Grief After Perinatal Loss: A Descriptive Phenomenological Study

Marlena Jalise Baxter-Dunn

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Approved by:

Jason K. Ward, Ph.D., Committee Chair

Brandon Simmons, Ph.D., Ed.D., Committee Member

Abstract

The purpose of this descriptive phenomenological study was to describe the experiences of grief, coping, and spiritual crisis in the lives of women who faced perinatal loss. The theory guiding this study was Pargament's Theory of Religious Coping, as it explains the role of religious coping in the potential development of complicated grief and complicated spiritual grief. One central research question guided this study: how do women with religious/spiritual beliefs describe their lived experience of grief from perinatal loss? The sample size for the study was eight women with religious/spiritual beliefs who experienced perinatal loss. Data were collected using an unstructured, open-ended interview in an online setting using the Zoom videoconference platform. Data were analyzed using an eidetic analysis method. The findings of this study described the common experience of grief after perinatal loss in women with religious/spiritual beliefs. The data analysis revealed thirteen constituents that comprise the essential structure of grief related to perinatal loss in women with religious/spiritual beliefs. This study is significant to community counseling and mental health professionals as it informs those working with women who experienced perinatal loss concerning their loss and grief experiences. Additionally, this study contributes to the gap in the literature on the grief associated with perinatal loss in women with religious/spiritual beliefs.

Keywords: perinatal loss, grief, complicated spiritual grief, religious coping

Copyright Page

Dedication

This work is dedicated to my angels

My babies, Zoë-Paige, Richard, and my four other babies in Heaven

My daddy, Richard

My grandparents, William, Marie, Joseph, and Mary

My godmother, Chamos

My Aunt Cukye

My best friend, Bertila

And all those who have endured the pain of perinatal loss.

Acknowledgments

Thank you, God, for Your sovereignty, goodness, and love. Thank you, Jesus, for Your sacrifice and for saving my soul. Thank you, Holy Spirit, for dwelling within me.

Trent, since we met over ten years ago, you've always known how to make me smile. Thank you so much for all the love and support you've shown me for encouraging me when I wanted to throw in the towel. Thank you for your kindness, like bringing me a Diet Dr. Pepper or keeping the kids quiet, so I could sleep a few minutes longer after a long night of writing. Thank you for all the prayers. Thank you for driving when I needed to work on my paper. Thank you for being my biggest cheerleader. I love you the most.

Beckham, Luna, and Penelope, mommy loves you three so much. Since I started this journey, Beckham, you've been there every step of the way. You always know what to do to make me laugh. Luna, you came into our lives during a crazy time. You are a ray of bright sunshine and a spitfire. Finally, Penelope, you are the blessing I did not think I needed. You are such a happy baby. Each of you has seen mommy stressed, frustrated, and even losing my cool, but your love for me has not wavered. I am not perfect, but you think I'm the best mommy, and that means so much to me. I love you all with my whole heart.

Surprise baby, I never thought I would be pregnant without the help of fertility treatments. I was so scared when I found out I was pregnant with you. Anxiety set in, and I was afraid of something horrible happening again. But then I realized I needed to trust God and His masterful plan. I cannot wait to see the person that you will grow up to be. I pray that God continues to allow this pregnancy to continue without a hitch and that you will have a long, healthy life ahead of you. I love you so much, and I have not even met you.

Delc, thank you for being the best mommy a girl could ask for. Thank you for all your prayers and support. Thank you for driving down to keep the kids so I could work on my paper and defend my proposal. Thank you for encouraging me from my youth and telling me I could do anything with God's grace and hard work. Thank you for everything. Love unlimited.

To my family and friends: I told myself I would not try to name everybody because I would forget someone and then feel bad. So, I am not going to do that. But I will give a detailed thank you to ensure I cover all my bases. Thank you for all the prayers and support. Thank you for the words of encouragement. Thank you for the goodies and pick-me-ups. Thank you for offering to keep the kids and for even saving them. Thank you for loving my kids like you love your own. Thank you for the random compliments. Thank you for saying I'm smart. Thank you for celebrating with me. Thank you for being a friend.

Thank you so much to my wonderful dissertation committee, Dr. Jason Ward and Dr. Brandon Simmons. Coming into this dissertation phase of this journey, I was worried and doubted myself a lot. My grandmother, a Ph.D. and retired English professor, had just passed away, and I was anxious because she was my go-to for help. Through your help and guidance, my anxiety lessened. Thank you for your hard work and attention to detail. Thank you for responding to my emails with millions of questions with answers. Thank you for being patient with me. I appreciate you two very much.

Thank you to my participants. Without you, this study would not have been possible. You shared some of the most painful moments of your lives with me and trusted me with your stories. I am in awe of your tenacity, strength, and courage. Through the execution of this research, I hope to honor your stories and your sweet angels. Thank you a million times.

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List of Abbreviations

Cognitive Behavioral Therapy (CBT)

Cognitive Processing Therapy (CPT)

Complicated Grief (CG)

Complicated Spiritual Grief (CSG)

Dilation and Curettage (D&C)

Dual Process Model (DPM)

Interpersonal Therapy (IPT)

Major Depressive Disorder (MDD)

Maternal Antenatal Attachment Scale (MAAS)

Maternal-Fetal Attachment (MFA)

Maternal Fetal Attachment Scale (MFAS)

Posttraumatic Stress Disorder (PTSD)

Premature Rupture of Membranes (PROM)

Prenatal Attachment Inventory (PAI)

Religious/Spiritual (R/S)

Religious Spiritual Struggles (RSS)

Vanishing Twin Syndrome (VTS)

Chapter One: Introduction

Overview

Many families across the world suffer perinatal loss and the grief that follows. Research indicates that experiencing perinatal loss is associated with negative consequences and that sometimes, the grief can be debilitating (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017.) It is common for individuals to turn to religious/spiritual beliefs, practices, and/or communities during times of anguish, but the literature shows that the impact of turning to those beliefs can either be positive or negative (Abu-Raiya et al., 2015; Braam et al., 2019; Exline et al., 2013; Jung, 2020; Villani et al., 2019). Complicated grief (CG) occurs when individuals struggle to adapt to their loss (Burke & Neimeyer, 2012; Burke & Neimeyer, 2013; Burke et al., 2011), and this experience is documented through the literature relating to perinatal loss and grief (Gold et al., 2014; Huffman et al., 2015). However, one aspect that has not yet received much attention in the literature is the issue of complicated spiritual grief (CSG), a spiritual struggle associated with CG for those experiencing a traumatic loss (Burke et al., 2011; Neimeyer & Burke, 2017).

This chapter addresses the background of perinatal loss through a historical and social context, introduces the theoretical framework, highlights the reason for exploring this phenomenon, provides the problem and purpose statements and shows the significance of the study. In addition, I present the study's problem and purpose, a central research question and sub-questions, and a list of defined terms.

Background

While grief is a universal response to the loss of a loved one and the grief that results from perinatal loss (i.e., early or late-term miscarriage, stillbirth, ectopic pregnancy), it can

manifest itself in different ways. One factor that impacts how grief manifests itself is the ambiguous nature of perinatal loss, which often leads to disenfranchised grief (Lang et al., 2011). In many instances, this leads to the bereaved struggling to adjust to their loss, causing them to experience what is known as CG (Gold et al., 2014, Lang et al., 2011). Other factors complicating grief are the gestation period and reproductive and fertility history (Gold et al., 2014; Huffman et al., 2015; Lang et al., 2011). In addition, individuals with religious/spiritual beliefs often turn to their beliefs and community during grief and distress (Abu-Raiya et al., 2015; Klausi & Caudill, 2018; Villani et al., 2019). However, in some instances, individuals begin to have conflict, experiencing doubt and tension within their beliefs, which negatively impacts their grief, known as complicated spiritual grief (CSG) (Burke et al., 2011; Exline, Pargament, et al., 2014). CSG can negatively impact not only the grief experience, but CSG can also contribute to further distress. This aspect of grief is a significant problem that needs thorough examination to bring awareness to these experiences. Therefore, providing historical, social, and theoretical insight is beneficial.

Perinatal loss is not new. Although the topic has historically been considered taboo, there is historical evidence for perinatal loss. A trip to an old cemetery provides a wealth of information for anyone interested in history. Looking at headstones provides a chilling reminder of the dangers associated with pregnancy, childbirth, and infancy. One would be surprised at the number of women buried with an unborn or neonate. One early example of perinatal loss is in the Bible in the book of 2 Samuel. Following David's unfortunate actions with Bathsheba and Uriah, the prophet Nathan informed David that his infant son would die (2 Samuel 12: 14, New International Version). After he was born, he was stricken with an illness and lived for seven

days before he died (2 Samuel 12: 18, New International Version). This account took place sometime after 960 BC. Historical accounts of perinatal loss exist but are sparse in the literature.

History and archeological journals present earlier historical accounts of perinatal loss. For example, one researcher examined maternal and infant death evidence in medieval Ireland. The researcher found that miscarriages and stillbirths were common (Murphy, 2021). In addition, many folklore accounts detail the use of herbs and other remedies to assist in passing the deceased baby from the mother's body to spare her life (Murphy, 2021). Another historical researcher, Felicity Jensz (2020), studied the accounts of female European missionaries and their accounts reported miscarriages, stillbirths, and neonatal loss. These earlier accounts of perinatal loss come from archeological sources (excavations, examining remains), personal accounts (diaries, journals, stories passed down), with a few instances of miscarriages reported in primitive medical notes and references (Jensz, 2020; Murphy, 2021). The lack of earlier accounts of perinatal loss in primitive medical notes and references could be because they did not manage births in hospitals or birthing centers like they are today.

One factor leading to more historical accounts of perinatal loss in medical writings is the shift from births being social events to medically managed events. In the 1800s, births transitioned from being attended by family or community midwives to being medically supervised in a hospital attended by male doctors, traditional midwives, or other trained health professionals, which led to more medical records reporting perinatal loss (Jensz, 2020). Until the 1980s, the research did not cover perinatal loss. According to Wright (2017), perinatal loss has recently gained prominence in research over the past 40 years. Most literature centered on prevalence, causes, attachment, and grief. Recent focuses are investigating coping methods and resources, complicated grief, and the experiences of marginalized populations.

Across the world, the expectation is for women to procreate. For example, scripture states, “God blessed them and said to them, “Be fruitful and increase in number; fill the earth and subdue it” (Genesis 1:28, New International Version). There is an expectation for women to get pregnant and have children without any complications. In a qualitative study exploring women’s experiences of social support after miscarriage, Bellhouse and colleagues (2018) found that many participants experienced loneliness, isolation, and overall poor support because of the stigma surrounding perinatal loss. Unfortunately, while perinatal loss is common, it remains stigmatized (Andalibi, 2021). Perinatal loss even causes women to question God or their beliefs (Allahdadian & Irajpour, 2015; Kalu, 2019). Many of these factors negatively impact the grief, causing a prolonged and complicated grieving process filled with religious spiritual struggles (RSS).

People use religion/spirituality in times of distress. Perinatal loss is no exception to that rule, especially for those with religious/spiritual (r/s) beliefs. According to Pargament’s (1997) theory of religious coping, using religion/spirituality is helpful in the search for significance and a means of coping. People use r/s beliefs as a coping mechanism to understand and deal with life stressors in ways related to the sacred (Pargament et al., 2011). Based on this, someone can use religious coping to understand why perinatal loss occurred and to deal with the grief related to that loss. However, it is essential to note that this has positives and negatives.

According to the assumptions of the theory of religious coping, religious coping can have positive or negative impacts when used. There are instances of religious coping providing comfort and solace and instances of religious coping providing confusion and distress. Research on perinatal loss and religious coping has associated positive religious coping with less distress and negative religious coping with more distress (Cowchock et al., 2011). Literature on traumatic

loss also associates negative religious coping with the development of CSG (Burke & Neimeyer, 2013; Burke et al., 2011; Neimeyer & Burke, 2017). In cases of perinatal loss, religious coping can be helpful or harmful, resulting in positive or negative impacts on the overall grief experience for the bereaved parents.

Situation to Self

Although we had only been married for a few months, my husband and I felt ready to expand our family. After two rounds of fertility treatments, we were elated to learn we were pregnant and even more surprised when we discovered we would have twins. My pregnancy progressed normally and without any complications. At our anatomy scan, we learned we would have a girl and a boy. Shortly after that scan, I began feeling discomfort at work. I brushed it off as everyday pregnancy aches and pains and continued my day. The pain was still there that evening, so I called my OB/GYN, requesting an appointment the next day, and went to bed.

Throughout the night, I woke up in excruciating pain. I cried myself to sleep and did my best to keep quiet, so I would not wake up my husband. Early the following day, I went to the bathroom and felt something slide out of my body. I was frightened and woke my husband to take me to the local emergency department. Once there, they confirmed my worst fears. It was our baby girl's amniotic sac, and I was completely dilated and effaced at 20 weeks gestation. The ambulance rushed me to the hospital in a neighboring county where my OB had privileges, and they admitted me. The doctors told me there was nothing they could do outside of bedrest and fluids because the risk of infection was too significant. This day was August 28, 2015. I went into labor with our daughter, Zoë-Paige, on August 31. She lived for a little over an hour before she died. I went into labor with our son, Richard, on September 2. It just happened to be my

birthday. He lived for a little over an hour before he died. I was heartbroken, shocked, angry, and traumatized.

I immediately began questioning why a loving God could allow me to experience something like that. We had done everything right. We were married, employed, and not abusing drugs or alcohol, so I figured we were not doing anything to deserve punishment in this manner. I was angry with God. I spiraled into a deep depression. The following year we could conceive, and while I was anxious and doubtful, it was a successful pregnancy. However, future attempts to continue expanding our family were not as easy. I suffered an early-term miscarriage in 2018, and then in 2019, I suffered a second-trimester miscarriage of identical twins. Later in 2019, I was pregnant with twins again, but by the 10th week of that pregnancy, one twin miscarried (vanishing twin syndrome), and I was able to bring our daughter into the world in 2020. We recently had another little girl in 2021.

This study has personal significance because I have experienced perinatal loss four times. I grew up in church, believe in God, and love God wholeheartedly. Still, after my first loss, I could not understand why and my questioning turned into doubt. I wrestled with what I believed for years, even after the birth of my son—experiencing these RSS through negative religious coping impacted my psychological health and spiritual well-being negatively and further complicated my grief. In my social circles, I felt ashamed to admit that I questioned my belief in God and His love for me. I often wondered if other women with religious/spiritual beliefs who experienced perinatal loss also experienced RSS, what type of religious coping methods they utilized, and how it impacted their grief.

Even though I have experienced perinatal loss, I understand that others may have vastly different experiences. The ontological philosophical assumption led to my choice of research. I

based this research on an ontological philosophical assumption that supports the understanding that individuals have different realities (Creswell & Poth, 2018). By using an ontological assumption, I acknowledge multiple realities and can highlight various perspectives and experiences (Creswell & Poth, 2018). Additionally, a pragmatic framework shapes this study because the focus is on the research outcome and finding a solution to the problem (Creswell & Poth, 2018). While perinatal loss is frequently researched, some aspects, like experiences with CG, RSS, and CSG, are not addressed. One way to solve this problem is by sharing the lived experiences of women who have faced this.

Problem Statement

The problem is the nature of the grief associated with perinatal loss and the implications this has for the overall grief experience. Perinatal loss disrupts the natural order of life and death and represents a harsh ending to the hopes and dreams parents had for their children (Znoj & Keller, 2002). In the literature, researchers discuss the use of religion/spirituality as a means of coping with traumatic losses like perinatal loss, but they also discuss the potential complications that impact those with religious/spiritual (r/s) beliefs (Abu-Raiya et al., 2015; Klausi & Caudill, 2018; Villani et al., 2019). These factors impact the grief experience, often resulting in persistent grief, or CG (Burke & Neimeyer, 2012; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017). In addition, research on CG has an association with another troubling form of grief known as complicated spiritual grief (CSG) (Burke & Neimeyer, 2013; Burke et al., 2011). Unfortunately, the current literature on perinatal loss, CG, and CSG falls short, thus creating the necessity for this study. Therefore, this study focuses on women with r/s beliefs who experienced perinatal loss. It is essential to explore and describe their experiences navigating perinatal loss, their use of religious coping, and how it impacted their grief and spiritual well-being.

Purpose Statement

The purpose of this phenomenological study is to describe the experiences of grief, coping, and spiritual crises in the lives of women who faced perinatal loss. CSG is generally defined as RSS, or tension and distance from God and the religious/spiritual (r/s) community (Burke & Neimeyer, 2013; Burke et al., 2011). The theory guiding this study is the Theory of Religious Coping (Pargament, 1997). Some people use r/s beliefs to cope with adverse life events, like perinatal loss. Based on the theory of religious coping, religious coping can positively or negatively impact grief (Pargament et al., 2011). The use of positive religious coping positively impacts grief, while negative religious coping negatively impacts grief leading to CG (Kersting & Wagner, 2012; Kishimoto et al., 2021). CG is associated with CSG in research, but the focal point of the studies is violent losses as opposed to other forms of traumatic loss (Burke et al., 2011). Thus, it is important to describe these lived experiences of this specific population of women who have experienced perinatal loss to add to the body of the literature.

Significance of the Study

Due to the prevalence of perinatal loss and those who possess r/s beliefs in the United States, community counselors, other members of the mental health profession, and even clergy will likely encounter someone grieving the loss of their baby. Statistics show that 1 in 5 pregnancies ends in loss (Boynton, 2018). In addition, research indicated that the bereaved parents are likely to experience anger, shock, and psychological distress like depression, anxiety, posttraumatic stress disorder (PTSD), and persistent grief (i.e., complicated grief, CG) (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017). CG is associated with adverse mental health implications, and it is also associated

with another troubling form of grief known as complicated spiritual grief (CSG; Burke & Neimeyer, 2013; Burke et al., 2011).

One of the prominent themes within the literature is using religion/spirituality as a resource during times of distress, like grief. Most Americans have religious or spiritual beliefs (McGoldrick et al., 2016). Although many famous psychologists, like Freud, were critical of religion, he admitted that having religious/spiritual beliefs could benefit an individual's overall mental health (Freud, 1930/2018). Hence, the body of literature regarding the relationship between religion and mental health is vast. The literature indicates a positive association between religion/spirituality and grief (Abu-Raiya et al., 2015; Klausi & Caudill, 2018; Villani et al., 2019). The literature also indicates a positive association between religion/spirituality and increased distress (Abu-Raiya et al., 2015; Exline, Grubbs, et al., 2014; Exline, Pargament, et al., 2014). There is a wealth of research on various aspects of religion/spirituality to alleviate or exacerbate the effects of adverse life events.

Even though there is increased research on grief and perinatal loss, and there is an impressive body of literature concerning the impact of religion/spirituality during times of grief, some aspects of grief have not received much attention as it relates to perinatal loss. Literature highlights an association between CG and CSG (Burke et al., 2011), but there is a gap regarding perinatal loss. While perinatal loss is widespread and a traumatic loss, little research has been done to describe further the experiences of grief, religious coping, and spiritual crisis in the population of women who have had perinatal loss.

