THOUGHTS ON MISCARRIAGE

The anonymous article printed below, by a mother who recently suffered a miscarriage, was originally published in the Newsletter of the Miscarriage Association, and we are grateful to them for allowing us to reproduce it in "Bereavement Care". We have not previously been able to publish an article on this subject.

EDITOR

Miscarriage affects people in different ways. Probably most people don't think about it, or properly realise what it is, until it happens to them or to someone else. Then our reactions are conditioned by shock, by ignorance of what to expect, and by the narrowness of our understanding. I have been assured that for many women, particularly those who have had one or more children, miscarriage is something which is fairly easily accepted. This is doubtless true, but I do not believe that a woman can entirely dismiss a miscarriage, or fail to accord it some importance (to do this would seem to me to be contrary to the basic function of women); and I do know of several women, now grandmothers, who have never forgotten their miscarried babies, and who still remember them with some sorrow and perhaps with a sense of unfulfilled motherhood in relation to them.

At the time a miscarriage happens, it can be for both parents of the baby something much bigger and harder to cope with than they would perhaps have expected. Our society is spreading its wings in many different directions emotionally and spiritually, but I cannot help feeling that it is still inadequately equipped to deal with miscarriage, perhaps because of the very diversity of people's opinions and beliefs about the death of a baby—foetus if you like—in the womb. It seems to me that there are still taboos about informing pregnant women of what to expect should they miscarry. Do pregnant women prefer to ignore the possibility? When I miscarried my third child at three months I could not believe it was happening to me. I was a healthy mother of two, and while my husband and I were lucky to have the best of medical attention, and spiritual help had we required it, I still felt that the shock of the baby's death, its suddenness, the inevitability of it, were the hardest things to bear. Had I been more conscious that I might lose the baby, would I have felt more for it during the three months I carried it? Would I have put it first whenever my toddler wanted to be lifted up and carried? When I saw my dead baby I could not have loved it more than I did; but by then it was too late.

Open discussion of what miscarriage means could be beneficial in terms of preparing pregnant women for emotions of which they are unsure, emotions which they might struggle to cope with if a miscarriage or a stillbirth occurred. I remember being amazed at the doctor's suggestion that we would perhaps like to have a service held in church for our baby; the narrowness of my attitude to miscarriage had prevented me from seeing that the three month foetus could matter as much as a full term baby did. Whether or not you believe that the foetus is a human being with a soul, it still matters as the beginning of such—something that is developing into what we define as a human being. If it isn't a human being then what is it? A part of humanity, still having a right to a place in our awareness of our world. It cannot be discounted simply because it has not reached its independent form.

The church is not without responsibility in this. I believe the Catholic Church takes some stance on infant mortality. The Protestant Church, as far as I gather, admits it doesn't really know; but neither seems aware that in a society where religious feelings, emotions and psychological reactions to our environment are constantly being examined and interpreted, issues such as this need to be accorded some place, and discussed more freely, that we may better understand them. A miscarriage is indeed a very private thing. We did not feel that we wanted a public service for our child that had not shared in public life, and we buried the baby privately; but at the same time people should not feel that it is something to be secretive or embarrassed about. I have met with the attitude that women should not make their pregnancy public until they have passed the "danger spot" of twelve weeks. I feel that this is entirely up to the woman herself, but that in the early weeks of pregnancy she is very liable to feel the need of sympathetic friends because she may not be feeling well, and may be unable to pursue her usual activities. If it does then happen that the baby is lost, she should not be made to feel that the baby's presence in her womb ought to have remained a secret.

Indeed our doctor advised us to mourn for our baby as we would have done had it reached full term. To push it from one's mind, to tell oneself that the pregnancy should never have happened, to regard it as some sort of failure on the mother's part, all this seems to deny the baby its tiny, temporary place. It does not do justice to a life that struggled and didn't quite make it. Our personal tributes to our baby have been few, and small, but they mattered. When we buried it we placed it with a little toy that had been, by chance, near at hand throughout the hours of the miscarriage, and, from the baby's two sisters, daisies that they had picked for me because I wasn't well. Our biggest tribute, and for us the most important, has been to avoid filling its place with another baby. The baby I lost would have been full-term now, and I would then have been breast feeding it; until that time is over when it would have been tiny, and suckling, we keep its place.

Allowing oneself grief is a much more positive way of coping with a miscarriage than trying to reject it. In this way, you work your feelings out as you would in grieving for any lost relative. Coming to terms with inevitable death is something which is almost beyond us. When it happens to a person we love, have loved through that person's life perhaps, or throughout our own, we cling on to their personality, their possessions, our memories of them—but when it happens to an unborn baby, we have nothing on which to lean; the blank face of death meets us and mentally we shy away.

