trigger to psychological morbidity? *Psychology and Health, 18*(3), 403-415.

Matthews, A. (1987). Social worker: Hospital advocate for the immediate and extended family. In J. R. Woods & J. L. Esposito (eds.), *Pregnancy Loss: Medical Therapeutics and Practical Considerations* (pp. 144-152). Baltimore, MD: Williams & Wilkens.

McCartney, M. & van der Meer, A. (1990). *The Midwife's Pregnancy and Childbirth Book*. New York, NY: HarperCollins.

Neugebauer, R. (2003). Depressive symptoms at two months after miscarriage: Interpreting study findings from an epidemiological versus clinical perspective. *Depression and Anxiety, 17*, 152-161.

Neugebauer, R., Kline, J., Shrout, P., Skodol, A., O'Connor, P., Geller, A., Stein, Z., & Susser, M. (1997). Major depressive disorder in the 6 months after miscarriage. *JAMA, 277*(5), 383-388.

Pizer, H. & Palinski, C. O. (1980). *Coping with a Miscarriage*. New York, NY: The Dial Press.

Pontifical Council for Pastoral Assistance to Health Care Workers (1995). *Charter for Health Care Workers*. Boston, MA: Pauline Books and Media.

Puddifoot, J. E. & Johnson, M. P. (1999). Active grief, despair, and difficulty coping: Some measured characteristics of male response following their partner's miscarriage. *Journal of Reproductive and Infant Psychology, 17*(1), 89-93.

Shannon, M. (1992). Consolation in a home funeral. *CCL Family Foundations*, Sept-Oct 1992, 20-21.

Stirzinger, R. M., Robinson, G. E., Stewart, D. E., & Ralevski, E. (1999). Parameters of grieving in spontaneous abortion. *International Journal of Psychiatry in Medicine, 29*(2), 235-249.

Troyer, R. (1987). Funeral director. In J. R. Woods & J. L. Esposito (eds.), *Pregnancy Loss: Medical Therapeutics and Practical Considerations* (pp. 153-166). Baltimore, MD: Williams & Wilkens.

United States Catholic Conference (1989). *Order of Christian Funerals* (vol. 8 of the Liturgy Documentary Series). Washington, D.C.: United States Catholic Conference, Inc.

Vatican II. (1965). *Gaudium et Spes*. Retrieved from http://www.vatican.va/archive/hist_councils/ii_vatican_council/ on 12/4/04.

Verny, T. (with Kelly, J.) (1988). *The Secret Life of the Unborn Child*. New York, NY: Dell Publishing.

Endnotes

1. I do not mean to imply by my emphasis on the mother and child that others such as the father or siblings are not affected by miscarriage. Indeed, miscarriage is a sorrowful event for the entire family. However, in this paper I wish to focus on the mother-child

couplet because they are the two individuals *most* affected by the miscarriage and others' responses to it.

2. I am only interested in clinically recognized pregnancies. Although many fertilized ova are lost prior to implantation or at the beginning of implantation, these are not usually detected by the mother or her physician (Carlson, 2004). My concern is for those cases where a child is known to have been conceived and then lost.

3. This is true of all women, even those who choose consecrated virginity, which the Pope reaffirms as a higher state of life than marriage. The consecrated virgin gives herself totally to Christ in and through her religious vows. This nuptial union is fruitful by way of spiritual motherhood through which new children of the Church are begotten and nurtured.

4. While this passage speaks of aborted children, the thrust of its teaching applies equally to miscarried children as well. The only difference between the two types of children is the cause of death.

5. For more examples of this type of response to miscarriage see Kippley & Kippley (1996, p. 437-438) and for an analogous response to late miscarriage/stillbirth see Shannon (1992).

Version: 12th January 2005

HomePage **Prof May Home Page**