Research Question

The research question is how do women with r/s beliefs describe their lived experience of grief from perinatal loss? The question centers on the grief experience related to perinatal loss,

CG, and CSG. Studies show that various factors contribute to the intensity of grief related to perinatal loss and the experience (Cassaday, 2018; Gold et al., 2014; Goldman et al., 2014; Huffman et al., 2015; Isguder et al., 2017). Religious coping can impact the grief experience, which can be positive or negative. According to the literature, positive religious coping affected grief positively, and using negative religious coping worsened grief and led to CG in studies of women who experienced perinatal loss (Cowchock et al., 2011). Researchers indicate that the impact of religion/spirituality is mixed. Some studies on perinatal loss and religion/spirituality report positive impacts (Fenstermacher & Hupcey, 2013; Kavanaugh & Hershberger, 2005) and negative impacts (Bakker & Paris, 2013; Fenstermacher, 2014; Sturrock & Louw, 2013) on r/s beliefs. Although grief differs in individuals, it is essential to allow each participant to describe their grief experiences after their loss.

Definitions

Definitions are provided for the terms significant to the stud to provide clarity to the study. The terms are bereavement, chemical pregnancy, complicated grief (CG), complicated spiritual grief (CSG), dilation and curettage (D&C), ectopic pregnancy, grief, molar pregnancy, negative religious coping perinatal loss, positive religious coping, religion, religion/spirituality, religious/spiritual (r/s), religious spiritual struggles (RSS), spirituality, stillbirth, and vanishing twin syndrome (VTS).

1. *Bereavement*- the experience of a loved one dying (Shear, 2012)
2. *Chemical Pregnancy* – a positive pregnancy test (urine or blood detecting the presence of human chorionic gonadotropin (hCG), it is a pregnancy loss that happens before the 5th week (Annan et al., 2013). In chemical pregnancies, the egg is fertilized but does not fully implant in the uterus (Annan et al., 2013)

3. *Complicated grief (CG)*- an impaired form of grief that causes increased pain characterized by prolonged and intense symptoms of grief, complicated thoughts, frequent questioning and ruminating, and feelings of guilt, envy, or anger. Thereby causing distress and interfering with the healing process (Shear, 2012)
4. *Complicated spiritual grief (CSG)*- a form of distress in grief characterized by the presence of religious spiritual struggles (RSS) such as wondering why God is punishing them, questioning God's love, doubting religious/spiritual beliefs, feeling like an outsider in the church community, and more (Burke et al., 2011).
5. *Dilation and curettage (D&C)*- a procedure, typically done in the first trimester following a miscarriage that allows the surgeon to remove the products of conception from the uterus (Boynton, 2018).
6. *Ectopic pregnancy*- a pregnancy where the fertilized egg implants in a place other than the uterus, commonly the fallopian tube, but can occur in other reproductive organs as well (Boynton, 2018).
7. *Grief* – the natural response to bereavement categorized by sadness and yearning (Shear, 2012).
8. *Miscarriage*- also referred to as spontaneous abortion, a naturally occurring event resulting in the loss of a fetus before the 20th week of pregnancy, commonly caused by chromosomal problems that impede the development of the baby (Boynton, 2018). Other causes include substance abuse, clotting disorders, hormonal problems, weight, issues with the mother's reproductive organs, the body's immune response, infection, smoking, other preexisting conditions in the mother, and in other cases the cause is unknown (Boynton, 2018).

9. *Molar pregnancy*- a pregnancy where a nonviable, fertilized egg implants in the uterus but does not come to term (Boynton, 2018).
10. *Negative Religious Coping*- religious coping practices shown to have detrimental impacts on those experiencing negative life experiences (Bjork & Thurman, 2007). Strategies include viewing the stressor as punishment from God, trying to cope on one's own without any r/s help, feeling abandoned by God, questioning God, doubting God's love (Burke et al., 2011; Lee et al., 2013; Pargament et al., 2011)
11. *Neonatal death*- a type of perinatal loss where the baby is born alive but dies within the first 28 days of life (Boynton, 2018).
12. *Perinatal loss*- loss of an infant through unintended or involuntary loss of pregnancy by miscarriage (early losses <20 weeks; chemical pregnancy, ectopic pregnancy, molar pregnancy, vanishing twin syndrome) stillbirth (>20 weeks), neonatal death (within the first 28 days) (Boynton, 2018; Fenstermacher & Hupcey, 2013).
13. *Positive Religious Coping*- religious coping practices shown to have positive impacts on those experiencing negative life experiences (Bjork & Thurman, 2007). Strategies include viewing God as a partner, turning to a faith-based community for support, seeking God's love, and viewing the stressor as helpful or constructive (Pargament et al., 2011).
14. *Religion*- religious practices, beliefs, and feelings expressed denominationally or institutionally (Richards & Bergin, 2005). The practices and beliefs and feelings include scriptural or sacred text readings, fellowship through weekly meetings, and taking part in sacred rituals/customs (Richards & Bergin, 2005).

15. *Religion/Spirituality*- used to delineate a person that has religious beliefs, spiritual beliefs, or a person that expresses their spirituality in and out of an institutional setting (Pargament, 1999; Richards & Bergin, 2005).
16. *Religious Spiritual Struggles (RSS)*- Struggles that develop as a result of one aspect of a r/s practice of belief becoming a focus of negativity stemming from the processes that guide in the search for significance (Exline, Pargament, et al., 2014; Pargament & Exline, 2022). RSS are broken into 3 domains; supernatural (divine, demonic), interpersonal, and intrapsychic or intrapersonal (moral struggles, doubt-related struggles, and struggles of ultimate meaning) (Exline, Pargament et al., 2014).
17. *Religious/Spiritual (R/S)*- the abbreviation used to represent religious/spiritual, commonly used by researchers in the field (Pargament, 1996). With the influx of people identifying as spiritual but not religious, there is a negative connotation surrounding religion (Pargament, 1999). However, people can express their faith beliefs in an institution and still have the spiritual component of the closeness and oneness with God (Pargament, 1999; Richards & Bergin, 2005).
18. *Spirituality*- a personal connection with a higher being or deity (referred to here as God) with an emphasis on the connection and closeness to God (Richards & Bergin, 2005).
19. *Stillbirth*- a loss that occurs after 20 weeks, typically resulting in the baby dying in utero, or in other instances, the mother has to give birth to the child/ren and they die shortly after being born because they were too young to survive outside of the womb (Boynton, 2018)
20. *Vanishing Twin Syndrome (VTS)*- a pregnancy that begins as a twin pregnancy, but one twin miscarries causing the pregnancy to become a singleton pregnancy. It occurs when

one twin stops developing, the baby that stopped developing typically reabsorbs into the body or is passed during the birth of the surviving twin depending on gestation that development stopped (Zamani & Parekh, 2021).

Summary

Every positive pregnancy test does not result in a happy ending. Many families will move from joy to sorrow because they have experienced perinatal loss. The term perinatal loss covers several types of loss, from early miscarriage to neonatal death (Boynton, 2018; Johnson et al., 2016). Because of cultural and societal norms, the grief experience for bereaved parents is largely disenfranchised, partly due to the ambiguous nature of the loss (Lang et al., 2011). Additionally, aspects related to reproductive history and gestation, along with other factors, have also been shown to complicate grief further (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017). While the parents may turn to r/s beliefs and practices to help cope, the literature shows that there can be positive and negative implications (Fenchermaster & Hupcey, 2013). In other grief-related literature, the experience of RSS during grief is referred to as CSG (Burke et al., 2011). Despite this information, there are still gaps in the literature regarding CG, CSG, and perinatal loss. Thus, this study aims to address that gap and add to the literature by describing the experiences of grief, religious coping, and spiritual crisis in the population of women who have had perinatal loss.

The next chapter includes a literature review on perinatal loss, grief, and religion/spirituality. The chapter will address the theoretical framework for the study and the rationale, followed by a detailed review of the literature. Additionally, the chapter addresses the literature gaps that prompt the study's necessity.

Chapter Two: Literature Review

Overview

The death of a loved one and the following grief are experiences everyone will have in life. However, there are some types of loss that only certain people experience, and one of those is perinatal loss. Perinatal loss is a traumatic loss that shatters the hopes and dreams of men and women worldwide. The stage of the pregnancy, the woman's reproductive history, and underlying mental health conditions can make grieving worse (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017). Additionally, because perinatal loss is ambiguous, individuals are often left searching for ways to handle their grief and distress while navigating a disenfranchised grief experience (Lang et al., 2011). Sometimes, individuals have a more disruptive, longer-lasting grief response, known as complicated grief (CG) (Kersting & Wagner, 2012; Kulathilaka et al., 2016). When a traumatic loss or stressor, like perinatal loss, occurs, individuals who espouse r/s beliefs often turn to their religious/spiritual communities and practices for comfort, strength, and refuge (Pargament, 1997; Pargament et al., 1998; Pargament et al., 2000; Pargament et al., 2007). Conversely, turning to religion/spirituality in a maladaptive way can negatively impact an individual (Lee et al., 2013; Pargament et al., 1998; Pargament et al., 2000; Pargament et al., 2011). Researchers have now indicated associations between CG and complicated spiritual grief (CSG), a spiritual struggle following loss often manifested as a divine or doubt-related struggle (Burke et al., 2011; Shear, 2012). Therefore, I seek to understand the phenomena of CG and CGS relating to perinatal loss.

This chapter is a review of the literature on perinatal loss, grief, and religion/spirituality. First, the study's theoretical framework is identified by examining Pargament's (1997) Theory of

Religious Coping concepts. Next, there is a detailed review of the related literature. Following the literature review, I highlight the gaps that prompted this study's necessity.

Theoretical Framework

Grounding a study within an established theoretical framework helps establish the significance of the study. The Theory of Religious Coping serves as the theoretical framework for the study and allows the findings to be situated within a greater context. This research was grounded in the theory of religious coping. This theory originated from the work of Pargament and others interested in the relationship between religion and coping (Pargament et al., 2011). When an adverse event occurs in an individual's life, they often try to find ways to cope with that situation and its impact on their life. However, coping is traditionally viewed without any attention to religion or spirituality. Therefore, researchers were specifically interested in the relationship between religion and coping associated with mental health and adjustment to adverse life events (Pargament et al., 2011). Furthermore, this theory is supported by the assumption that religion/spirituality should be considered in the context of mental health to treat the whole person (Pargament et al., 1998). As a result, Pargament developed the theory of religious coping.

In his research, Pargament (1997) noticed that individuals desire significance. Significance can include the purpose or the meaning of life, refuge from pain, belonging in a community, and improving physical and mental health. When an internal or external stressor threatens our significance, coping is warranted (Pargament, 1997). According to Pargament (1997), coping is attempting to find significance in stressful situations. There are two types of coping methods. The two coping methods are conservation and transformation (Pargament, 1997). The conservation coping method is used to protect one's significance and is the strongest

method utilized (Pargament, 1997). Transformation is used when preserving or protecting significance is no longer possible, so new significances must be formed (Pargament, 1997). These methods mutually rely on one another to help individuals face and overcome stressors (Pargament, 1997). Pargament incorporated the concept of religion/spirituality to connect this to the sacred.

Religion/spirituality is often used in the search for significance. It is also a means of coping. As a method to conserve significance, religion/spirituality is beneficial in providing support from God/divine entity and community, a way to reframe the adverse event into an opportunity for growth, or through rituals of prayer and the readings of the sacred text (Pargament, 1997). People use religion/spirituality as a method to transform. R/s beliefs can help individuals make meaning of circumstances and provide clarity when old assumptions are ruined (Pargament, 1997). Pargament defined religious coping as "efforts to understand and deal with life stressors in ways related to the sacred" (Pargament et al., 2011, p. 52). The theory of religious coping intersects religion with the theories of general coping perfectly.

Building from Pargament's initial work on the theory of religious coping, researchers added to the theory by forming categories of religious coping. Mahoney and colleagues (2006) identified two categories: primary religious appraisals and religious coping processes. Essentially the primary religious appraisal stems from Lazarus and Folkman's (1984) definition of the primary appraisal. The appraisal refers to an individual's perception of the event. In the theory of religious coping, if an event is perceived as threatening, individuals use the religious coping processes (Mahoney et al., 2006). In addition, some thoughts can be helpful (thinking that it is all in God's plan) or harmful (assuming it is punishment for sin), which reflect the individual's coping goal (Mahoney et al. 2006). The overall goal falls into one of four categories: religious

coping for control, religious coping for comfort, interpersonal religious coping, and transformative religious coping (Mahoney et al., 2006). Pargament's theory has several assumptions.

The assumptions of Pargament's theory are explained in this paragraph. The first point is that religious coping can have different purposes (Pargament et al., 2011). For example, religious coping can be used in the search for meaning or identity, the search for the sacred, or to quell anxiety (Pargament et al., 2011). Second, religious coping involves emotions, behaviors, thoughts, and relationships (Pargament et al., 2011). The third is that religious coping changes over time, situation, and setting. The fourth is religious coping is a process that can lead to beneficial or harmful outcomes (Pargament et al., 2011). Finally, the fifth concept is that religious coping adds something to the coping process because it is concerned with the sacred, and the last is that because of its focus on religion, religious coping can be helpful in our understanding of religion and its benefits/risks (Pargament et al., 2011). In this study, the assumptions help explain the problem and develop the purpose of the study.

Application of Religious Coping

In recent years, religious coping has been investigated in various studies. Researchers have applied the theory of religious coping to studies on trauma, illness, depression and anxiety, grief, and more. One cross-sectional study examined the relationship between religious coping strategies and emotional adjustment in women with infertility problems (Nouman & Benyamini, 2018). Researchers found that using positive religious coping methods was associated with reduced psychological distress, whereas other coping methods, like validation seeking, were linked to more psychological distress (Nouman & Benyamini, 2018). Wilt and colleagues (2019) conducted a study investigating what aspects of religious coping were associated with spiritual

growth. The research indicated that viewing themselves as a partner with God (an element of positive religious coping) was related to positive spiritual transformation after experiencing RSS (Wilt et al., 2019). Religious coping has been examined in qualitative studies as well.

In a qualitative study investigating religious coping and divorce, Simonič and Klobučar (2016) found that religious coping was helpful in the participants' efforts to cope with the stress caused by divorce. However, different forms of religious coping also led to varying perceptions of divorce (Simonič & Klobučar, 2016). Zhang and colleagues (2021) recently conducted a qualitative study investigating RSS and coping during the COVID-19 pandemic. The study results showed that 26% of the participants engaged in religious coping to maintain a connection to God during times of confusion (Zhang et al., 2021). These studies show that the theory of religious coping is helpful in qualitative studies to help understand a phenomenon potentially.

My specific research focus relates to the theory of religious coping in several ways. First, the literature indicates that religion helps cope with life's difficulties, including losing a child (Pargament, 1997). Secondly, the literature is clear that religious coping can have benevolent or malevolent impacts on the coping process (Pargament, 1997). Cowchock and colleagues (2011) found that positive religious coping was associated with lower perinatal grief scores, while negative religious coping was associated with higher scores. Additionally, this study indicated that negative religious coping puts women at risk for developing CG (Cowchock et al., 2011). Kalu (2018) identified three themes in a qualitative study investigating women's experiences of religious coping after miscarriage. For example, Kalu (2018) found that women were angry with and questioned God but eventually found meaning in their loss. The study results indicated that religious coping was helpful in the lives of women experiencing perinatal loss (Kalu, 2018). In

addition to religious coping being useful in studying perinatal loss and grief, religious coping is also helpful in studying RSS.

RSS are not uncommon after a loss like perinatal loss. Cruz-Ortega and colleagues (2015) found that r/s-based messages had mixed results on the development of RSS. Some messages were associated with healing, while others were associated with RSS (Cruz-Ortega et al., 2015). For example, someone could say that the loss is all a part of God's plan and can either be helpful or harmful to an individual experiencing loss. For someone who views this as a positive, it would be no issue, but for someone who views this as a negative, it could cause more significant distress (Seftel, 2006). Additional research showed that questioning why and doubting God (engaging in a negative religious coping practice and RSS) is associated with rejecting or strengthening r/s beliefs (Tedeschi & Calhoun, 2004). The theory of religious coping helps examine the grief related to perinatal loss and experiences of CG and CSG.

Grief is a normal response, but it manifests itself in ways outside the norm in certain situations. In situations where the bereaved experience distress, or CG, it can further complicate the coping responses and even lead to CSG (Burke & Neimeyer, 2012; Burke & Neimeyer, 2013 Burke et al., 2011; Shear, 2012). Perinatal loss was a precursor for experiencing CG in a study investigating the factors that impact grief after perinatal loss (Kersting & Wagner, 2012; Kishimoto et al., 2021). The literature on perinatal loss and grief points to associations between religious coping and grief outcomes. I hope to expand this theory by exploring the lived experiences of those who have experienced perinatal loss and CG and its impact on their spiritual well-being.

Perinatal Loss

Most young couples are excited to begin their families by adding a child. Unfortunately, the road to realizing that dream is full of heartache and unimaginable pain for many. Statistics show that many pregnancies will end in the loss of the baby. Specifically, 1 in 5 pregnancies ends in losing the baby (Boynton, 2018). Over 80% of the losses occur in the first trimester of pregnancy (Boynton, 2018). Some women will experience an ectopic pregnancy when the baby implants in a place other than the uterus (Boynton, 2018). In other cases, women can experience a molar pregnancy when a nonviable, fertilized egg implants but does not come to term (Boynton, 2018). Other forms of loss can occur later in the pregnancy, like a stillbirth or even after the baby is born within the first minutes to the first month of life (early neonatal death) (Johnson et al., 2016). All of these represent perinatal loss.

The risk of miscarriage rises with maternal age. For women under 30, the risk is 7-15%, increasing to 34-52% for women over 40 (Huffman et al., 2015). Miscarriage can occur because of chromosomal abnormalities causing the pregnancy to develop abnormally (Huffman et al., 2015). Other causes are hormonal issues that impact pregnancy, like diabetes, thyroid problems, and high blood pressure (Boynton, 2018). There could also be problems with the mother's reproductive organs, like an incompetent cervix that causes the cervix to open early and the baby to be born too soon. The baby's placenta can also cause issues leading to loss. Falls, injury to the abdomen, and other incidents can lead to trauma and the baby's death (Boynton, 2018). Birth is also traumatic, leading to many problems during labor and delivery, like a prolapsed umbilical cord or birth asphyxia, causing the baby to die (Boynton, 2018). In other instances, no definite answers explain what causes perinatal loss.

Symptoms of Perinatal Loss

The symptoms of perinatal loss are primarily physical. Physical symptoms include stomach pain, period-like cramps, vaginal bleeding, passing clots, and reduced pregnancy symptoms (Boynton, 2018). In cases where the loss is further along, the symptoms might stop, and the mother could not feel the baby moving anymore (Boynton, 2018). In their book, Grief and Loss Across the Lifespan: A Biopsychosocial Perspective, McCoyd, and Walter (2015) discuss some physical symptoms associated with perinatal loss. Hormone levels eventually decrease, leading to symptom reduction and cessation (McCoyd & Walter, 2015). The McCoyd and Walter (2015) text also covers emotional and psychosocial symptoms. The physical and emotional pain is grueling if a woman has to give birth to a stillborn baby or a baby they know will not live long after birth (McCoyd & Walter, 2015). Hormonal changes also can cause baby blues and lead to postpartum depression, which is worsened by the loss (McCoyd & Walter, 2015). Perinatal loss is not only physically painful, but the emotional toll of the loss is also significant.