With this in mind I do feel that parents of a dead baby, whether it was still a foetus or whether it was full term, should to try to look at their child—even though it may be unformed or malformed. In our case it happened to be a perfectly formed little baby, at twelve weeks in the womb a greyish colour, with pink veins. All the limbs were there as far as we could see, and the eyes were forming in the tiny face. We loved it and lost it simultaneously; but we saw it, and because of that it will always be with us. I must admit that when I knew my child had not been physically deformed, my relief was enormous. But, trying to think as objectively as possible, I believe that it would have been better to see no matter what it had been like. Had it lived, and been deformed, I should have

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not in ultimate control, he cannot truly be God". Yet the conclusion is similar—not "Why?", but "What response shall I give?" For health care workers and bereaved families trying to understand in some depth how a cancer patient with great personal resources faces the prognosis, the uncertainty or false hopes, the likelihood or inevitability of death, and so on, David Watson's book is of great interest. He bravely tackles, head-on, all sorts of tough issues. How do you counteract the anxieties and negative fears that keep looming up? What does the nature of death seem to be, as viewed by someone getting close to it? What is it like fighting for your life? Like Kushner's book, the insights here could be of great interest to a readership much wider than those of his own faith. It is a worthy postscript to a momentous life, lived unsparingly.

AGNES WHITAKER

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loved it: had it been a deformed foetus I should like to think that I would still have loved it. Even if the initial shock of seeing deformity in a foetus might have prevented the spontaneous love which my husband and I felt on seeing our baby, we would still have had some form of visual contact with it which might have served to help us later to remember our child as it had been, not as something dark inside my womb that we had never seen. At the very least, visual contact with the child would have provided it with a kind of existence, preserved in its parents' memory. The concept of entering the world and leaving it totally unseen and unknown is one I find horrifying.

When the doctor encouraged us to think of our dead foetus as we would have thought of a full-term child he was confirming and supporting our own instinctive feelings and wishes. He enabled us to give full vent to our grief where the limits of our own understanding and the constrictions imposed by traditional attitudes would have held us back. The few minutes we spent with our dead child are amongst the most precious in my life. How could we not love it? The motionless calm of death, the perfect, untouched peace of that tiny baby still encased in its sac, preserved and protected from further harm. Does my baby have a soul? Is it with God? These are the questions which became superfluous at that moment. My baby returned whence it had come, back into the earth, the life force which had begun it. Who are we to judge its validity in God's eyes? Death is a part of life; we cannot push it aside. In the same way our dead baby is still part of us, and of our life's expression on this earth.

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SOCIAL ISOLATION

There is another reason for recommending social activity. This is that widows and widowers are vulnerable to a second kind of loneliness, in addition to the loneliness of emotional isolation. Loneliness of this second kind—sometimes called "the loneliness of social isolation"—is apt to be experienced as a sense of being marginal or distant from people who are doing things that matter. Going along with this may be a feeling that others are intentionally evasive or distant; that the social isolation being experienced results from a kind of ostracism.

Insofar as the widow or widower had, when married, participated in a social world of couples, bereavement may have brought about the loss, not so much of individual friends, although this too can happen, as of the friendship network. There are fewer invitations to dinners and parties. To the widow or widower it may seem that they have somehow begun following an isolated pathway whose direction diverges from that of their former friends.

This form of loneliness, happily, responds well to effort The widow or widower must find one or more accessible, reasonably attractive social groups, and then show up at their meetings and be friendly. Friendliness tends to elicit friendliness. With a bit of time, a feeling of being part of things can in this way be re-established.

CRUSE ACADEMIC PAPERS

SUICIDE

Academic Paper No. 1 comprises a reprint of the article on *The Risk of Suicide following Bereavement* by Dr. C. Murray Parkes (originally published in **Bereavement Care,** Vol. 1, No. 1), together with A Review of the Literature on Bereavement following Suicide by Dr. S. Henley.

SUPERVISION

Academic Paper No. 2 is a reprint of the article on *Supervision and Consultant Care —Counselling the Counsellors* by Gill Parker, Family Therapist, from **Bereavement Care,** Vol. 1, No. 2.

BEREAVEMENT IN ISRAEL

Academic Paper No. 3 is an expanded version of the paper on *Bereavement in Israel from War, Holocaust & Terror,* given by Prof. Shamai Davidson to the 1983 Cruse Conference on Bereavement following Violence. *NEWLY PUBLISHED.*

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Cruse wishes to appoint a Training Officer, a full-time post based at Cruse House in Richmond. In addition to all the training aspects, both within Cruse and for healthcare workers and others, the post will include involvement in Cruse's research programme.

Full details and application form from Derek Nuttall, Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR.

Notice: The 1986 Cruse course in counselling before and after bereavement, for professional workers, will be held in Manchester in the autumn.

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