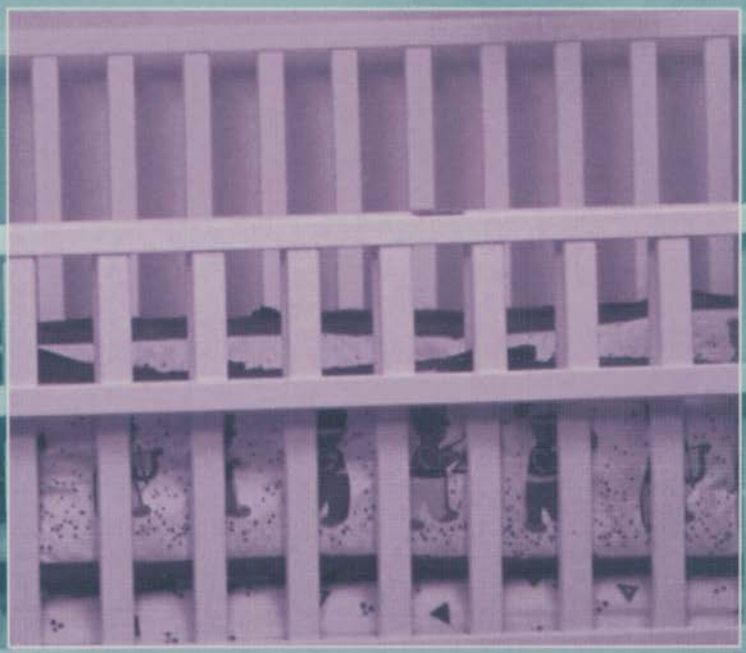
Pastoral Care in Pregnancy Loss

A Ministry Long Needed



Thomas Moe

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Thomas Moe, DMin

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Publisher's Note
The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original may be apparent.

To Brian James Moe
Born and died July 6, 1980
Some people come into our lives
and we are never ever the same
From Mom, Dad, Elisabeth, Cynthia
and Eric.

ABOUT THE AUTHOR

Thomas Moe, DMin, is an ordained minister serving in the United Methodist Church. Dr. Moe has been a consultant to several organizations providing care to individuals experiencing pregnancy loss, including RTS Bereavement Services, a hospital-based program specializing in providing multidisciplinary care for those who have experienced pregnancy loss. Since its beginning in 1981, this program has expanded to over 100 units worldwide. Dr. Moe received his Doctor of Ministry degree from Bethel Theological Seminary with a specialty in pregnancy loss ministry and has led numerous clergy seminars on the subject.

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Preface

Many a church leader will, at first, cringe at the thought of a book such as this. After all, most church leaders already have more than enough to do. Their schedules are well filled with existing programs. Very likely, their churches struggle to provide the resources to maintain these existing programs. The thought of adding another program of ministry will not be immediately welcomed by these folks.

My purpose is not just to add more stress to the existing program life of a church. Instead, this writing intends to help the church focus upon the people in its midst who suffer hurt from pregnancy loss. These people are a part of almost every church. Yet, most faith communities could not be less prepared to meet their needs and deal with their hurt. The leadership in most churches do not know how to provide even basic ministry to these people. Instead, these individuals tend to travel from church to church, staying long enough to exhaust resources but seldom finding a ministry of help. It is my hope that churches and other faith communities will begin to understand those who have experienced grief from pregnancy loss and to learn means of effective ministry to them. With this understanding, faith communities will be able to help these bereaved persons work through their grief and grow in the resolution process. Instead of church members and leaders feeling inadequate as they watch these grievers continually traveling from location to location for ministry, a church can grow with them as resolution takes form.

Hopefully, the reader will understand that this ministry requires more effort than simply setting up another program within the church. While such a program can be very helpful, it often merely isolates the churches from feeling the experiences of their people. This writing wishes to help the church transcend programming to enter the world of those who grieve from pregnancy loss. Like the busy priests and Levites of a too-familiar parable, many of us have been able to walk by the sufferers of pregnancy loss and not notice the suffering. This book

attempts to move us into the role of Samaritans who can actually stop, experience the suffering, and nurture healing.