Impact of Perinatal Loss

Those who have experienced perinatal loss would say nothing is positive about the experience. Immediately during and after the loss, there are feelings of shock, anger, disbelief, anger, and fear (Boynton, 2018). Parents who experience losses after the first trimester also report feeling embarrassed because they embraced that they would be parents and now have to explain what happened (Christiansen et al., 2014). Many women feel like a failure because their bodies did not sustain the pregnancy, making them feel like they did not do what they were designed to do (McCoyd & Walter, 2015). Men may feel like they did not protect their partner and child. Some of these feelings lead to more psychological consequences.

Perinatal loss harms mental health. In a study conducted to investigate how women who had a miscarriage respond to trauma, what coping strategies they use, and what factors indicate posttraumatic growth, researchers found that the women who experienced perinatal loss experience psychological distress (Isguder et al., 2017). Perinatal loss can lead to anxiety, acute and posttraumatic stress disorder (PTSD), substance abuse disorder, and more (Isguder et al., 2017). A study investigating the prevalence of psychological distress in women after early pregnancy loss found that after the loss, 25% of the participants had symptoms of PTSD, 32% anxiety, and 15% depression, while three months after the loss, 35% had PTSD (Farren et al., 2016). Other studies indicated that grief, anxiety, and depression could develop in the weeks and years following the loss (Brier, 2004; Cumming et al., 2007; Lok & Neugebauer, 2007; Neugebauer et al., 1992). In a study investigating the impact of perinatal loss on psychological functioning, Cassady (2018) found that the grief and psychological effects of the loss are long-lasting, in most cases, between one to two years. Hamama and colleagues (2010) found that women explain grief from perinatal loss differently from other types of grief. A lesser-discussed aspect of perinatal loss is the impact on men.

Impact on Men

Perinatal loss is centered mainly around the woman, so the male partner is often an afterthought. Historically, research on the effect of loss on men was rarely discussed or researched. This omission led researchers to conduct a qualitative study to understand the male partner's experience (Miller et al., 2019). This study identified five themes that explained how men felt, their perceived role, coping strategies, lack of healthcare support, and the need to share their experiences (Miller et al., 2019). Other studies identified similar findings related to the impact of perinatal loss on men. Men view their role as supporters; their main focus is supporting

their partners. Because of this and other factors, they deal with the loss less openly (Due et al., 2017; Farren et al., 2021; Jones et al., 2019; Lizacno Pabón et al., 2019; Miller et al., 2019; Nguyen et al., 2019). A meta-synthesis study examining the male experience of perinatal loss found that men tend to blame themselves similarly to the mothers and would benefit from the support of family, friends, and healthcare professionals following the loss (Aydin & Kabukcuoglu, 2020). Another study investigating what contributes to the male partner's grief indicated that men experience a high degree of grief after loss (Obst et al., 2021). This study identified several factors that can impact the intensity of a man's grief. The factors include support, loss history, marital satisfaction, and attachment to the baby (Obst et al., 2021). Perinatal loss affects the woman and man individually and impacts the couple's relationship.

Impact on the Couple

Perinatal loss is hard on a couple. In a study applying the Relational Turbulence Theory perspective to grief following a miscarriage, Tian and Solomon (2020) found that many changes negatively impact the couple. Issues include difficulty expressing emotion, decreased togetherness, increased tension, feelings of disconnectedness, and decreased sexual intimacy (Tian & Solomon, 2020). According to the Relational Turbulence Theory, changes in the relationship environment can amplify qualities that intensify specific experiences (Tian & Solomon, 2020). The cognitive appraisals of trauma directly impact the trauma's intensity (Tian & Solomon, 2020). Additionally, the loss causes a shift because the couple is transitioning and preparing for a baby, and that transition is drastically halted, causing more uncertainty in the relationship (Tian & Solomon, 2020). The loss causes self-uncertainty, partner uncertainty, and relationship uncertainty (Tian & Solomon, 2020). In this situation, the partners' ability to

influence and assist each other can be harmful or helpful (Tian & Solomon, 2020). The strain on the couple and the other stressor may worsen the grief experienced after perinatal loss.

Grief

After a loved one dies, people typically experience deep sorrow related to their death, known as grief. Grief is a normal response to a loss and is such for perinatal loss. When discussing grief, most people gravitate to Kubler-Ross's five-stage grief model presented in her book On Death and Dying (1969). In the book, she described the stages of grief as denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). However, John Bowlby developed the stage-theory model for describing grief in his extension of Freud's concept of grief work (Strobe et al., 1992). According to Bowlby, grief is a form of separation anxiety because the bereaved seek to restore the bond severed by the individual's death (Bowlby, 1980). However, restoring attachment was not ideal or beneficial for healing, so the relationship had to transform to adjust to a new reality (Strobe et al., 1992). As a result, Bowlby presented four phases of grief: numbing, yearning and searching or disbelief, disorganization and despair, and reorganization (Bowlby, 1980). In alignment with his attachment theory, Bowlby's approach centers on believing that the maternal-child relationship indicates how an individual will grieve (Bowlby, 1980). Therefore, theorists developed stage theories from Bowlby's work.

Earlier, Kubler-Ross' theory was discussed. Other stage theories include Worden's (2009) four tasks of grieving. The tasks are accepting, processing, adjusting, and seeking a new connection (Worden, 2009). One component of his beliefs is that the individual must complete a task for any adjustment (Worden, 2009). These theories provide a basic understanding of grief's nature but do not consider the nature of perinatal loss and its complexities. Unfortunately, many

people still do not understand why parents may grieve after losing a baby. The attachment theory is an excellent way to explain a grief reaction.

Attachment Theory to Explain Perinatal Grief

The foundation of maternal-fetal attachment (MFA) stems from Bowlby's Attachment Theory. According to Bowlby's Theory of Attachment, to develop into healthy individuals, infants need a nurturing, consistent relationship with a caregiver (Bowlby, 1979/2015). People turn to their attachment figures for safety and security. Unresponsiveness can contribute to insecure attachment and psychopathology, whereas responsiveness contributes to secure attachment and a low risk for distress (Bowlby, 1979/2015., 2016; Cherniak et al., 2021). Bowlby posited that if a child receives comfort from their caregiver, they develop healthy attachment bonds that transfer to other relationships (Bowlby, 1979/2015). On the other hand, rejection of affection and attention keeps a child from developing healthy attachment styles that can hinder them in future relationships (Bowlby, 1979/2015). Theorists applied the attachment theory to other topics, including the maternal-fetal relationship.

The attachment theory is the basis for numerous studies. For example, to explain the profound grief response after experiencing perinatal loss, researchers might apply the attachment theory through the Maternal-Fetal Attachment Theory. Many women (and men) are emotionally invested in their pregnancy and their child's life from the moment they learn of their pregnancy (Kohan & Salehi, 2017; Ussher et al., 2020). There is a unique relationship between the mother and fetus, and this relationship is crucial because it helps the attachment after birth (Kohan & Salehi, 2017). This attachment is essentially the bond between mother and baby during pregnancy.

There was more research that helped to develop this theory further. Rubin (1977) posited that the bond between mother and child develops during pregnancy due to experiences that create emotional proximity to her baby. Additionally, Cranley (1993) found a concurrent development process wherein the woman develops into a mother while the fetus develops. Rubin (1975, 1984) identified behaviors helpful in fostering the development of MFA, which are specific tasks women navigate through before birth (Rubin, 1975; Rubin, 1984). These behaviors are seeking safe passage, ensuring acceptance of the child by significant persons, binding-in to the unborn child, and giving oneself (Rubin 1975; Rubin, 1984). These behaviors served as the framework for the theory.

After Rubin defined this concept, the theory developed further. Expanding on Rubin's work, Cranley (1979) explained prenatal maternal attachment as the behaviors representing a connection and interaction with their unborn child and described the concept as multi-dimensional. After this, Cranley coined the term "maternal-fetal attachment" to depict the relationship between mother and fetus during pregnancy (Cranley, 1981). MFA has six aspects: differentiation of self from the fetus, interaction with the fetus, attributing characteristics to the fetus, giving of self, role-taking, and nesting (since removed) (Cranley, 1981). Based on this work, in addition to a scale she developed to measure MFA, Cranley is considered the creator of the theoretical concept (Brandon et al., 2009). This account summarizes the official foundation of the theory. The theory's development is crucial, but that does not mean it was without critique.

There were critiques of the theory centered on the aspects included in the development of attachment. Other researchers found that the theory was too limited because of the exclusion of thoughts and fantasies that also were important in developing the attachment between mother and baby (Brandon et al., 2009). Müller proposed incorporating aspects of the mother's

attachment to her mother because she believed that this attachment played a part in the adaptation of the mother to her pregnancy and the baby (Müller, 1990). Additionally, Condon proposed that MFA should include love in how the mother tries to "know, be with, avoid separation or loss, to protect, and identify and gratify the needs of her fetus" (Condon, 1993, p. 359). Doan and Zimerman (2003) redefined prenatal attachment as "an abstract concept, representing the affiliative relationship between a parent and fetus, which is potentially present before pregnancy, is related to cognitive and emotional abilities to conceptualize another human being, and develops within an ecological system" (p. 110). This definition contains crucial aspects from the theory's original definition and essential aspects from some of the original's critiques.

Researchers did additional work to expand the theory. Leifer (1977) attributed the gestational stage of the pregnancy to the strength of the attachment. By this explanation, one could expect stronger MFA during the third trimester because of more intense attachment behaviors (Leifer, 1977). Gaffney (1988) posited that MFA was a crucial aspect of interaction with the baby by a mother before giving birth. While Lindgren (2001) described MFA as existing along with other factors in women's lives, and other researchers attributed a positive pregnancy experience to increased attachment (Caccia et al., 1991). There have also been developments and advancements in the ways MFA is measured.

There were several scales designed to measure MFA. As noted, Cranley developed the Maternal Fetal Attachment Scale (MFAS) based on the six aspects she identified (1981). It was revised to remove the nesting component and was integral in advancing the research of prenatal attachment (Brandon et al., 2009). Müller developed the Prenatal Attachment Inventory (PAI), which is not as widely used as the MFAS (Huang et al., 2004; Müller, 1990). Condon (1993)

developed the Maternal Antenatal Attachment Scale (MAAS), which focused on thoughts and feelings instead of attitude. The MFAS and MAAS are the most commonly used measures to assess MFA (Brandon et al., 2009). The MFAS and MAAS are the scales used in research investigating MFA.

Certain factors can influence maternal and paternal-fetal attachment. Hearing the heartbeat, seeing ultrasounds, and feeling movement are some factors that increase attachment levels (Salisbury et al., 2003). It is important to note that not all women and men have a solid attachment to their unborn child. It is influenced by environmental and cultural factors, mental health conditions, the history of the mother's attachment to her mother (or the father's to his father), social support, age, and gravida (Kohan & Salehi, 2017). Researchers utilize maternal-fetal attachment (and paternal-fetal attachment) to support explanations for the grief and psychological distress experienced following the loss (Branjerdporn et al., 2021; Nguyen et al., 2019). Maternal and paternal-fetal attachment is essential in understanding the grief reactions following the loss.

Complicated Grief

After a loved one dies, people commonly experience deep sorrow related to their death. This sorrow is known as grief. Grief is normal, but some individuals suffer from complicated grief (Burke & Neimeyer, 2012; Burke & Neimeyer, 2013; Shear, 2012; Shear, 2015). Researchers use the term CG to describe situations when grief becomes debilitating. In the early 1900s, Freud began observing debilitating grief, and researchers' interest in this topic continues to date (Koingsberg, 2011). In any situation, an individual can suffer from complicated grief, which is valid for those who experienced perinatal loss (Gold et al., 2014; Kersting & Wagner, 2012). According to Shear (2015), CG impacts a small population worldwide. However, it has

been studied more in-depth in violent, traumatic deaths (Burke & Neimeyer, 2012; Burke & Neimeyer, 2013). Shear (2015) indicated that CG is more common after the loss of a romantic partner (spouse, significant other) and the loss of a child. Even though CG is commonly researched in violent deaths, traumatic deaths, like perinatal loss, can also cause CG.

CG is associated with PTSD symptoms, substance abuse, suicidal ideation, and physical health problems (Shear, 2015). Researchers indicated that PTSD was diagnosed more often for those who held their babies (Turton et al., 2009). While this is a major psychiatric issue, many women who experienced perinatal loss have not received psychological care (Ussher et al., 2020). This fact is disturbing, given the psychological risk factors for developing CG.

Complicated Grief and Perinatal Loss

CG impacts those who have experienced perinatal loss. In a study of bereaved parents after loss, Lin and Lasker (1996) found that 59% of the study participants showed signs of CG. Characteristics of CG include yearning, emotional pain, preoccupied thoughts, denial, and difficulty picturing a future without the deceased (Shear, 2015). Specific to perinatal loss, CG reactions can differ from other CG reactions. Various studies of CG in perinatal loss report guilt and self-blame as common reactions, with many women reporting feeling as if their bodies are failures and that they are somehow less of a woman (Lin & Lasker, 1996; Stirtzinger & Robinson, 1989; Frost & Condon, 1996). Some women report being envious of those who have been pregnant without any complications or losses and find it hard to be around those who may have been pregnant at the same time as them, and this leads to them isolating themselves, which further contributes to the CG (Lin & Lasker, 1996). Other factors associated with perinatal loss are the lack of rituals or norms to honor and celebrate the baby's life.

Researchers have conducted studies to help understand CG in perinatal loss. Kishimoto and colleagues (2021) conducted a recent study to understand specific risk factors for CG following perinatal loss. The researchers found that individuals with certain personality traits and psychiatric symptoms have a long grieving process and a maladaptive coping style (Kishimoto et al., 2021). Other moderating factors include prior losses and a history of infertility. Bhat and colleagues (2016) found that those experiencing infertility often undergo psychological distress. Infertile women and men can experience depression, anxiety, and low self-esteem (Bhat et al., 2016). Those experiencing infertility often have planned pregnancies. Therefore, the loss of one can be especially devastating (Bhat et al., 2016; Huffman et al., 2015). Planned pregnancies and difficulty conceiving are often exclusive to those with fertility problems. Couples with infertility histories tend to have higher levels of distress and an increased sense of hopelessness after a loss (Huffman et al., 2015). Additionally, the gestation period when the loss occurred significantly impacts grief.

It is not surprising that the gestation period impacts grief following perinatal loss. Cassaday (2018) noted that late-trimester losses are a risk factor for more significant emotional distress and intense grief. If the loss is second or third-trimester, the woman may physically give birth to the baby, adding more trauma to an already traumatic situation. Other factors include having prior children, age, gender, and social support (Huffman et al., 2015). There are certain risk factors for developing CG. Mental health disorders can be comorbid with grief responses (Gold et al., 2014). Severe anxiety, social phobia, and obsessive-compulsive disorder (OCD) are comorbid conditions and grief in bereaved mothers (Gold et al., 2014). Women with depression and other psychiatric illnesses have experienced negative adjustment periods after perinatal loss (Huffman et al., 2015). Certain factors contribute to the emotional impact of the loss (Huffman et

al., 2015). Other factors leading to troubling grief responses are no warning signs of the loss and poor coping habits (Isguder et al., 2017). These factors influence the intensity and duration of the grief experienced after a loss.

Another factor related to CG is the ambiguity of the loss and disenfranchisement of grief. Pauline Boss developed the ambiguous loss theory after researching families who experienced stressors of chronic illness, natural disaster, war, and disability (Boss, 2006). Ambiguous loss is defined as an unclear, traumatic loss (Boss, 2006). When working with families in the 1970s, Boss realized that psychological absence could be applicable in other situations and named the term ambiguous loss (Boss, 2007). This loss can be experienced in cases like divorce, having a child with special needs, perinatal loss, and others.

Based on the theory, there are two ways in which one can experience ambiguous loss (Boss, 2006). The first is a physical absence with psychological presence (i.e., early-term losses that include molar and ectopic in addition to vanishing twin syndrome), and the second is a physical presence with psychological absence (i.e., dementia, brain injury, stroke). The loss is not clearly defined as a traditional loss; the typical rituals do not apply, making coping and achieving closure more difficult while increasing the risk of psychological distress (Boss, 2007, 2010). A vital aspect of an ambiguous loss is the lack of validation of the loss.

The concept of disenfranchised grief is also a factor in CG. Disenfranchised grief is when a person's loss is not openly acknowledged and supported or publicly mourned (Lang et al., 2011). The lack of support and validation stems from societal or cultural norms that dictate who should grieve, how they should grieve, and how society should respond to the bereaved (Attig, 2004; Doka, 1989). The societal and cultural norms make it difficult for the bereaved to grieve and essentially disenfranchise the bereaved by interrupting their grieving process (Attig, 2004).

Disenfranchised grief further complicates the grieving process for individuals experiencing perinatal loss.

Many people do not think perinatal loss is traumatic. According to Lang and colleagues (2011), society does not view death in perinatal loss as being traumatic in part to the fact that the baby was not born or, if the baby was born, he or she only lived for a short period, and because of this, the grief cannot compare to the death of an older child or adult. Additionally, in disenfranchised grief, there is no way to acknowledge or validate the grief of the bereaved (Lang et al., 2011). For example, when a loved one dies, it is customary to send cards or flowers, but in disenfranchised grief related to perinatal loss, there are no customs, and an individual may feel like no one cares about their loss.

Five conditions could lead to disenfranchised grief (Doka, 2002). The conditions are excluding the griever, circumstances surrounding the death, not recognizing the relationship, not acknowledging the loss, and the ways individuals grieve (Doka, 2002). One aspect of disenfranchised grief that complicates grief following perinatal loss is the attempt to make meaning of the loss because of the lack of acknowledgment, social support, and public mourning.

Lack of Acknowledgement, Social Support, and Public Mourning

A common theme in the literature regarding disenfranchised grief and perinatal loss is negative interactions with medical personnel. Historically, following a stillbirth, parents were discouraged from seeing or interacting with their baby (Blood & Cacciature, 2014). In their study of hospital-based interventions during and after miscarriage, Stratton and Lloyd (2008) found that women expressed displeasure with the service they received from the hospital staff and that their attitudes were not helpful. In another study, researchers noted that women felt lost and

confused by the lack of assistance provided by healthcare providers after their loss (Smart et al., 2013). For example, providers may tell women that the good news is that they can get pregnant and that they may be able to try again once they heal. The lack of acknowledgment and support from healthcare professionals adds to the disenfranchisement of their grief.

Individuals may experience disenfranchisement in perinatal loss through interactions with other people. Harris (2010) noted that social and cultural norms often negatively influence how individuals should respond, and their responses can worsen someone's grief and feelings of shame. For example, society knows what is acceptable for grief and bereavement (Harris, 2010). Perinatal loss lacks validation as a loss; in some instances, people act in ways that minimize the loss. For example, people with good intentions might make statements like "At least you had not grown attached to the baby yet" or "At least you had not had years and years as their parent; you can always try again," but these statements are not helpful and they add to the pain of the loss not being acknowledged. Even though the child may have died before it was born or only had a small amount of time alive, their death represents an essential loss with valid feelings of grief and distress. The disenfranchised grief can further complicate the parents' grieving process and lead to relationship problems and mental health issues (Lang et al., 2011). There are also issues in interpersonal relationships for individuals.

Some women may choose to withdraw from certain groups because of their loss. Women who have experienced perinatal loss but have not yet had a living child reported withdrawing from friend groups because of being reminded of their loss and inability to have children (Mulvihill & Walsh, 2013). Women report a strain in their marital relationship because their grief experience differs from their husbands (Lang et al., 2011). In other social settings like churches, individuals receive uncompassionate comments. Some might say that it was all "God's

will," and while those with religious/spiritual beliefs may eventually agree, this statement does not mitigate their pain or the blow of losing a child.

Discussing perinatal loss has historically been taboo in the United States and many other parts of the world. For example, in Nigeria, the baby is not viewed as a person, nor is the loss is not recognized by loved ones making the grieving period complicated for the women who experience perinatal loss (Adebanke et al., 2018). One article explained how people expect the parents to deny the situation and to forget it ever happened, and up until the 1990s, psychologists thought that breaking bonds was most appropriate (Faro, 2020). In most Western cultures, people send floral arrangements, fruit baskets, and sympathy cards when someone dies, but with perinatal loss, no grieving practices or customs are established (Lang et al., 2011). People typically have wakes or funeral services when someone dies; in many cases, these traditions do not exist for perinatal loss. These cultural norms can potentially be stressful to a woman already in a fragile state.

Religion and Spirituality

In recent years, much discussion has been regarding the meaning of religion and spirituality. The field of social sciences differentiates between religion and spirituality. Often, many people will refer to themselves as spiritual instead of religious, but the terms are defined for this study. Religion is defined as religious practices, beliefs, and feelings that can be expressed denominationally or institutionally (Richards & Bergin, 2005). These practices, beliefs, and feelings include scriptural or sacred text readings, fellowship through weekly meetings (i.e., attending church, synagogue, or other meeting places), and participating in sacred rituals and/or customs. In recent years, religion has developed a negative connotation, but

according to Richards and Bergin (2005), people should not vilify religion because it can be Holy and personal.

Spirituality is defined as a personal connection with a higher being or deity (God). The relationship and closeness to God are essential in differentiating the two, as religion and spirituality are not mutually exclusive. Some people may choose not to affiliate with a specific religion. Still, they identify as spiritual, while others may affiliate with a particular religion and simultaneously have the oneness and closeness with God (Richards & Bergin, 2005). Separating religion and spirituality into different entities can pose some disadvantages. According to Pargament (1999), this distinction does not allow for the recognition that people can express their faith beliefs in different settings. Additionally, the implication that religion is harmful and spirituality is favorable negates that expressions of spirituality in various faith backgrounds can appeal to other people in multiple facets (Pargament, 1999). For example, people who identify as Christians feel the presence of the Holy Spirit moving among them and participants at a church service, encompassing a religious institution and an expression of spirituality.

Regardless of choice, religion/spirituality is a fundamental resource in life and has been used in various cultural traditions (McGoldrick et al., 2016). Moreover, while religion/spirituality has had a long history of being resourceful, it has not always had a place in the world of mental health. Some of the most prominent psychologists and psychiatrists viewed religion/spirituality as pointless and detrimental to mental health (Dein, 2018). However, for people experiencing hardships, traumatic events, and other stressors, religion/spirituality is often used to help them as a source of strength or community (McGoldrick et al., 2016). Unfortunately, other sources point to religion/spirituality as having the potential to exacerbate further the difficulties of those experiencing hard times (Dein, 2018). Amplifying those

difficulties leads to religion/spirituality becoming an additional stressor for the individual.

Benefits of Religion/Spirituality

In recent years, more research has focused on the relationship between r/s and mental health. Religion/spirituality is associated with many positive outcomes. For example, multiple studies noted that religion/spirituality is associated with greater life satisfaction, well-being, and lower levels of psychological distress (Dein, 2018; Koenig & Larson, 2001; Walker et al., 2020; Villani et al., 2019;). Villani and colleagues (2019) found that religion/spirituality is associated with a positive outlook on life and staying positive in times of adversity. In this same study, the researchers found that religion/spirituality positively influences affect and emotional regulation (Villani et al., 2019). In another study, Walker and colleagues (2020) indicated that attending religious services and meetings is associated with positive psychological well-being because of the support in a faith-based community. In sum, researchers have identified religion/spirituality as a potential buffer for adults against the impact of adverse life events and mental health disorders and as an influencing factor for one's outlook on their quality of life.

Religious Coping

Pargament's work in religious coping is crucial to understanding it and its impact on individuals. Pargament (1997) defines coping as a search for significance in stressful times. However, religious coping is a means to find significance in adverse life events dealing with the sacred (Pargament, 1997; Pargament & Raiya, 2007). As aforementioned, people turn to religion/spirituality during difficult times to cope. There is much research on using religion/spirituality to cope with life, particularly adverse life events and other stressors. Based on Pargament's work in developing the instrument to assess religious coping, there are five primary functions of religious coping (Pargament et al., 2000). These functions are discovering

meaning, garnering control, acquiring comfort by closeness to God, achieving intimacy with others, and transforming life (Pargament et al., 2000). Religious coping with significant life events is associated with health and mental health outcomes (Pargament, 2001). R/s beliefs help to conserve significance in crisis by allowing an individual to maintain a sense of meaning and a close spiritual connection (Pargament 1996). Pargament's work can explain why people turn to their r/s beliefs in stressful times.

Many people turn to religion/spirituality during difficult times in their lives. This turn to religion/spirituality is proven by research, as researchers found that r/s beliefs can be helpful and provide comfort and meaning (Wilt et al., 2022). For example, people may turn to their congregation or faith-based community members for support. Others may read a sacred text to try to understand their situation. People may pray and ask for help or strength, while others may choose a different aspect of religion/spirituality to cope. In studies, religious coping proved to be an adjustment indicator compared to other secular coping mechanisms (Pargament, 1997). In addition, people who utilize religious coping mechanisms are likely to experience less anxiety and depressive symptoms with an increased sense of well-being (Dolcos et al., 2021). These are positive impacts of utilizing religious coping. Moreover, their relationship with God can further explain how individuals use their r/s beliefs to cope.

Attachment theory helps understand an individual’s perceived relationship with God. Kirkpatrick and Shaver expounded on Bowlby’s work and noted that an individual’s relationship with God is representative of an attachment bond (Cherniak et al., 2021). People with r/s convictions may view God as a source of refuge and security (Cherniak et al., 2021). A secure relationship with God is linked to having more positive images of God, like viewing Him as loving and benevolent. At the same time, an insecure attachment is associated with viewing Him

as a tyrant who wants to punish everything (Cherniak et al., 2021). Noffke and Hall (2007) found that attachment is easily transferred to understanding personal views and relationships with God. Ultimately, researchers have found that attachment to God can reflect the attachment experiences formed in infancy and throughout life (Kirkpatrick, 1998). In sum, attachment to God impacts coping practices, specifically the religious coping to which an individual gravitates.

Religious coping, like anything, can be positive or negative. Both coping patterns impact adverse life events and psychological functioning (Bjork & Thurman, 2007). Bjork and Thurman (2007) found that adverse life events are related to increasing positive and negative religious coping and decreased psychological functioning. In contrast, positive religious coping can have a buffering effect on the impact of adverse events. The religious coping mechanisms one uses depend mainly on views of God and attachment to God (Kelley & Chan, 2012; Klausi & Caudill, 2018). Secure attachment to God and a benevolent view of God are related to positive religious coping. At the same time, negative views of God and an insecure attachment are related to a weak spiritual life, which is a predictor of one using negative religious coping (Klausi & Caudill, 2018). More often than not, people who utilize positive religious coping techniques have better God experiences than those who use negative religious coping. Both positive and negative religious coping are discussed.

Positive Religious Coping

Positive religious coping practices can positively impact those experiencing negative life experiences. Positive religious coping is considered a buffer against the impacts of adverse events (Bjork & Thurman, 2007). Positive religious coping strategies include viewing God as a partner, turning to a faith-based community for support, seeking God's love, and viewing the stressor as helpful or constructive (Pargament et al., 2011). Furthermore, positive religious

coping strategies reflect a secure relationship with God (Pargament et al., 2011). Additionally, the results of numerous studies have shown positive religious coping as being associated with improved well-being and less psychological distress (Pargament, 2008; Pargament et al., 2004; Pargament et al., 2011). Therefore, positive religious coping is often a beneficial tactic in distress.

Negative Religious Coping

Negative religious coping practices, on the other hand, have detrimental impacts on those experiencing negative life experiences. Negative religious coping practices include viewing a traumatic experience as punishment from God, trying to cope on one's own without any r/s help, and feeling abandoned by God (Burke et al., 2011; Lee et al., 2013; Pargament et al., 1998., Pargament et al., 2011; Park et al., 2018; Vitorino et al., 2017; Wilt, Stauner, et al., 2019). In a study conducted to investigate the influence of religion on grief and bereavement, Lee and colleagues (2013) found that the use of negative religious coping practices has a negative impact. Specifically, negative religious coping can cause heightened reactivity and prolonged recovery in addition to causing maladaptive emotional responses (Lee et al., 2013). This same study found that negative religious coping practices are directly related to lower mental health outcomes (Lee et al., 2013). Much research done on religious coping, specifically the use of negative religious coping practices, has linked negative religious coping to religious/spiritual struggles (Ellison & Lee, 2010; Exline, 2013; Pargament et al., 1998; Pargament et al., 2011; Park et al., 2018; Wilt et al., 2022). Negative religious coping practices can worsen any distress experienced as a result of adverse life events or stressors.

Religious/Spiritual Struggles (RSS)

While good things are associated with religion/spirituality and coping with loss, there are also some negative associations. Research indicates some instances where religion/spirituality can be a source of distress (Braam et al., 2019; Jung, 2020). As stated above, one's relationship with God and perception of God play a significant role. The religious coping theory supports the idea that individuals use r/s to cope with significant life stressors (Pargament et al., 2000). In their research identifying RSS, Exline, Pargament, and colleagues (2014) found that these struggles develop due to one aspect of a r/s practice or belief becoming a focus of negativity. Many people experience RSS after a traumatic event, such as a health issue, natural disaster, or losing a loved one.

Many scholars link negative religious coping and RSS. According to Pargament (2007), negative religious coping methods are essentially RSS, expressions of struggles with God. For example, the negative coping method of viewing the stressor as a punishment from God correlates with the Divine Struggle. In the same aspect, viewing the stressor as an act of the Devil is associated with the Demonic Struggle.

The best way to explain RSS is through the framework of Pargament's theory of religious coping. The search for significance was mentioned earlier concerning religious coping. According to Pargament and Exline (2022), RSS stem from the processes guiding the search for significance. The RSS are the product of the significant purpose, an individual's orienting system, and the transitions and life events they experience in their quest (Pargament, 1997; Pargament & Exline, 2022). Within these facets, religion/spirituality can be integral to their significance goals and orientation system (Pargament, 1997). Individuals can have sacred goals of significance, and their religion/spirituality can be the foundation for their orientating system

(Pargament & Exline, 2022). However, individuals sometimes experience challenges, stressors, and transitions threatening their pursuit of significance and orienting system (Pargament & Exline, 2022). When the challenges and stressors impact their spirituality and create strain or conflict about their fundamental beliefs, people find themselves in a state of distress, thus representing a time or RSS (Abu-Raiya et al., 2015; Breuninger et al., 2019; Ellison & Lee, 2010; Exline, 2013; Exline, Pargament, et al., 2014; Pargament & Exline, 2022). This best explains how RSS develop in an individual.

The nature of RSS looks pretty problematic. In their study investigating the relationship between RSS and psychological distress, Abu-Raiya and colleagues (2015) found that experiencing any RSS predicted higher symptoms of depression, anxiety, and lower satisfaction with life. Pargament's theory of religious coping asserts that one's religious views often help lead someone through life and help them come to terms with what happened (Abu-Raiya et al., 2015). When RSS happens, this causes a crisis that can negatively impact an individual's functioning by disrupting the foundation of their beliefs (Abu-Raiya et al., 2015). The three domains of RSS are supernatural, interpersonal, and intrapsychic or intrapersonal (Exline, Pargament, et al., 2014). Exline, Pargament, and colleagues (2014) identified six RSS from the three domains of this basic concept. The RSS are divine struggle, demonic struggle, interpersonal struggle, moral struggle, doubt-related struggles, and struggles of ultimate meaning (Exline, Pargament, et al., 2014). The following few sections contain information related to each domain of RSS.

Supernatural Struggles

The first domain of RSS is the supernatural. Supernatural struggles focus on beliefs related to the supernatural, like God or another deity and demonic forces. The supernatural

domain includes divine and demonic struggles. This section highlights supernatural struggles, influencing factors, and the impact supernatural struggles have on an individual.

Divine Struggles. Divine struggle is the term psychologists use to describe when a person has struggles that deal with ideas about God and/or a perceived relationship with God (Exline, Pargament, et al., 2014). In an article describing the development of the RSS Scale, Exline and colleagues explain how divine struggles can differ in form. For example, divine struggles can present in the form of anger with God, fear of punishment or disapproval of God, and/or feeling alienated from God (Exline, Grubbs, et al., 2014). These experiences are troubling and distressing.

Divine struggles are not a one size fits all experience. Individual experiences may differ, but research points to a commonality. Divine struggles typically occur after adverse life events (Grubbs & Exline, 2014). People often blame God and begin to feel angry at Him for their current circumstances (Grubbs & Exline, 2014). Anger can range from simple frustration with God to rage or even hatred of God (Pargament & Exline, 2022). There is an abundance of literature related to anger toward God. This feeling is common among those who are experiencing an adverse life event, like a severe illness or the death of a loved one (Exline et al., 2011; Exline, Grubbs, et al., 2014; Grubbs & Exline, 2014; Grubbs et al., 2018; Wilt et al., 2016). Anger at God is just one manifestation of a divine struggle.

Other times individuals may feel God is punishing them for their sins. The Bible teaches that sin is not without consequence; however, many individuals may apply that and believe that every bad thing that happens to them is a direct result of disobeying God (Exline et al., 2011; Exline, Grubbs, et al., 2014; Grubbs & Exline, 2014; Grubbs et al., 2018; Wilt et al., 2016). Some examples of thinking of an adverse life event as a punishment include severe illness or

disaster. Studies of individuals with serious illnesses revealed that people see their diagnoses as punishment for sins (Morgan et al., 2014; Winkelman et al., 2011). In the United States, many people feel that the nation's current state results from sin and turning away from Christian values. Some people attributed the COVID-19 pandemic to a message from God telling us to repent for our sins. A study of natural disaster survivors indicated that most survey participants attributed the event to God or being part of His plan (Stephens et al., 2013). This view could be comforting to some, but it causes tension in the spiritual relationship for many.

In other situations, people feel abandoned by God. This subtype of divine struggle is common among natural disaster survivors or those with serious illnesses. For example, a study examining the God images after Hurricane Katrina found that many of the respondents felt that God had alienated them (Aten et al., 2008). Additionally, a study of breast cancer patients in the UK found that feelings of being abandoned and punished by God were prevalent among many participants and had a significant relationship with negative religious coping (Thuné-Boyle et al., 2013). Feeling abandoned by God is not helpful for individuals who desire to feel comforted by their r/s beliefs.

Each of these instances of divine struggles can further contribute to an insecure relationship with God. Insecurities in any relationship can be troublesome, but this issue impacting a relationship with God can be especially troubling. Divine struggles involve maintaining a secure relationship with God (Ellison & Lee, 2010). Some adverse life events are significant enough to cause individuals to struggle in their relationship with God. Research indicated various predictors of divine struggle in individuals. These predictors include low religious commitment, thinking adverse events are God’s fault, and personality traits like entitlement and low agreeableness (Wilt et al., 2016). The most significant role in one’s

experience with divine struggle is a person's view of God (Exline, Grubbs, et al., 2014). For example, someone seeing God as cruel and/or distant correlated with divine struggle (Exline, Grubbs, et al., 2014). Ellison and Lee (2010) found that people with a negative view of God often experience divine struggle, which causes them to feel disappointed and question God's love for them. It can even lead to the feeling of abandonment and the development of dangerous coping strategies.

Depending on an individual's belief system, people have different explanations for pain and suffering (Wilt et al., 2016). For example, some people view God as loving and responsive to needs, while others believe God to be a puppet master that does not care about what happens to the individual (Jung, 2020). Based on their belief in God and views of God, people experience divine struggles to some extent, and research indicates that experiencing divine struggles is linked to mental health issues (Wilt et al., 2016). When someone struggles with any of the forms of divine struggles, it can be an additional stressor that leads to increased depressive symptoms and lower levels of well-being (Jung, 2020). This research suggests that divine struggles exacerbate negative psychological symptoms.

Researchers indicated that divine struggles are related to "lower levels of positive indicators of mental health like self-esteem, problem-solving skills, life satisfaction, meaning, and positive affect as well as to higher levels of negative indicators of mental health such as anxiety, anger, depression, and greater emotional distress" (Wilt et al., 2016, p.353). Grubbs and colleagues (2018) found that divine struggles cause shifts in one's foundational beliefs of their religion and relationship with God that can send them down a tailspin. Negative religious coping due to divine struggles predict increased depression, psychological distress, poor physical health, and lower quality of life (Wilt et al., 2016; McCormick et al., 2018). Divine struggles are the

strongest indicator of distress (Ellison & Lee, 2010). The other r/s struggle that deals with the supernatural is the demonic struggle.

Demonic Struggles. The fear of the devil and demonic forces has long been documented throughout history and various cultures. Many believe in witchcraft, dark magic, voodoo, and other things associated with dark forces. For example, a 2005 survey revealed that 75% of the individuals surveyed absolutely believe in the devil, nearly 50% profess absolute belief in demons, and over 55% say they absolutely believe in hell (Baker, 2008). Some people believe that the devil or other demonic, dark forces can interfere with an individual's life. The demonic struggle is another one of the six r/s domains. This term describes a concern that evil spirits or forces, like the devil, are causing adverse life events (Exline, Pargament, et al., 2014). Demonic struggles appear to be terrifying in addition to distressing.

Demonic struggles are more than thinking that an individual is cursed or hexed. Pargament and Exline's (2022) text on religious struggles in psychotherapy suggests that demonic struggles have different forms, but the overarching theme is experiencing opposition from an evil force with bad intentions. Based on the RSS Scale, those experiencing demonic struggles often identify as feeling haunted or attacked by evil spirits, that evil spirits cause their struggles, and that the spirits want them to turn away from good (Exline, Pargament, et al., 2014). Certain factors are attributed to individuals believing that demonic forces interfere in their lives, leading to demonic struggles. Believing that supernatural evil exists, seeing the devil as one who intervenes in the world, involvement in specific religious groups, certain life experiences, and psychological disorders are just a few examples of things that can foster demonic beliefs (Pargament & Exline, 2022). Attributing something to demonic forces becomes

a struggle for individuals when a sense of threat is involved (Pargament & Exline, 2022). This experience could lead to some negative psychological impacts.