I would like to thank my loving family for their support and encouragement in this writing. I am extremely grateful to the many caring people who have given of their time and expertise, which allows me to present this information to you. My special appreciation goes to those individuals who have allowed their experiences in pregnancy loss to become the living documents that you may now study. While their identity has been hidden from you, I hope that in some way the lives so greatly missed by many may live in our minds as we expand our scope of ministry.

Acknowledgment

I would like to acknowledge the past and present staff of Bereavement Services RTS at Gundersen Lutheran Medical Center, Wisconsin. They truly are people who know how to care.

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Chapter 1

Pregnancy Loss Ministry

UNDERSTANDING THE PROBLEM

Most religious leaders today do not mean to be insensitive to those suffering from pregnancy loss. Unlike the religious leaders in the Good Samaritan parable who saw suffering and ignored its victims, most church leaders today are caring people who do not minister because they are completely unaware that any suffering is involved with a pregnancy loss. They may see the symptoms of suffering and grief but never understand that actual suffering and grief are taking place. This has happened for a number of reasons. I highlight two major ones.

The first reason that the church is not adequately ministering to those suffering from pregnancy loss is that we have bought into the American success myth. In this success myth, one assumes that the death of a baby is an extremely rare occurrence. This makes sense to many since America has some of the world's best health care facilities and some of the world's most health-conscious people. Therefore, many assume that America is unlike other lesser developed countries where the death of a baby can be a frequent event.

This view of America and American health care is far from reality. America, while ahead of many other nations in the quality of health care, remains behind most industrial nations in all forms of infant survival rate. The number of babies who die from pregnancy loss every year is unusually high. While it is difficult to obtain accurate data, a consistent pattern has remained over the recent decades: approximately only three-fourths of all conceptions actually create a living baby. Some statistics indicate an even higher rate of pregnancy loss, perhaps as high as 50 percent or even higher.[1]

Statistical accuracy is difficult because many of the miscarriages occur so early in the pregnancy that the mother is unaware of the miscarriage. She may think that menstruation is late, and when the miscarriage occurs it is just "unusually heavy"; thus, she does not even recognize the loss. Whatever the actual statistic, it is clear that a large number of pregnancies in America every year will not come to term. Many of these losses will leave the bereaved family devastated. This book will focus upon three types of these losses: miscarriage, stillbirth, and neonatal loss, and the ministries that can be helpful to those who experience these tragedies.

For too long the church has lived in the myth of successful American health care. We have not entered into a deliberate style of ministry to those suffering from pregnancy loss because we have not been aware of the problem's magnitude. The task of the contemporary church requires that we move from our world of myth to one that faces reality. Reality will force us to minister among those people who hurt from these tragedies. In setting up these ministries, the church must also develop a strategy for fulfilling such ministry. Simply put, we must avoid letting the American success myth limit the scope of our ministry. By understanding the magnitude of the loss, we will be compelled to find ways in which we can respond with quality ministry.

The second reason that the church has not played the role of a Good Samaritan to those suffering from pregnancy loss is our ignorance that victims of pregnancy loss may be truly grieving. There are so many ways to avoid seeing people grieving from pregnancy loss. By not seeing any hurt, we have convinced ourselves that our distortions are the reality. These distortions have been around for some time. As for the disciples of Matthew 19:13-15, our world often minimizes the small child as "lesser" than a grown child. Sometimes the parents who have suffered pregnancy loss will also help enforce that distortion by pretending that they do not experience hurt. Our world will encourage them "to get on with their life," or assure them, "that they can have another," and encourage them to cover their grief with meaningless clichés. For pastoral caregivers who become aware that grief may be occurring in those who suffer from pregnancy loss, ministry is often withheld assum-

ing that "the needs are mostly medical and hospital or medical staff will care for all that."

In reality, pregnancy loss includes emotional grief and suffering. It creates many spiritual problems. As church leaders we overestimate the possibilities of health care being able to touch and meet the needs of people affected by such grief and suffering. While medical personnel are caring people, most have enough responsibility in meeting the physical needs of patients without ministering to their deeper emotional needs. All of this causes the griever suffering from pregnancy loss to "fall between the cracks" of the support systems.