Surprisingly, experiencing demonic struggles is not abnormal. Exline, Pargament, and colleagues (2014) found that 32% of American adult study participants reported experiencing demonic struggles. Several researchers investigating demonic struggles said that someone experiencing a demonic struggle could have hallucinations or be hostile, aggressive, or paranoid (Krumrei et al., 2011; O'Donnell, 2020; Pargament et al., 2007). Additionally, those that experience demonic struggles are likely to have psychological distress (Exline, Pargament, et al., 2014). Researchers found correlations between depression, anxiety, and demonic struggles in various studies on religious struggles (Abu-Raiya et al., 2015; Exline, Pargament, et al., 2014; Pargament et al., 2001). Demonic struggles can lead to distress because an individual may experience inner conflict, difficulties with morality, or feel as if they are evil and have no purpose left (Pargament & Exline, 2022). On the contrary, research indicates that struggling in this domain can provide a sense of meaning for adverse life events and even give an individual meaning or purpose (Pargament & Exline, 2022). Research is somewhat limited on demonic struggles. Pargament and Exline's (2022) text attributes it to methodological issues in previous studies, individuals feeling shame regarding the possibility of struggling with supernatural evil, and because of the overlap of demonic struggles and other RSS. The following section addresses interpersonal struggles.

Interpersonal Struggles

One of the aspects of r/s affiliation is the idea of a sense of community and fellowship amongst other like-minded people. Strong, positive relationships with other individuals in a r/s group lead to physical and mental health benefits (Walker et al., 2020). Interpersonal struggle is

another domain of the RSS Scale and its own category. This section addresses interpersonal struggles, influencing factors, and the impact of interpersonal struggles on an individual.

The term interpersonal refers to relationships with others. Therefore, interpersonal struggles are defined as conflict with others regarding r/s issues and negative experiences with a r/s institution and/or people (Exline, Pargament, et al., 2014). Out of the adults surveyed, over 45% reported experiencing interpersonal struggles (Exline, Pargament, et al., 2014). As with the previous RSS domains, interpersonal struggles can present differently. One form of interpersonal struggle is disagreements or tension with others in their r/s community (Pargament & Exline, 2022). For example, individuals may disagree over scriptural interpretation or feel offended by the pastor or clergy's message during a service. Other experiences stem from being shunned by r/s community members due to an individual's life choices (i.e., an extramarital affair, unwed pregnancy, or divorce). Other forms of interpersonal struggle involve the institution of organized religion, different faiths, an individual's group, and/or a larger culture (Pargament & Exline, 2022). This RSS could be an individual not feeling supported by their culture because of their r/s choices or being disillusioned by the institution of organized religion (i.e., the belief that all Christians are hypocrites).

R/s disagreements are common today. It is not unusual to see people debating r/s views on social media or television. Studies have shown that people experienced being ridiculed and mistreated because of their r/s beliefs (Abu-Raiya et al., 2015; Exline, Pargament, et al., 2014). Other interpersonal struggles can stem from negative experiences like abuse, rejection, or hypocrisy (Pargament & Exline, 2022). For example, the numerous reports of the molestation and sexual abuse of young boys by Catholic priests, instances of pastors sexually abusing teenage girls, or rejection based on one's race.

Interpersonal struggles can range from being a minor bother or something more painful with lingering impacts. Regardless of the type or intensity, interpersonal struggles impact those it affects. A study examining the effects of RSS on mental health found that interpersonal struggles are associated with depression and anxiety (Abu-Raiya et al., 2015). Conflicts in an individual's r/s community are also related to distress (Pargament & Exline, 2022). For example, researchers investigating social support in the church and depressive symptoms among Black young adults found that those who disengage from religion leave the church and experience ostracization by their family and friends who are still religious (Chatters et al., 2018). In a study examining the reasons behind religious disengagement among Black young adults, researchers indicated that in some instances, disengagement stemmed from a fractured relationship within their church community, feeling as if the institution itself was problematic, and stigmatization for sexual orientation and/or gender identity (Cooper & Mirtra, 2018). These situations often precipitate feelings of 'church hurt' and separation from their specific faith group/institution.

Even ministers experience interpersonal struggles in their lives. A study of Presbyterian clergy revealed that interpersonal struggles could worsen the impacts of adverse life events (Ellison et al., 2010). Not only do interpersonal struggles impact mental health, but they impact relationships as well. A study investigating the impact of different religious beliefs on the spousal relationship found that these struggles are associated with marital conflict, the likelihood of divorce, and adverse effects on the social and emotional health of their children (Bartkowski et al., 2008; Curtis & Ellison, 2002; Vaaler et al., 2009). Unfortunately, the literature on interpersonal struggles and growth is scarce (Pargament & Exline, 2022). In sum, the significant impact of interpersonal struggles appears to be negative. The next group of RSS is considered intrapsychic or intrapersonal struggles.

Intrapsychic/Intrapersonal Struggles

The third RSS domain is intrapsychic or intrapersonal. Intrapsychic struggles are RSS centered on an individual's thoughts and actions (Exline, Pargament, et al., 2014). The three types of RSS in this domain are moral, doubt-related, and struggle around ultimate meaning (Exline, Pargament, et al., 2014). This section covers the three intrapsychic struggles, influencing factors, and their impact on an individual.

Moral Struggles. People who are r/s often try to hold themselves to a standard of morality. For example, professing Christians try to use the teachings of Jesus to guide their day-to-day interactions. Even those who are not r/s try to adhere to specific values. Moral struggle deals with an individual experiencing difficulty following moral doctrines or feeling guilty when they fail to follow the moral principles to which they adhere (Exline, Pargament, et al., 2014). Specifically, individuals can experience a moral struggle when their actions are inconsistent with their moral standards. A study of military veterans identified moral struggles as the most common r/s struggle they experience (Breuninger et al., 2019). This struggle is attributed to experiencing difficulties accepting what they did in the war, conflicting with their r/s beliefs. Other examples of a moral struggle are someone wrestling with the decision to abstain from sexual intercourse before marriage or someone who has had an extramarital affair.

A moral struggle can cause an individual to question their beliefs about themselves. Someone experiencing a moral struggle could have issues with their self-worth, identity, or character (Pargament & Exline, 2022). In addition, these struggles cause an individual to question whether they are a good person or worthy of love and forgiveness (Pargament & Exline, 2022). Finally, moral struggles can be questions about responsibility for specific actions (Pargament & Exline, 2022). For example, researchers studying moral struggles in military

veterans found that many had difficulties assigning blame for their efforts during the war because it was not their decision; ultimately, they were told what to do (Farnsworth et al., 2014). This experience obviously can be a source of contention.

Moral struggles can be harrowing for those who experience them. Believing oneself is morally flawed leads to depression, anxiety, and low self-worth (Pargament & Exline, 2022). Experiencing moral struggles can lead to shame and fear of the consequences of actions that do not align with one's moral values. Moral struggles are also associated with PTSD and suicidal ideation (Raines et al., 2017). Moral injury is a common topic related to the negative impact of moral struggles (Pargament & Exline, 2022). While the subject is still new, the idea behind moral injury is that people either commit or witness acts that violate their moral code and as a result, they experience negative consequences (Pargament & Exline, 2022). Substance abuse, PTSD, suicidal ideations, aggressive behavior, depression, and anxiety are some of the psychological effects caused by moral injury (Pargament & Exline, 2022). The relationship between moral struggles and injury suggests that moral struggles can intensify psychosocial distress symptoms.

Conversely, there are potential benefits of experiencing moral struggle. Some mental health professionals view the lack of moral struggle as a sign of a potentially dangerous problem (Pargament & Exline, 2022). For example, if someone committed a violent crime without feeling remorse, their actions could be deemed a psychopath. On the other hand, people who experience moral struggles could experience growth following their struggle by making them less likely to re-offend and regulate impulsivity (Pargament & Exline, 2022). Additionally, individuals are more inclined to repair broken relationships and make positive changes (Pargament & Exline, 2022). This action is supported by anecdotal evidence. People often share stories of their

experience as a drug addict (moral violation of drug use), recovery, and making amends with estranged loved ones.

Doubt-Related Struggles. The next intrapsychic struggle deals with doubt. An individual may have questions surrounding their r/s beliefs, but these are quickly cleared up by confiding in a trusted resource. In another scenario, an individual may also be firmly convinced not to believe in God or any other entity. These examples are not instances of doubt-related struggles. Doubt-related struggles occur when people have troubling questions or doubts about their r/s beliefs (Abu-Raiya et al., 2015). Doubt-related struggles could also look like questions about the truth of religious claims (Abu-Raiya et al., 2015). An individual experiencing doubt-related struggles may question the existence of God or the existence of life after death.

Doubt-related struggles stem from a variety of factors. A common factor is a troubling life experience. According to Pargament and Exline (2022), if an individual experiences a negative life experience that is particularly distressing enough to cause an injury to their belief system or worldview, this could lead to a doubt-related struggle. For example, anecdotal evidence points to many people questioning the existence of God following the most recent mass shootings in the United States. In addition, many people may develop doubt-related struggles from asking why bad things happen to good people. For example, Dransart (2018) studied individuals whose loved ones committed suicide and found that many developed questions surrounding their faith. These are just some instances of doubt-related struggles following a catastrophic event.

Other experiences that are not tragic can lead to doubt-related struggles. In Kooistra's (1990) doctoral dissertation, he found that doubt-related struggles can also stem from bad experiences with r/s leaders or institutions, the perception of unanswered prayers, association

with people of other r/s beliefs that claim theirs to be real, personal disappointments, and conflicting evidence related to r/s teachings. In addition, the other RSS can lead to doubt. People who experience other RSS are likelier to have doubt-related struggles (Exline, Pargament, et al., 2014). Doubt-related struggles can also happen during transitional periods (Pargament & Exline, 2022). Adolescence and early adulthood are considered natural periods for doubt (Pargament & Exline, 2022). Much research has been focused on the prevalence of young adults leaving their r/s group.

Troubled parent-child or marital relationships can also influence doubt-related struggles. Again, this stems from the application of the attachment theory. For example, children that reported strained relationships with their parents and viewed them as strict or authoritarian experienced more doubt-related struggles (Hunsberger et al., 2002; Kooistra & Pargament, 1999). Interestingly, an individual's perception or view of God is another factor in doubt-related struggles (Exline, Grubbs, et al., 2014). Someone with an insecure attachment to God is more likely to doubt his or her r/s beliefs.

Struggles with doubt can be distressing for individuals. Those who struggle with doubt are likely to have uncertainties about the foundation of their beliefs. In studies of r/s struggles, doubt-related struggles are associated with depression and anxiety (Ellison & Lee, 2010; Zarzycka & Zietek, 2019). One study showed that religious doubts are associated with paranoia, obsessive-compulsiveness, phobias, and hostility (Galek et al., 2007). Experiencing doubt-related struggles can be incredibly distressing for those with r/s convictions because of the threat doubt poses to their beliefs. On the other hand, doubt-related struggles can also have some positive implications. For example, an individual who questions God's existence could experience r/s growth in their quest to learn more information to affirm their faith. However, instances like this

have not been empirically proven (Pargament & Exline, 2022). Like with some of the other RSS, the impact of experiencing doubt-related struggles appears to be largely negative. The final intrapsychic struggle is known as struggles of ultimate meaning.

Struggles of Ultimate Meaning. Many people want to know their purpose in life. They desire to know what they were put on this Earth to accomplish. Others may need to know that there is a purpose for everything they experience. The last intrapsychic struggle deals with struggles of ultimate meaning. This struggle is defined as the feeling of not having an ultimate meaning in life (Exline, Pargament, et al., 2014). Struggles of ultimate meaning imply that an individual may feel like they do not have a reason for living or a purpose in life and are searching for that significance.

Struggles of ultimate meaning stem from the internal conflict when an individual feels their life has no deeper meaning or purpose. People who experience a struggle of ultimate meaning might wonder if they will make a difference in the world or if life matters (Exline, Pargament, et al., 2014). These struggles are not uncommon. In a study of adults in the United States, over half of those surveyed indicated that they experienced a struggle of ultimate meaning (Exline, Pargament, et al., 2014). According to research, adverse life events and transitions can influence struggles of ultimate meaning (Van Tongeren et al., 2017). Examples include sudden physical health and abilities decline, retirement, or empty nest syndrome. While struggles of ultimate meaning are relatively common, this struggle is not without potential consequences.

Psychological distress is linked to struggles of ultimate meaning. Individuals experiencing struggles of ultimate meaning are likely to have depression, anxiety, low self-esteem, life satisfaction levels, and anger (Exline, Pargament, et al., 2014; Wilt, et al., 2017). In addition, struggles of ultimate meaning can predict sharp declines in mental health and suicidal

ideation (Currier et al., 2019; Currier et al., 2018). In contrast, struggles of ultimate meaning could present opportunities for growth and transformation. However, as with the previously discussed intrapsychic struggle, little empirical support links growth with struggles of ultimate meaning (Pargament & Exline, 2022). Therefore, it can be assumed that struggles of ultimate meaning are more likely to have negative implications for psychological distress.

Perinatal Loss, Religion/Spirituality, and Grief

Researchers attribute religion/spirituality as a positive coping method that can buffer against the effects of trauma, chronic stressors, and other issues (Pargament et al., 1998; Ellison & George, 1994). Some researchers have explored the benefits of religion/spirituality in those who have experienced perinatal loss. These studies show how one's r/s preferences aid in reducing the impacts of the loss on an individual's mental health status. For example, one study found that r/s convictions lessen the pain of the loss (Cowchock et al., 2010). Fenstermacher and Hupcey (2013) found that faith modifies bereavement for perinatal loss. In qualitative studies, women credit their r/s beliefs for helping them overcome the most intense part of their grief (Kavanaugh & Hershberger, 2005; Tseng et al., 2014; Wright, 2016). R/s beliefs have allowed families to experience closure by providing the means to participate in rituals like graveside/memorial services. Other aspects of r/s beliefs, like the belief in eternal life through Heaven or existing in some spiritual realm, were noted to provide comfort and hope to those who experienced perinatal loss (Kavanaugh & Hershberger, 2005). Some researchers attributed believing that God is in control and trusting in God allowed a chance to heal and grow in faith (Kavanaugh & Hershberger, 2005; Fenstermacher & Hupcey, 2013). Turning to religion/spirituality to find acceptance and meaning was common in previous research.

However, researchers also highlight the negative impacts of religion/spirituality concerning coping with perinatal grief. Bardos and colleagues (2015) revealed that people with r/s beliefs were more likely to view the loss as the death of a child and their emotions and grief responses were similar. In some instances, instead of using religion/spirituality as a positive coping mechanism, others may view religion/spirituality as the cause of or harmful to their situation (Ellison & Lee, 2010). For example, in Bardos and colleagues' (2015) study, some participants thought their loss was a punishment from God. One's view of God can be a protective factor or add more strain.

Religion/spirituality often serves as a sense of community and fellowship. However, RSS can lead to some abandoning their r/s community and losing the resource, which could lead to negative emotions. Individuals may begin to question their meaning and lose sight of hope. For some, their view of God's role in hardships may make them feel deserving of what they are experiencing, leading to anger toward God and more distress (Grubbs & Exline, 2014). Perinatal loss is troubling, but perinatal loss coupled with experiencing a divine struggle has the potential to amplify the distress. Wondering why something has happened and having no hope can worsen their condition. Several studies showed that perinatal loss caused women to question their relationship with God and their faith (Fenstermacher, 2014; Sturrock & Louw, 2013; Bakker & Paris, 2013). Some report feeling let down, angry, and even hatred toward God, eventually leading to guilt and low self-worth (Bakker & Paris, 2013); experiencing RSS while grieving could further complicate the grief experience.

Perinatal Loss and Complicated Spiritual Grief

While the literature on perinatal loss and CSG is scarce, based on the relationship between CG and perinatal loss and CG and CSG, one can assume that someone experiencing CG

due to perinatal loss could likely experience CSG as well. Perinatal loss can contribute to experiencing RSS and using negative r/s coping mechanisms; therefore, individuals may experience CSG. While the literature shows the benefits of r/s on coping (Exline, Pargament et al., 2014; Wilt, et al., 2017), other studies have shown that experiencing CG can challenge one's faith (Shear et al., 2006). A study of African American bereaved found that the loss caused their faith to decrease in 19% of the study participants (Shear et al., 2006). Burke and colleagues (2011) determined that CSG is a severe form of bereavement distress that CG predicates. Those who experienced CG were more likely to experience CSG by 55% (Burke et al., 2011). Perinatal loss could be even more distressing for those who struggle with their r/s convictions.

There have been many contributions to help understand perinatal loss and mental health, but there is a gap related to the mechanisms of religion. Religion/spirituality is a positive resource for many, but it can also be a source of an additional stressor. Based on Magyar-Russel and Pargament's (2006) work, an adverse life event, like perinatal loss, can destroy perceptions of fairness and meaning of life that extends to the r/s aspects of one's life. Isguder and colleagues (2017) identified perinatal loss as a trauma that has the propensity to change an individual's beliefs. Those changes affect how one responds to the trauma (Isguder et al., 2017). For the r/s, perinatal loss could be considered a strain that leads to turning to r/s beliefs. Some may turn away from their religion/spirituality because they cannot understand why this happened and how a loving God could allow this, while others may turn to religion for comfort, strength, and reassurance—questioning God and wondering why may lead to doubts and uncertainty.

In ideal circumstances, turning to religion/spirituality is a resource for the individual, and their religion/spirituality serves as a protective factor, protecting them from the negative impacts of stressors. There are often specific tools and/or resources that protect the individual from the

harmful effects of the stressor. However, in other situations, negative religious coping and divine struggles lead to psychological distress (Ellison et al., 2009; Exline, 2002). Trying to make sense of the situation through negative religious coping is counterproductive and can harm the individual (Pargament et al., 1998). However, even though there are negative impacts, there are some positive ones.

There are positive impacts of religion/spirituality in times of grief. In a study of Christians and grief, researchers found that Christianity did not moderate depression, but a belief in God indicated lower levels of depression following a significant loss (Austin & Lennings, 1993). In a review of empirical studies, Pargament and colleagues (2005) found that the content of belief is an essential factor that dictates positive or negative religious coping during the grieving process. A benevolent view of God helps people adopt positive coping methods (Pargament et al., 2005). And while religion/spirituality plays an important role, mental health professionals also have a part in addressing the psychosocial concerns of those who experienced perinatal loss. The following section addresses the role of mental health professionals in perinatal loss.

Role of Mental Health Professionals

Perinatal loss is still something not frequently discussed. Many women and men would like follow-up psychological care, but it is not usually offered (Ussher et al., 2020). Current professional care models do not consider the attachment of the unborn child/neonate to the mother or father (Ussher et al., 2020). Literature indicates that screening for depression, referrals for mental health, and detailed discussion with the OB/GYN should be available following perinatal loss (Ussher et al., 2020). Some studies have examined the impact of psychological interventions on treating post-pregnancy loss psychological disorders (Barat et al., 2020). While

this is promising, there is still a lack of evidence regarding the effectiveness, uncertainty regarding the kind of intervention, and limited studies that explore brief therapy immediately following the loss (Barat et al., 2020). Nevertheless, there are some recommendations based on the common psychological conditions that develop following perinatal loss.