Even in the best of settings, the church has generally understated the effects of grief upon human life. Research is just beginning to see how grief affects the entire person. Unresolved grief is being traced as a root problem in numerous significant illnesses, including cancer, compulsive behavior disorders, and many emotional disorders. Research in 1944 by Erich Lindemann found that mourners can be at risk for:

> some seven deadly diseases including heart attack, high blood pressure, cancer, skin diseases, rheumatoid arthritis, diabetes, and thyroid malfunction. Others have added numbers of emotional disorders, compulsive disorders, and many various chronic "aches and pains."[2]

These illnesses can result from pregnancy loss as well as any other type of grief. We can only speculate as to other possible results of such loss.

Perhaps a tragic irony can be found that all of this ignorance is occurring during the time of the abortion crisis, which should be bringing significant focus upon the worth of the unborn and the rights of parents to make choices. Ironically, in spite of all the concern that has come from the issues regarding induced abortion, little focus has moved to compassion for those who have experienced pregnancy loss.

TYPES OF PREGNANCY LOSS

The following is a general explanation of the three types of pregnancy losses:

1. *Miscarriage* is, by far, the most frequent cause of pregnancy loss. While actual definition may vary with different medical organizations, a miscarriage is often described as a pregnancy loss that occurs before twenty weeks of gestation. A baby born dead after twenty weeks of gestation is often referred to as a stillbirth. Miscarriage may sometimes be referred as a "spontaneous abortion." Miscarriage is overwhelmingly the most frequent among all types of pregnancy loss, accounting for some 95 percent of such losses. Again, while accurate statistics are difficult to obtain, it is believed that at least 15-25 percent of all conceptions will end in a miscarriage. Some consider these statistics quite conservative. The vast majority of these miscarriages will be so early in the pregnancy that the mother is not even aware that the pregnancy ever occurred.

2. *Stillbirth* is another type of loss that can occur during a pregnancy. In stillbirth, the baby is born dead. It is estimated that perhaps as little as under 1 percent of all conceptions terminate in stillbirth. While this number appears small, it is important to note that there may be over 30,000 such losses in America each year. That will be three times the equivalent of the number of annual losses to Sudden Infant Death Syndrome (SIDS). In spite of the equal frequency, the church is much more equipped and available to sympathize with those experiencing the latter loss than those experiencing stillbirth, or any other form of pregnancy loss.

3. *Newborn death* is a death of a baby within the first month of birth. It is often referred to as "neonatal loss." Newborn loss usually results from a difficulty during gestation, such as lack of organ development. Each year in the United States there are approximately 35,000 newborn deaths.

4. *Other pregnancy losses* can occur due to problems such as ectopic pregnancy, in which the embryo has not attached to a part of the uterus that can support the life of the baby. An "incompetent cervix," where the uterus cannot hold the fertilized egg, can also lead to a loss. There are other less common forms of pregnancy loss that can be better explained in resources found in the bibliography.

A final type of pregnancy loss, *induced abortion,* will not be included in this study. Induced abortion occurs when a pregnancy is medically terminated. While this book can be helpful in ministry to those who have had an induced abortion, this form of pregnancy

loss may create entirely different sorts of problems that are greater than the capacities of this writing.

THE NATIONAL PROBLEM

The fact that the United States has a large number of baby losses comes as a surprise to most people. Yet, it is a fact. America has continually been a per capita leader in many different types of baby losses compared to other industrialized nations. Most countries do not keep an accurate record of miscarriages and stillbirths. It is difficult, then, to get accurate statistics to discover how the United States actually compares to these countries. However, The World Health Organization has kept accurate statistics in infant mortality across the world.[3] Their statistics indicate that the United States has significantly more infant losses than other nations of similar economic strength. Table 1.1 lists some statistical examples.

One notes that the United States ranks very high in infant mortality compared to other nations around the world. Even with our much superior health care, we still rank behind Canada in preventing infant mortality per live births. Our slower improvement rate over the past twenty years has allowed nations such as Spain, Israel, and even Taiwan to pass the United States. While the United States still ranks significantly higher than lesser economically developed coun-

Table 1.1
Infant Mortality Per 1,000 Live Births (3)

Nation	Year: 1977/8	1994	1995
Taiwan	18.0	6	5.6
Israel	17.8	9	7.0
Spain	15.6	7	7.6
United States	14.0	10	8.3
Australia	12.5	7	6.1
Canada	12.2	7	7.0
Japan	8.9	4	4.4
Sweden	7.7	6	4.8