Posttraumatic Stress Disorder (PTSD) is a known complication of perinatal loss. According to research, trauma changes the victim's beliefs, affecting the trauma response (Isguder et al., 2017). In the case of perinatal loss, the loss flips a switch that causes women to blame themselves, leading to many negative thoughts (Isguder et al., 2017). The rigid negative beliefs make them more vulnerable to developing traumatic reactions (Isguder et al., 2017). Because perinatal loss is a trauma, those who experience it process the loss utilizing accommodate, assimilate, and overaccommodation (Isguder et al., 2017). Cognitive Processing Therapy (CPT) is helpful in cases of perinatal loss by focusing on assimilated beliefs like self-blame, minimization, and denial, and overaccommodation like excessive modification and overgeneralization (Isguder et al., 2017). CPT can help those who have experienced perinatal loss by challenging the negative beliefs and assumptions developed after the loss and deconstructing them to eventually become more balanced thinking patterns (Isguder et al., 2017). Changing those beliefs into balanced thinking patterns is one step toward reducing the negative psychological impact of the trauma.

Another complication of perinatal loss is depression. According to research, 11% of women experienced a major depressive episode following their loss, and 72% were diagnosed with Major Depressive Disorder (MDD) following (Johnson et al., 2016). Furthermore, over 50% of the women with a history of MDD experienced a recurrence (Johnson et al., 2016). MDD causes women to struggle with everyday activities due to overwhelming sadness, irritability, loss

of interest, and withdrawal from family and friends (Johnson et al., 2016). These symptoms are expected in those who experienced perinatal loss.

Interpersonal therapy (IPT) could be beneficial for individuals who experienced perinatal loss. IPT is a form of psychotherapy that identifies a traumatic event or problem and helps individuals improve their communication, change their expectations, and use their social support network (Johnson et al., 2016). This treatment modality for perinatal loss addresses issues specific to the loss (Johnson et al., 2016). It helps with mourning, re-establishing relationships, and coping with others' reactions to the loss (Johnson et al., 2016). One difficulty of perinatal loss is dealing with interactions between family and friends who may not recognize the loss as valid (Johnson et al., 2016). One aspect is helping the individual deal with the reactions of others and their responses (Johnson et al., 2016). The loss can also cause interpersonal conflict between spouses, and IPT has been shown to improve communication and the grieving process (Johnson et al., 2016). Social support and marital satisfaction are two previously identified factors that can worsen psychological distress following perinatal loss; remedying this problem can be beneficial.

Pregnancy after a loss is complicated and often terrifying for women and men. Women who experience perinatal loss can experience anxiety in subsequent pregnancies (Campillo et al., 2017). Pregnant women who have experienced perinatal loss also describe their pregnancies following a loss as stressful and full of anxiety (Lee et al., 2017). Many women fear another loss will occur (Lee et al., 2017). However, research shows that women develop self-preserving coping mechanisms during their pregnancies (Lee et al., 2017). In most instances, women have guarded emotions, routinely track the pregnancy's progress, avoid many activities, seek extra care and information, and sometimes avoid becoming attached to the pregnancy (Lee et al., 2017). Based on this, Cognitive Behavioral Therapy (CBT) helps remedy this anxiety.

CBT is used consistently for anxiety. The trauma of perinatal loss causes maladaptive thoughts to develop, thinking another loss will occur or believing that if an individual does certain things, it will cause a loss (Campillo et al., 2017). CBT seeks to identify, challenge, and modify errors in thought and behavior (Tan, 2011). Therefore, CBT is useful for perinatal loss because it helps develop coping skills with those negative thoughts.

The Dual Process Model (DPM) is another theoretical approach to grief, loss, and adjustment. This model has been used with perinatal loss (Shannon & Wilkinson, 2020). Developed by Stroebe and Schut (1999), the DPM promoted loss- and restoration-focused coping styles (Shannon & Wilkinson, 2020). Loss-oriented coping focuses on the experience of the loss, while restoration-oriented coping focuses on accepting the new reality of life without the deceased (Stroebe & Schut, 2010). This model could be helpful for those experiencing grief related to perinatal loss because expectant parents often construct new realities for themselves centered on welcoming a new baby into their family.

DPM has similar and different characteristics to traditional grief models. Like traditional grief models, the DPM involves managing symptoms, articulating emotions, and meaning-making (Stroebe & Schut, 2010). However, the allotment for individuals experiencing complicated and/or disenfranchised grief separates the DPM from traditional grief models. Specifically, the DPM encourages a transition from loss-oriented to restoration-oriented for perinatal loss to prevent complicated grief symptoms (Shannon & Wilkinson, 2020). This model benefits those who experienced perinatal loss because it acknowledges and honors the loss while providing an opportunity for the bereaved to look toward the future.

Summary

The current literature on perinatal loss has a wealth of information on the loss's psychological impact and experience. Studies on the grief associated with perinatal loss addressed CG's impact on the bereaved and provided statistical evidence to further empirically support the idea (Kersting & Wagner, 2012). Research on religion/spirituality and religious coping focuses mainly on religion as a potential buffer against grief, depression, and anxiety and its ability to improve quality of life (Dein, 2018; Koenig & Larson, 2001; Walker et al., 2020; Villani et al., 2019). The literature on RSS and religious coping highlights the potential impacts of RSS and the implications for psychological health (Braam et al., 2019; Exline, Pargament et al., 2014; Jung, 2020; Pargament et al., 2000; Pargament & Exline, 2022). From this, it is easy to identify the gaps in the literature.

When researching the topics together, the literature is scarce. Some studies on religion/spirituality and perinatal loss examine the relationship between religion and perinatal loss, but the methodology differs. For example, Petts (2018) utilized data from the National Longitudinal Study of Youth 1997 (NLSY97) to examine if religion influenced the mental health of those who have had a miscarriage. The methodology differs because researchers did not explicitly assess participants' grief and mental health status concerning their loss; instead, their mental health was surveyed as a part of a more extensive study (Petts, 2018). Another study examined religious coping for high and low-risk pregnancies in women with depression (Vitorino et al., 2017). Other studies investigated other protective factors and coping mechanisms for perinatal loss.

R/s beliefs serve as a tool for many. Across the literature, it is a protective factor against many mental health conditions and the effects of grief. Conversely, r/s beliefs can potentially

harm an individual's mental health and grief through the development of RSS. People will lean on their r/s foundation for strength and support, or they could begin to wonder how or why their circumstances came to be, leading them to question their beliefs. This world of questioning, anger and doubt can heavily influence an individual's grief.

The literature on CSG mainly focuses on violent losses, identifying violent losses as traumatic losses (Burke et al., 2011). However, many connections indicated that for those with r/s beliefs, CSG is associated with CG (Burke et al., 2011). Through their research, Burke and colleagues (2011) demonstrated that CG predicts RSS and found that the experience of RSS was a predictor for CSG. In this respect, perinatal loss is also considered traumatic, but the literature lacks any studies of CSG within the context of perinatal loss.

This study aims to address the literature gap and provide insight into the grief of women who have experienced perinatal loss. While the topics have been researched quantitatively and qualitatively, there remains a need for more synergistic research in these areas. Therefore, it is crucial to describe the stories and experiences of women from this perspective. The next chapter addresses the proposed methodology of the study. First, the rationale for choosing a qualitative phenomenological approach is discussed. Finally, the proposed procedures, setting, and criteria for participants are also described, along with the proposed data collection and analysis method.

Chapter Three: Methods

Overview

This qualitative descriptive phenomenological study explored the lived experiences of women who have experienced perinatal loss. Experiencing perinatal loss is a traumatic experience that sets in motion a variety of feelings and emotions related to that loss. Many factors can make grief worse in this situation, like the gestation period, history of infertility, and even marital satisfaction (Bhat et al., 2016; Cassaday, 2018; Gold et al., 2014; Huffman et al., 2015). In addition, these experiences can complicate grief and cause spiritual strife (Huffman et al., 2015; Lin & Lasker, 1996; Shear, 2015). The study was designed to explore women's experiences with perinatal loss, CG, and CSG. This research's findings can be helpful to future researchers, mental health and medical professionals, and clergy.

This chapter includes the research design and the research question. Additionally, this chapter contains information regarding the participants, procedure, and researcher's role. This section also consists of the data collection instruments, method of data collection, and analysis procedures. The final sections outline the trustworthiness and ethical considerations of the study.

Design

I used a qualitative method for this study. Qualitative research is best suited when the research aims to describe the lived experience of a group of people. Creswell (2007) noted that qualitative research is appropriate when studying a group of people whose voices have been silenced. Women who have experienced perinatal loss often feel like they have no voice because it is taboo to discuss perinatal loss and some aspects of their grief. The concept of qualitative research is that an individual's reality is considered within a social construct that reflects different meanings (Creswell, 2007). Qualitative research has five features that include: (1)

examining the meaning of people's lives in the context of real-world situations, (2) representing perceptions of the study participants, (3) covering the context where people live, (4) adding to the explanation of human social behavior; and (5) using several sources of evidence (Yin, 2011). Unfortunately, women who have experienced perinatal loss are not often allowed to speak freely. Therefore, I chose this research method to let the participants share their experiences (Creswell, 2007; Lang et al., 2011; Merriam & Tisdell, 2016; Wentz, 2014). The topics of perinatal loss, grief, and RSS require individuals to share their thoughts, feelings, and their overall lived experiences.

To understand the human experience, qualitative is the best choice over quantitative. According to Creswell (2007), qualitative research is best suited for this purpose because of the inquiry process and the derived narrative that effectively paints a picture of how an issue impacts a group of people. Harper and Thompson (2021) noted that qualitative research methods help researchers understand the experience, which is vital in improving the quality of services available in community counseling. At the same time, quantitative research attempts to support a hypothesis or set of hypotheses. Quantitative research uses detached language and statistical data to support the findings of a research design (Polit & Beck, 2020). Hence, a qualitative approach is most appropriate for the general nature and purpose of the study.

The specific design of this study is descriptive phenomenological. A descriptive phenomenological design was best suited for this study because of the focus on the participants' experiences. The basis of phenomenology is understanding the nature of a phenomenon through the viewpoint of those who experienced the phenomenon (Merriam & Tisdell, 2016). A re-telling of an experience includes interpreting the experience, allowing the researcher to make sense of the data to show an in-depth experience (Merriam & Tisdell, 2016). The descriptive

phenomenological design enabled participants to describe the meaning of their experiences of a phenomenon and to focus more on their experiences than the researcher's interpretation (Giorgi, 2009; Moustakas, 1994). The intent behind descriptive phenomenology is to explore the lived experiences of individuals (Giorgi, 2009; Jackson et al., 2018). The purpose of descriptive phenomenology is to allow the participants to describe how the experience impacted them, therefore, it was the best choice for the research design.

Brief Historical Overview of Phenomenology

Edmund Husserl was a German philosopher credited with being the principal founder of phenomenology. Husserl developed phenomenology in the 20th century as an inductive qualitative research approach (Husserl, 1931/2012; Jackson et al., 2018). Husserl's text, originally published in 1931, believed phenomenology did not allow any hypotheses and is based only on an individual's experience (Husserl, 1931/2012; Jackson et al., 2018). Nevertheless, Husserl thought that the human experience was valuable enough to be the object of a study (Lopez & Willis, 2004). Therefore, he developed an approach highlighting important human experience aspects that require the researcher to separate prior assumptions to understand the participants' experiences (Lopez & Willis, 2004). The goal of the research is to achieve the concept of transcendental subjectivity, which implies that the researcher assesses their biases and preconceptions and neutralizes them through the use of epoche methods not to influence the study (Colaizzi, 1978; Lopez & Willis, 2004; Van Manen, 2014).

Husserl's approach has some other essential aspects. In addition, Husserl's method contends that all human experiences, while different, share common features called universal essences that explain the nature of what is being studied (Lopez & Willis, 2004). To adequately present the universal essences, the research must assume a blank slate through a series of

reductions (Ashworth, 1996). The first reduction is the transcendental stage that requires using epoche (bracketing) or setting aside previous assumptions about the phenomenon of interest (Ashworth, 1996; Lopez & Willis, 2004). Scientific rigor, per Husserl, was achieved through bracketing on the researcher's part (Lopez & Willis, 2004). The second reduction is transcendental-phenomenological reduction, where each participant's experience is considered independently, and the phenomenon's meanings and essences are derived (Moustakas, 1994). Then through imaginative variation, all the participants' descriptions are condensed to an amalgamation of essences through free variation (Gill, 2014). Free variation requires imagining multiple versions of the phenomenon to find the essences, which essentially becomes the foundation for knowledge about the phenomenon (Gill, 2014).

Giorgi's Descriptive Phenomenology Methodology

Amedeo Giorgi's descriptive phenomenology methodology is frequently utilized in phenomenological research. Giorgi developed his approach based on the work of Husserl and Maurice Ponty (Jackson et al., 2018). According to Jackson and colleagues (2018), this method changed phenomenological research from a philosophical to social science background and allowed the researcher to stay close to the data. Giorgi (2009) designed the method to capture the lived experience without adding or taking away any information presented by the participant. Descriptive phenomenology describes the structural foundation of the psychological processes that allow the phenomenon to be intentionally lived (Giorgi, 2009). Unlike other forms of phenomenology, descriptive phenomenology describes what is necessary for the phenomenon under study to be experienced (Giorgi, 2009). An important aspect is phenomenological reduction, which allows the researcher to bracket past experiences (Giorgi, 2009). Along with the reduction, the researcher must use free imaginative variance to discover the essence through a

natural desire to learn more about the phenomena. The last step of the method is describing the essence by describing elements of the phenomenon (Giorgi, 2009). The goal is to describe the experience and not interpret the experience (Giorgi, 2009). With this knowledge in mind, I believe Giorgi's research method best suited this study.

Rationale and Implementation

I used this research design because it best aligned with the purpose of my study. In my goal of describing the experiences of grief and spiritual crisis in the lives of women who faced perinatal loss, my research objective was to understand the essence of this phenomenon from my participants' experiences and points of view, making the descriptive design the best choice. According to Giorgi (2009), the descriptive phenomenological approach allows the participants to tell their experiences from their voices. The design includes their thoughts' feelings, and interpretations of their lived experience (Giorgi, 2009). The requirement of phenomenological reduction is crucial to the nature of descriptive phenomenology. As such, because I experienced the phenomenon studied in this research, I had to show up as a blank slate (Ashworth, 1996) and not let my own experience influence my understanding of the participants' experiences. Additionally, to ensure this, I employed various techniques that the literature recommends for bracketing.

This design provided me with participants' details regarding their experiences, which can change how counseling and clergy professionals assist individuals through the grief associated with perinatal loss. The results of this study can give insight to counseling and clergy professionals when dealing with clients who experienced perinatal loss. In addition, these results can add to the literature to further develop best practices.

Research Questions

1. How do women with religious/spiritual beliefs describe their lived experience of grief from perinatal loss?

Setting

I conducted the interviews via Zoom for various reasons. First, Zoom allowed for audio recording and saving of the interview. This aspect was essential for transcription and data analysis. Second, it is user-friendly; based on the nature of the world over the past few years, many people are familiar with Zoom. Another reason for using Zoom is to ensure safety and security. While most of the world has re-opened following pandemic shutdowns, many people fear infection (Fitzpatrick et al., 2020). Zoom ensures security through some of the platform's features. I used the waiting room feature, and a password allows me to ensure that the correct participant has access to the meeting space. Zoom also allows for the meeting to be locked once it has started so that no one can join, even if they have access to the password. Zoom protects data and ensures privacy by offering encryption and authentication. Another benefit of using Zoom is the option to audio-record only, thereby further protecting the participants' identities.

After I scheduled the interviews, I sent the consent forms to the participants. Before conducting interviews, I asked participants to find a quiet, private location to ensure a clear recording and privacy. I offered to review the consent forms with the participants, and they all stated that they read the form and had no questions or concerns. I reminded the participants that their information would remain confidential, that participation was voluntary, and that they could withdraw without penalty. I reviewed that interviews would be audio-recorded and transcribed and that they would have the opportunity to review their individual transcript for accuracy. I

conducted the interviews in a private, locked room where there was no threat of any inference. I also used a headset to ensure privacy further.

Participants

I recruited 8 study participants. The literature varies on the appropriate sample size for phenomenological research (Ellis, 2016). Recommendations vary from a specific range of 5-25 (Creswell, 1998) and at least 6 (Morse, 1994). Research indicates that sample size is often best determined by time, available resources, and study objectives (Patton, 1990). According to Morse (2000), the nature of the topic, quality of the data, study design, and scope of the study determine the appropriate sample size. Morse (2000) noted that phenomenological research using in-depth interviews requires fewer participants. I used social media to recruit participants via convenience sampling. Convenience sampling allowed me to choose participants that were easily accessible for data collection and those who met the criteria for participation (Creswell, 2007, 2008). I developed hashtags using perinatal loss, miscarriage, stillbirth, neonatal death, grief, religion, and spirituality to help circulate the post. I used the following criteria for selection:

1. Women who were English-speaking U.S. citizens
2. Women who were between 21-65 years old and of sound mind, able to make autonomous decisions
3. Women who have experienced perinatal loss (molar pregnancy, ectopic pregnancy, miscarriage, stillbirth, neonatal death, VTS, chemical pregnancy)
4. Women with r/s beliefs who were part of a r/s community
5. Women who had a difficult grieving period and spiritual crisis following perinatal loss

The targeted age range was between 21 and 65 years old. I chose a wide age range because some women start families early in life, while others begin at later stages (Bellieni, 2016). This age

range allowed me to capture experiences from varying perspectives based on age. I also aimed to have various socioeconomic, educational, career, and ethnic backgrounds. I assessed eligibility through the use of a demographic questionnaire. Women with debilitating mental health conditions were excluded from this study because the risks to them did not outweigh the benefits of this study. I compensated participants with a $20 Amazon gift card and emailed it after they completed the member checking.

Procedures

I began developing my interview questions during the proposal stage of the dissertation process. I realized that it would be difficult not to ask leading questions based on the line of questioning I was pursuing. I eventually decided on one guiding question for the unstructured interview, which was discussed with and reviewed by experts in the field. I received approval from the Institutional Review Board in October 2022, after which I began circulating the approved promotional posts via Facebook. I used hashtags to help the posts attract the attention of potential participants. I posted flyers on public bulletin boards in my town and the surrounding communities. I also passed out recruitment flyers at two Perinatal Loss Awareness events.

The recruitment material gave prospective participants enough detail to decide their best interests. Correspondence included my phone number and email address so they could reach me with any questions or concerns about the study. Interested participants scanned the QR code on the recruitment flyer or clicked the link on the social media posts to access the Google Form eligibility questionnaire. I reviewed each form to ensure that the respondents met the study criteria. I omitted some respondents because they were phishing accounts and others because a criterion was not met. Once the participants were selected, they were emailed an informed consent form to sign. The informed consent had full disclosure of the information regarding the

study along with information regarding privacy and voluntary participation. As each participant returned their signed consent document, we scheduled an interview. Participants were assigned pseudonyms and informed that I would use the pseudonym during the interview. I emailed participants their meeting invitations, including the passcode, as the interviews were scheduled. I also sent a reminder email the day before the interview.

The Researcher's Role

An important aspect of the qualitative approach is the role of the researcher. As the researcher, I am the instrument, and I collect the data, which allowed me to have an in-depth experience with each participant (Chenail, 2011; Kallio et al., 2016). I am a doctoral student in Liberty University Community Care and Counseling Department. I am an African American female who identifies as a Christian. I have experienced perinatal loss, CG, and CSG. In addition, I experienced grief with family, friends, and my r/s community. Therefore, I am aware of perinatal loss's emotional response and grief. Additionally, my r/s beliefs and practices are fundamental and were influential in my grieving process. But unfortunately, the loss caused me to experience some spiritual struggles. As a result, I separated myself, my experiences, and my preconceptions from the research.

Bracketing required me to set aside my preconceptions about the phenomenon and not let it influence the research, is unique to the phenomenological approach (Giorgi, 2009; Moustakas, 1994). I know that my experiences with the phenomena could impact the study, so I addressed my biases to keep them from influencing the study (Giorgi, 2009; Moustakas, 1994). To achieve bracketing, I remained open when looking at the data to keep my biases from interfering with data interpretations. As such, I recorded the interviews and allowed participants to clarify through member checking to ensure their experiences were not misconstrued (Doyle, 2007). In

addition, I kept a self-reflective journal to document my feelings, thoughts, and experiences as I listened to the stories and experiences of participants (Vagle, 2018). I was in therapy and continued my scheduled appointments with my therapist, and addressed my feelings with her. Also, as the researcher, I had to address my assumptions. The assumptions I had were:

1. Study participants may experience emotional distress when sharing their experiences of perinatal loss.
2. The terms CG, RSS, and CSG may be unfamiliar to the participants.
3. Participants may be uncomfortable retelling some aspects of their experiences with grief, especially aspects dealing with RSS and CSG.
4. Participants may be ashamed of their RSS.

Data Collection

Data were collected in a three-week time frame between October and November 2022. Interviews were the main form of data collection for this study. Interviewing is commonly used as the data collection method in qualitative research (Creswell, 2007). Data were collected using unstructured, open-ended interviews. I used one open-ended question. All interviews were audio-recorded through the Zoom platform. Moustakas (1994) recommended that the interviews be completed relaxedly with active and empathetic listening. I used one open-ended question to allow the participants to tell their stories through their voices without my preconceptions influencing them (Creswell, 2007). Heppner and colleagues (2016) recommended having participants tell their stories in their way without feeling like they had to check a box with a response that did not necessarily describe their experiences. Using this data collection method, I obtained a detailed description of the participants' experiences.

Interviews

Interviews lasted from 62-80 minutes. I used unstructured interviews with one open-ended question. The question was, “As someone who has experienced perinatal loss, there is clearly a certain amount of grief and coping that you had to contend with. Additionally, you were presented with one or multiple spiritual crises. Tell me about your experiences with perinatal loss. Please share as much information as possible. I want to understand your whole experience.” Based on the response of the participant, I used probing questions like “tell me more about that” and “describe how this made you feel” to gather more information as necessary. I developed this guiding question to cover each aspect of the research study's purpose: to describe the experiences of grief, coping, and spiritual crisis concerning perinatal loss.

Unstructured interviews put the reins of the interview in the participant’s hands. The unstructured interview was guided by a question that asked participants to tell their stories (Corbin & Morse, 2003). Some researchers recommend asking questions for clarification after the participant is finished, while some recommend asking throughout (Fontant & Frey, 1998; Rubinstein, 2002). I asked questions throughout based on the participants’ facial expressions that indicated the end of a thought. Whenever I needed more clarification or information, I made a note and asked the participant when she finished her statement. According to researchers, unstructured interviews allow the individual’s experience of the phenomena to surface (Kvale & Brinkman, 1996). In addition, the unstructured format gave the participant control over their narrative.

In an unstructured format, it is common to have a participant who gradually opens up and needs more probing and others who are more comfortable telling their stories and sharing their innermost thoughts (Corbin & Morse, 2003). Some participants required more probing to go in-

depth, while others could share their experiences without much additional questioning. It is normal for both types of interviewees to gradually become immersed in the story's unfolding (Corbin & Morse, 2003). As the interviewer, it was important that I used active listening to ensure that I followed the cues of the participant and that I kept the participant's emotional state in mind. According to researchers, when participants got tearful, it was my responsibility to offer the participant an opportunity to take a break or even stop the interview (Corbin & Morse, 2003). A majority of the participants became tearful and cried during the interviews. They were offered breaks and an opportunity to re-direct, but no participant needed to stop the interview.

Based on the topic's nature, I ensured that the participants were at ease and comfortable during our conversation. Ensuring that participants are comfortable is also supported by research, as Moustakas (1994) recommended creating a relaxed environment during interviews. One way I did this was by establishing a rapport so that we could develop a relationship. In my experience as a social worker, I found that people are more likely to feel less intimidated and open up when they feel at ease. Therefore, before beginning the interview, I ensured the participant was comfortable.

Before the start of the interviews, I introduced myself and thanked the participants. I reminded them that their participation was voluntary and that they could withdraw at any time without penalty. I reminded them that their responses were confidential and that I would use their pseudonym. I also informed participants that if they said anything that could be used to identify them easily, I would modify it. For example, a few participants said the state where they reside or their child's name. For instance, I changed specific county or state names to "where we live" and assigned pseudonyms if the participant mentioned another person's name. I also reminded the participants that the interview would be audio-recorded and transcribed. I told the

participants that they could read their own transcripts for accuracy. Finally, I offered to review the informed consent form again, but the participants had no questions or concerns.

I opened the floor for any questions before beginning the interview. I took notes on the participant's facial expressions and effects during the interviews. I also took notes of my thoughts and feelings during each interview to understand the participants' lived experiences without any personal bias impacting the interview. I allowed the participants to add any additional statements if the interview did not capture anything. At the end of the interviews, it was my responsibility not to leave the interviewer distressed but to shift to a less emotional level (Corbin & Morse, 2003). I stopped the recordings and moved the topic to something less emotional. Due to the nature of the topic of grief associated with perinatal loss, I offered resources for perinatal loss support groups and other mental health resources.

I downloaded the interviews to my password-protected computer and stored them in a password-protected folder. Once I checked that the interview was downloaded securely on my computer, I deleted the interview from Zoom to ensure security and confidentiality. Next, I transcribed each interview and saved it in a password-protected folder on a password-protected computer. Finally, each transcript was sent in an encrypted email for member checking. None of the participants indicated any need for revision following their review. After each participant reviewed her transcript, I emailed her a $20 Amazon gift card.

Data Analysis

I conducted an eidetic analysis for this study. According to Giorgi (2009), this method is appropriate because it is discovery oriented. This study aimed to describe the experiences of grief, coping, and spiritual crises in the lives of women who experienced perinatal loss. As such, I intended to describe the structure of the phenomenon so that it could be understood. The eidetic

analysis brings about the phenomenon from its surface concept to reveal the essence of things (Wertz, 2010). Charmaz and colleagues (2011) noted that eidetic analysis is not just looking at the "what" is presented, but instead, it is identifying essential characteristics of what is being explored. Through an eidetic analysis, the participants' lived experiences emerged from comparing different phenomena and the participants' experiences (Charmaz et al., 2011). The key to successful eidetic analysis is reducing the quantity of the data by sorting and identifying patterns that form a structure that captures the essence of the data (Patton, 2002). According to Finlay (2014), eidetic analysis involves refining meaning or finding interconnected parts or "constituents" of the phenomenon and then looking for connections in the data and grouping essential meanings that emerge (p. 129). Instead of describing what the participants said, the goal is to reveal a more profound meaning.

Eight women who experienced perinatal loss, complicated grief, and spiritual crises were asked an initial open-ended question about their experiences. Probing questions were asked as needed. The interviews were transcribed. The participants verified that their words were not altered or misconstrued. After each participant verified their transcript through member checking, the data analysis followed the outlined steps below.

Adopt the Phenomenological Attitude

Bracketing or epoché is essential to conducting an eidetic analysis. Bracketing my preconceived ideas and prior knowledge was necessary to discover the true essence of the raw data (Giorgi, 2009). Moustakas (1994) noted that eidetic analysis requires being unbiased and open-minded. Giorgi (2009) recommended bracketing to reflect on past experiences and how they relate to present experiences to reduce the likelihood of presupposing that the experiences are the same. Bracketing ensured that my prior experiences did not influence the data analysis.

Sense of the Whole

The next step in the process was gaining a holistic sense of what was presented. According to Giorgi (2009), this is done by reading the data multiple times for a holistic understanding. Each participant provided their narrative in the way that she experienced things. I maintained a phenomenological attitude to reflect on each participant's experience to describe how it was experienced (Giorgi, 2009). Finlay (2014) describes this step as allowing the phenomenon to reveal itself to gain new understandings and allow the data to transform into meanings. According to Rallis and Rossman (2014), this step is becoming comfortable with the data and understanding its contained information. Getting a sense of the whole was essentially a data immersion. I became familiar with what was said, along with facial expressions, tones, and other non-verbal cues.

Meaning Units

Next in the process was identifying meaning units. According to Giorgi (2009), identifying meaning units allowed the data to be organized into workable segments. This step entailed reading through the data and determining shifts in meaning throughout the text (Giorgi, 1985). Giorgi (2009) noted that identifying meaning units is not absolute because different researchers could identify meaning units in different places in the same data set. I viewed the participants' statements from the lens of grief, coping, and spiritual crises to determine meaning units (Giorgi, 2009). Identifying meaning units helped me understand the participants' lived experiences and is a crucial step in data analysis.

Transform the Meaning Units

The fourth step was transforming the meaning units. This represented the first change to the data. In the eidetic analysis, it is crucial to remain in the phenomenological attitude (Giorgi,

2009). Therefore, the researcher must change the data to the third person to ensure this. Furthermore, changing the data to the third person ensured the researcher remained unbiased while not changing the meaning of the text (Giorgi, 2009). In this step, I transformed the meaning units into descriptive psychological expressions by reviewing each meaning unit under the context of the research topic (Giorgi, 2009). I utilized the concept of imaginative variation to find what was essential to the phenomenal structure of the participants' experiences and disregard what is not (Giorgi, 2009). This stage represented the beginning of the formation of the essences of the phenomenon.

Synthesize

The final step in the process was synthetizing the transformed meaning units. In this step, the researcher takes the transformed meaning units for each participant and provides the individual structure. Providing the individual structure validates each participant's experience (Giorgi et al., 2017). After providing each individual structure, the transformed meaning units were analyzed for constituents that form the core structure of the lived experience (Giorgi, 2009; 2012). According to Giorgi (2009), the psychological structure "depict[s] how certain phenomena that get named are lived, which includes experiential and conscious moments seen from a psychological perspective" (p.166). The result of the syntheses is a description of the phenomenon that is no longer concrete but general.

I completed the interview recordings, transcriptions, analysis, and imaginative variation in a quiet space so I would not be distracted. Before transcribing the interviews, I had a therapy call and discussed my assumptions and thoughts. I also journaled my thoughts and preconceptions, thus bracketing them aside to not interfere with the transcription process. Finally, I journaled before immersing myself in the transcripts to ensure bracketing further.

Data Saturation

Data saturation is an important concept in research. Data saturation is applied to the data collection and analysis aspects of research and refers to a point where no new information is found (Fusch & Ness, 2015). In qualitative research, data saturation is critical because it helps establish validity (Fusch & Ness, 2015). Having enough information that could allow replication of the study and there is no need for additional coding or no new information is found is a way of determining saturation is reached (Fusch & Ness, 2015). Other methods of ascertaining data saturation include collecting thick, rich, descriptive data (Fusch & Ness, 2015). In addition, data collection procedures used in prior research can be utilized in new research to indicate data saturation (Fusch & Ness, 2015).

For this study, I followed previous researchers' suggested methods to ensure I reached data saturation. I used unstructured, one-on-one interviews until I could not gather any new information from the participants. I used an open-ended question as the guiding post for the interviews and used probing questions as necessary to ensure that the participants gave enough descriptive data. Finally, I analyzed the data until there were no new constituents that emerged from the data.

Trustworthiness

Qualitative data differs from quantitative data in that no previously validated instruments are utilized to ensure the validity or trustworthiness of the study. Trustworthiness is important because it proves that the study's conclusions are reliable and that I was honest through conducting the study. Trustworthiness includes credibility, dependability and confirmability, and transferability (Morse et al., 2002). Proposed steps to ensure trustworthiness are listed below.

Creditability

Credibility is the internal consistency of a study. Specifically, this is how the results align with reality (Stahl & King, 2020). A study is considered credible when the description of the experience is accurate, and people who have shared the same experience recognize the depiction as what they experienced (Thomas & Magilvy, 2011). One way to ensure confirmability is by making sure that bias is minimized in the study. Due to my experience, I used strategies to ensure that the bias was minimized and that there was narrative truth. I took notes and reflected while interviewing the participants. I also conducted a psychological interpretation to remain authentic when analyzing the participants' experiences.

Another way to ensure trustworthiness is through member checks. Member checking consists of asking for the participants' input regarding the creditability of the findings (Creswell & Poth, 2018). Member checking is necessary to establish creditability by ensuring the phenomenon's essence is being captured correctly (Creswell & Poth, 2018). I used member checking to make sure that nothing was misconstrued. I asked participants to review their transcripts and make any corrections if necessary. The participants did not identify any problems with their transcripts.

Dependability and Confirmability

Dependability and confirmability refer to the ability of a study to be replicated and that the researcher's biases do not influence the findings. Dependability is assured by comparing the meaning units with the transformed meaning units and the psychological meanings to ensure that nothing about the original description was changed during analysis (Giorgi, 2009). Additionally, I established an audit trail by documenting my steps thoroughly. I clearly stated how I came to the psychological meanings from the data so that other researchers can follow my scientific

process (Giorgi, 2009). Based on this method, my results are reliable when other professionals understand how I derived the psychological meanings from the meaning units (Giorgi, 2009). For confirmability, I continued using reflexive journaling and therapy to set aside my preconceptions, in addition to helping make myself aware of my thoughts and feelings continuously.

Transferability

Transferability refers to the generalizability of the findings. However, research indicates that phenomenology does not allow for generalizations (van Manen, 1990). With this in mind, I was transparent in my descriptions of the methodology and findings for external validity. I did this by describing the methods and the results with sufficient detail. Also, I provided detailed descriptions of the experiences of the participants in the study for others to determine if the results were transferable to other circumstances.

Ethical Considerations

Any time humans are involved in research, researchers must seriously consider ethics. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (The Commission; 1979) wrote The Belmont Report to provide guidelines and ethical principles to consider when working with humans in research. There are three basic principles that The Commission recommended keeping at the forefront of ethical considerations in research: respect for persons, beneficence, and justice (1979). Based on the argument for respect for persons, each participant should complete informed consent that provides information related to the study in an easy-to-understand format, which should result in voluntary participation (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). I followed University protocol in conducting the study; I sought approval from

the IRB before engaging with any potential participants. Furthermore, I ensured that I was transparent about the purpose and nature of the study so that participants could make an informed decision regarding their participation. Participants were also reminded of their right to withdraw without penalty or to refuse to answer a question.

The second principle is that of beneficence. Beneficence is "an act of charity, mercy, and kindness, with a strong connotation of doing good to others, including moral obligation" (Kinsinger, 2009, p. 44). In other words, beneficence is ensuring I have the participants' best interest in mind while maximizing the benefits to participants and mitigating risk. Perinatal loss is a common occurrence. Additionally, many Americans have some r/s beliefs (Boynton, 2018; McGoldrick et al., 2016). As such, it is beneficial to the greater population to conduct this proposed study. Research indicates the risks of perinatal loss and CG on mental health in addition to the risks of RSS. Research is lacking on information regarding the experience of CSG and perinatal loss. The benefit to the greater population is by raising awareness and positing solutions. The study had the potential to trigger painful memories. Given the sensitive matter of the research, I was careful to ensure that participants were at ease and comfortable. I offered breaks and resource materials for mental health services.

The third principle is justice. Justice deals with the burdens and benefits of the research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Justice is being fair to the research participants concerning the risks and benefits of participating. The inclusion and exclusion criteria were outlined in an earlier section of this chapter. These criteria were assessed in potential participants in the pre-screening. Any participant who may have developed distressing issues during the study would have been withdrawn and referred to their local crisis counseling agency. None of the participants

experienced any mental health emergency in this study. Participants still received the mental health resource list.

There are other ways that I considered ethics in this study. Creswell and Poth (2018) noted that there are various ways to ensure the study is conducted ethically. As stated earlier, I followed the university's ethics guidelines. I ensured confidentiality by using pseudonyms, conducting interviews in a private place, storing interviews and transcriptions on a password-protected computer in an encrypted folder, and not disclosing information found from the interviews in general discussion. Finally, I ensured I did not engage in deceptive practice by ensuring that I had not influenced the study with my preconceptions by reflexive journaling, seeing my therapist, and member checking with the participants.

Summary

This chapter was an overview of the methodology for the study. I conducted a qualitative descriptive phenomenological study because it was the best way to capture the participants' experiences. According to research, qualitative research designs are best for understanding the human experience and adding to the explanation of human behavior (Cresswell, 2007; Yin, 2011). Furthermore, this was the more suitable method to answer the question, "how do women with r/s beliefs describe their experience of perinatal loss?" Finally, I proposed conducting the study virtually via Zoom based on the platform's recording abilities and simplicity for the participants.

I had eight participants in the study. The participants were women who have experienced perinatal loss, espoused r/s beliefs, and experienced difficult grief and a spiritual crisis. Participants were selected via convenience sampling and completed informed consent forms before interviewing. My role as the researcher was the primary instrument. Thus, I collected the

data via interviews. The proposed interview question was designed based on the problem and purpose statement outlined in Chapter One. I analyzed the data through an eidetic analysis method. This method allowed me to develop the essence of the lived experience. To establish trustworthiness, I ensured that I bracketed my prejudgments throughout. I conducted this study ethically by adhering to the principles of respect of persons, beneficence, and justice as outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) in addition to protecting confidentiality and refraining from deception.

Chapter Four: Findings

Overview

This qualitative descriptive phenomenological study aimed to describe the experiences of grief, coping, and spiritual crisis in the lives of women who faced perinatal loss. People often use r/s beliefs to cope with adverse life events like perinatal loss. Based on the theory of religious coping, the impact of grief can be positive or negative, with negative religious coping often leading to CG (Kersting & Wagner, 2012; Kishimoto et al., 2021). CG is associated with CSG in research, but only in cases of violent losses as opposed to other forms of traumatic loss (Burke et al., 2011). Thus, this study was designed to describe these lived experiences of this specific population of women who experienced perinatal loss to add to the current body of literature. This study took place virtually and involved eight women who experienced perinatal loss.

One central research question aligned with this study's purpose and problem guided this study. The research question was: How do women with r/s beliefs describe their experience of perinatal loss? Qualitative research was the best choice to better understand the human experience because of the inquiry process and the resulting narrative that portrays how an issue impacted a group of people (Creswell, 2007). Furthermore, to describe the lived experience, I used a descriptive phenomenological approach. As such, choosing a qualitative methodology was appropriate to address the research question.

In this chapter, I present the results of the data analysis. First, there is a detailed description of the study participants. I obtained this information from the eligibility questionnaire and the interview. Then, I discuss the study's results by detailing the participants' experiences and perceptions of grief related to perinatal loss. Thirteen constituents captured the experience.

Participants

This section is a description of the eight study participants. Each participant was randomly assigned a pseudonym. I used pseudonyms during the interview to store the participants' information to ensure confidentiality further. The participants met the inclusion criteria for the study: English-speaking women, U.S. citizens between the ages of 21-65; of sound mind and with the ability to make autonomous decisions; have experienced perinatal loss; have r/s beliefs and part of a r/s community; and have had difficult grief and a spiritual crisis following the loss. The participants' ages ranged from 29-65, and they had varying types of perinatal loss. For example, one had a molar pregnancy, one had a late-term loss, two had early-term losses, two had stillbirths, one had an early-term and neonatal death, and one had early-term, late-term and vanishing twin syndrome (VTS). In addition, there was an even distribution of racial/ethnic groups, with four participants identified as Black Americans and the remaining four as White Americans. Table 1 shows the demographic data of the participants.

Table 1

Demographic Data of Participant

Name	Age	Race/Ethnicity	Religion	# of Losses	Type(s) of Loss
Lucy	65	Black	Christianity	2	Early
Rose	49	Black	Christianity	1	Stillbirth
Whitney	37	White	Christianity	More than 3	Early
Morgan	29	White	Christianity	1	Molar
Sarah	42	White	Christianity	2	Stillbirth
Elise	35	White	Christianity	2	Early, Neonatal Death
Ella	33	Black	Christianity	2	Late
Monique	34	Black	Christianity	More than 3	Early, Late, VTS

Lucy

Lucy is a 65-year-old Black woman who had two early-term losses. Her first loss occurred before conceiving and giving birth to her only child. Lucy's second loss was after years of her and her husband trying to have another child. Lucy noted that she had always had heavier-than-normal periods and painful cramps, but other than that, she did not receive an explanation of what could have caused the losses. She felt that medical technology at the time was not as advanced as it is now, so she had a lot of unanswered questions.

After the second loss, Lucy experienced a crippling depression, which caused her to take a leave of absence from work. Lucy experienced many self-doubts and indicated she felt like her body failed her. She explained that she had self-esteem and image issues exacerbated by the losses and struggles to conceive. Lucy only wanted to stay in bed and was inactive in her family and social circles months after the second loss. Lucy questioned God, wondered why, and she experienced isolation from her r/s community. As a result, she stopped attending church services for three months. Eventually, Lucy sought professional counseling. She also resumed praying, reading the Bible, and attending church.

Rose

Rose is a 49-year-old Black woman who experienced a stillbirth. Rose and her husband conceived during their second round of IVF. Rose's pregnancy was considered high-risk due to her advanced maternal age. When she was 23 weeks pregnant, she experienced leaking fluid, and her friend advised her to go to the emergency department. When she arrived, they diagnosed her with premature rupture of membranes (PROM). Her baby was still fine, so they devised a bed rest and monitoring plan. That following week, when she went to the bathroom, she felt her

baby's membrane sac and returned to the hospital. The prognosis was drear, and the hospital staff prepared her to deliver the baby, a boy whose heart stopped in the womb.

Rose recalled having many different emotions. She was distraught and angry after the loss. Rose stated that she experienced much self-blame and felt like a failure. She also found it hard to be around women who were pregnant and those with newborns. One of the more difficult things Rose contended with was the spiritual crises. She was very angry with God. Rose also expressed that she questioned God, wondered why, and experienced isolation from her r/s community, as she stopped attending church for four months following her loss. Rose did attend grief counseling, but she stopped after a few sessions. Instead, she found solace through meditation, journaling, and mementos honoring her baby's memory.

Whitney

Whitney is a 37-year-old White woman who had multiple losses. She had four early-term losses, two of which were chemical pregnancies. Whitney and her husband had difficulties conceiving and had to seek assistance from an RE. During their first round of treatment, they conceived and had a child. After the birth of her first child and before the birth of her second, Whitney had three miscarriages. Her first loss was at 11 weeks gestation. She was discharged from her fertility doctor's care and went to her OB/GYN. Her miscarriage caught her by surprise because everything was fine. After the miscarriage, she and her husband got pregnant again, twice, but her hormone levels were not rising, so the doctors prepared her for a chemical pregnancy. After the second chemical pregnancy, she and her husband decided to take a break from fertility treatments. They got pregnant unexpectedly with their second child and delivered a healthy baby. Whitney and her husband wanted one more child, but because of the stress and expense of fertility treatments, they took a break from treatments. They were not preventing

pregnancy from happening if it happened. To their surprise, they conceived but unfortunately miscarried at 11 weeks.

Whitney was distraught after all her losses, but the pregnancies that progressed further than a few days were detrimental. She recalled suppressing her feelings after her first loss and not allowing herself a proper grieving period. After her second loss, she allowed herself to grieve but still experienced tearful moments. Whitney experienced much self-blame and felt like a failure and unworthy. She struggled with jealousy of seeing people in certain situations conceive and carry with such ease when she struggled to do both. Whitney also expressed being very angry. She questioned God, wondered why, and thought of the loss as punishment for sin. Instead, she found solace and comfort in her family and her faith.

Ella

Ella is a 33-year-old Black woman who experienced two late-term losses in one pregnancy. First, she and her husband used intrauterine insemination (IUI) and conceived identical twin boys. Then, they tried to conceive on their own for three years. Ella had a normal pregnancy with extra monitoring because twin pregnancies are considered high-risk. At 22 weeks, Ella was rushed to the hospital, where they told her that she was fully dilated and that they should prepare to deliver the babies. Ella decided she would not do that but instead try to do what she could to keep her "babies in" for as long as possible. After a few days in the hospital, labor started, and she gave birth to both babies. Unfortunately, they died after they were born. Ella left the hospital devasted.

Ella was very depressed to the point where she felt suicidal. She recalled did not want to get out of bed and she had no desire to do anything. Ella blamed herself and felt like a failure. She said she felt like she failed herself, her babies, and her husband. Ella and her sister were

pregnant at the same time. It was a challenge for Ella to be around her sister, whom she loved and was excited for; at the same time, Ella also had to contend with being sad and grieving her babies. Ella stated that she was angry at God and doubted her faith and beliefs. She stopped going to church for six months following the loss. Ella stopped praying and reading the Bible. Ella's struggles with her faith were challenging aspects of grief with which she had to contend. Ella briefly attended grief counseling but then quit; she did not think it was helpful. Ella found a therapist, and she attended sessions bi-weekly. She also resumed attending church, started reading the Bible and attending a perinatal loss support group in her area.

Sarah

Sarah is a 42-year-old White woman who had two stillbirths. Sarah's obstetrical history before her losses was unremarkable. Sarah experienced no complications in previous pregnancies. However, both losses were very traumatic for Sarah and her husband. Her first stillbirth was at 26 weeks. After experiencing limited movement the week prior, Sarah contacted her midwife. Her midwife suggested that her placenta's placement could be the issue, but it was not worrisome since she still felt movement. Sarah also experienced some cramping and spotting. After this, her midwife assured her that it was nothing alarming and that they would continue to monitor the situation. Later, Sarah woke up to her water breaking and delivered her baby to her bathroom. Her second loss was about a year after her first loss. She was twelve or thirteen weeks pregnant when she experienced cramping and bleeding and immediately went to the emergency department. The doctors confirmed that the baby no longer had a heartbeat and presented her with her options. She decided to see if her body would miscarry the baby naturally. The next day, Sarah began bleeding heavily and went to the emergency department out of an abundance of caution. She delivered the baby to the emergency room.

These experiences were very difficult for Sarah. She and her husband had children before their losses, so she recalled struggling with feeling like she wanted to "crawl in a cave" and the reality of caring for her family while navigating her grief. Sarah was devastated by both losses. She recalled feeling like a failure and blaming herself. She also felt very isolated. Sarah questioned God and wondered why. She also felt isolated from her r/s community. Instead, Sarah relied on her husband and her faith, which she said: "never faltered." She read scriptures and tried to replace negative self-thoughts with "Biblical truths." Sarah also found that sharing her story with others was helpful in healing.

Elise

Elise is a 35-year-old White woman who had two losses: one early-term miscarriage and neonatal death due to the death of her second born. Her first loss was at 12 weeks gestation. Elise went in for a routine ultrasound when the tech could not find the heartbeat. After some time, Elise became pregnant again. Her pregnancy started normally but progressed to high risk when she was diagnosed with preeclampsia. Despite monitoring, Elise's blood pressure spiked to dangerous levels, causing her daughter to be born at 25 weeks. After a week, Elise's daughter died after coding multiple times.

Elise had a difficult time grieving after her losses. She was depressed and anxious. She was even diagnosed with post-traumatic stress syndrome. Elise blamed herself for her losses. She felt like a failure and referred to herself as "defective." After her losses, Elise found it hard to be around pregnant women and would have been at the same gestation as she would have been. She was jealous of those who could get pregnant and do so without complication. Elise said she felt lonely after her losses, especially her second loss, and isolated herself from others, including her church community. Elise was angry with God, questioned God, and wondered why. She even

experienced doubts about her faith and spirituality and stopped going to church, reading the Bible, and praying. Elise eventually began seeing a therapist. She resumed praying, reading the Bible, and attending church. In addition to her husband, Elise found support through a grief support group at her church.

Morgan

Morgan is a 29-year-old White woman who experienced a molar pregnancy. After she and her husband decided to try and expand their family, Morgan found out she was pregnant and soon followed up with a midwife to establish care. During the ultrasound, the midwife explained that she could not find a heartbeat and took Morgan and her husband for a more detailed ultrasound. Unfortunately, the ultrasound revealed that the pregnancy was molar. Morgan was distraught and confused. She did not know what a molar pregnancy was, and many unknowns further complicated her grief.

Morgan recalled being very sad. She says that one day she reached a breaking point where she just "wept on the floor" from her sadness and grief. Morgan felt like a failure and that her body failed her. She found it hard to be around pregnant women and newborns and was jealous of those who could get pregnant without complication. In her grief, she was angry at God, questioned God, and wondered why. While she had these experiences, she allowed them to bring her closer to God instead of pushing her away. She found solace through prayer, scripture, and trusting God. Her parents and husband were also sources of comfort for her.

Monique

Monique is a 34-year-old Black woman who has had four losses. She had an early-term loss and two late-term losses before conceiving her son. When she got pregnant with her son, she experienced VTS. Monique and her husband also experienced infertility issues. Monique was

diagnosed with unexplained infertility and relied on assistive reproductive technology to conceive each time. With the early-term loss, she only required hormonal injections and timed intercourse. She and her husband underwent in vitro fertilization (IVF) to conceive the other times. Monique's OB/GYN explained her first loss as “an occurrence for which there is sometimes no concrete answer.” Her second loss was due to a premature rupture of membranes, and the third was an umbilical cord issue. There was no explanation for the VTS except that the twin was not developing as it should have been, based on the gestation period.

Monique experienced a wide range of emotions. She blamed herself and felt like her body failed her. She felt like she was "a defective woman" because she had issues conceiving and sustaining a pregnancy. With each loss, she doubted her faith, questioned God, and was angry at God. She became reclusive and did not want to socialize with other women she knew, especially those with families or those who were pregnant. She was "insanely jealous" of those who could conceive without assistance and carry easily. Monique sought counseling with a Christian counselor. She also started attending a local perinatal loss support group and began attending a grief support group at her church.

Results

The findings from the participants' experience of grief, coping, and spiritual crisis in the context of perinatal loss are presented in this section. In the section data analysis process, the steps for data analysis are discussed, as outlined in Chapter Three. Narrative data and verbatim quotes support the development of each constituent. The research question responses section contains a narrative response to the research question that drove this study. This section also includes direct quotes collected from in-depth, unstructured participant interviews.

Data Analysis Process

I conducted eight, unstructured interviews that lasted a total of 545 minutes and comprised 89.5 pages of single-spaced raw data. Table 2 shows the duration in minutes and the number of single-spaced, transcribed pages of each interview.

Table 2

Interview Duration and Transcribed Pages

Participant	Interview Duration	Transcribed Pages
Lucy	62 mins	9.5
Rose	75 mins	14
Whitney	65 mins	10
Morgan	63 mins	10
Sarah	80 mins	14
Elise	63 mins	9
Ella	70 mins	13
Monique	67 mins	10
Total	545 mins	89.5

The main interview question was: "As someone who has experienced perinatal loss, there is clearly a certain amount of grief and coping that you had to contend with. Additionally, you were presented with one or multiple spiritual crises. Tell me about your experiences with perinatal loss. Please share as much information as possible. I want to understand your whole experience." This question was followed by probing questions like "tell me more about that," "describe how that was for you," and "explain that in more depth for me" as needed for clarification and to expound on the participants' thoughts.

Throughout the interview process, I engaged in bracketing through therapy and self-reflexive journaling to prevent my thoughts and preconceptions from interfering with the data. After I completed each interview, I self-transcribed the recording and sent a copy of the

transcript to the individual participant to review for member checking. Once all interviews were conducted, transcribed, and reviewed, I used my self-reflexive journal to write down my thoughts about the interviews and the information the participants shared. I then began the data analysis and assumed the phenomenological attitude (Giorgi, 2009). It was important to ensure that I had an open mind and did not allow my experiences to cloud my analysis (Moustakas, 1994). Following assuming the phenomenological attitude, I began the process of reading to gain a sense of the whole.

I reviewed the data to gain a holistic sense of what was presented. I self-transcribed the interviews, which made me even more familiar with the raw data. I listened to the individual recordings and read each transcript carefully while I notated my thoughts and feelings to process the information. I then read through each interview transcript several times while I listened to the audio recording. I did not try to clarify or expound upon a participant's description during this time. Instead, I processed all the data as it was given to gain a holistic sense of how each participant experienced grief, coping, and spiritual crisis after facing perinatal loss.

While still maintaining the phenomenological attitude, I moved to the next step of delineating meaning units. I read through each transcript and marked shifts in meaning or dialogue flow with a forward slash (/) to separate meaning units. For example, Lucy stated, "I guess, like anyone else that loses, I wondered why. I wondered what was wrong with my body. I had terrible cramps and cycles. I always had to stay in the bed. I wondered if that was the cause. / My husband wanted six children. I was fine with just one." There was a change in the middle of the conversation. She discussed wondering why she miscarried and then started talking about her husband's desire to have a large family. Thus, I created two delineations of meaning units. Giorgi (2009) noted that delineating meaning units is not absolute and that different researchers

could identify meaning units in other places in the same data set. Delineating meaning units aims to break the data into workable portions (Giorgi, 2009). After delineating the meaning units for the study participants, I moved to the next step, transforming the meaning units.

The transformation of the meaning units represented the first changes to the data. The first part was changing all the meaning units into the third person. Once again, as the researcher, I ensured that I processed the data analysis from an open-minded, unbiased position. This transformation of meaning units to the third person did not change the meaning behind what the participants said but instead helped further ensure I remained in the phenomenological attitude (Giorgi, 2009). For example, Lucy stated, "I would have bad thoughts about everything, and I would just randomly cry at times," which I turned into third person, "Lucy would have bad thoughts about everything, and she would just randomly cry at times."

After changing the meanings to third-person form, I transformed each statement into a psychological meaning (Giorgi, 2009). Using the previous example, "Lucy would have bad thoughts about everything, and she would just randomly cry at times." was further transformed to "Lucy experienced negative intrusive thoughts and crying spells." The crying spells were due to the grief she experienced after miscarrying. According to Giorgi (2009), the intent of further transforming the meaning units into psychologically sensitive expressions is to "describe carefully the intuitive psychological senses that present themselves to the consciousness of the researcher" (p. 154). In other words, I examined the meaning units to see how to express them so that they represented and emphasized the psychological aspect of the participant's experience.

I used imaginative variation to transform the data into psychological expressions further and determine the experience's meaning (Giorgi, 2009). During this step, the transformed meaning units were generalized and integrated across the participants (Giorgi, 2009). In addition,

to bring forth the meaning of what the participants said about grief, I kept the phenomenon of grief in mind while generalizing (Giorgi, 2009). I used Microsoft Office tools to organize the meaning units and transformed statements. Finally, I copied and pasted the meaning unit from the transcribed interviews into a spreadsheet for each participant.

The next part of the analysis was to review the transformed meaning units to detect constituents. First, I analyzed the meaning units for shared experiences, which are constituents (Giorgi, 2009). Constituents are part of the whole structure (Giorgi, 2009). The constituents were identified by reviewing all the meaning units; comparing the converging meanings to understand the shared experiences of grief, coping, and spiritual crisis; and then applying a word or phrase that described what the participant was relating to each constituent. Doing this gave a general descriptive title to the psychological meaning and provided a structure for the experience (Giorgi, 2009).

After I identified all the constituents, I analyzed and determined which were essential and which were not required (Giorgi, 1985; 2009; Giorgi & Giorgi, 2003). According to Giorgi (2009), the invariant aspects of the experience were determined and tested to see if the structure still stood. In other words, I searched for what was a necessary, integral component of the phenomenon. If I removed a constituent and the developing structure was no longer the same, then I determined the constituent to be essential. These essential parts of the experience of grief related to perinatal loss are crucial to the stability of the structure of the lived experience. Thus, allowing me to move to the final step of the analysis.

The last step of the process was synthesizing a general psychological structure of the experience of grief related to perinatal loss. The essential constituents were summarized in a paragraph representing the general psychological structure of the experience of grief related to

perinatal loss (Giorgi, 2009; Giorgi et al., 2017). While every participant had an experience that differed from the others, "psychological meanings can be identical," which allowed for data from each participant to be integrated into the structure (Giorgi, 2009, p. 132). The eidetic analysis allowed me to develop a story that emerged from the raw data.

Constituents

As a result of the eidetic data analysis, I developed the general structure of grief related to perinatal loss. The constituents are the result of synthesizing each participant's lived experiences from their point of view. In this section, I identified the participants by their pseudonyms. The constituents are: attempting to process the loss, overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, comparisons of morality and deservedness, a spiritual and mental battlefield, post-loss disruptions, finding ways to cope, trusting God's plan, and transitioning from struggle to growth. Table 3 shows the constituents and the meaning of the constituents.

Table 3

Constituents and Meaning of Constituents

Constituents	Meaning of the Constituents
Attempting to Process the Loss	Describes actions and emotions of the participants when they learned of their impending loss or that the loss already occurred.
Overwhelming Emotions	Describes the varying range of emotions the participants experienced following their loss.
A State of Confusion	Describes the disorder and upheaval the loss had on the participants. Also highlights lack of direction in navigating the grief experience.
Grieving What Could Have Been	Focuses on the things participants grieved in addition to their children.

Doubting Your Innate Womanhood	Describes the feelings of doubt, blame, guilt, failure, and feeling like less than a woman because of difficulties carrying a child to term.
Feeling Alone and Misunderstood	Focuses on the participants feeling like they had no one to turn to and that no one understood their grief.
Uncomfortable Interactions with Others	Describes the participants encountering people unintentionally trivializing their grief experience.
Comparisons of Morality and Deservedness	Focuses on participants comparing or trying not to compare their lives with others based on principles of living right versus living wrong and who deserves to be rewarded for living with certain standards.
A Spiritual and Mental Battlefield	Describes the RSS the participants experienced.
Post-Loss Disruptions	Focuses on aspects of the participants' lives that were different following their loss/es.
Finding Ways to Cope	Describes the process of the participants trying to cope with their grief. Both secular and religious coping.
Trusting God's Plan	Focuses on the participants turning to their r/s beliefs in a way to help them begin to accept God's plan in their lives.
Transitioning from Struggle to Growth	Describes the participants process of resolving their RSS and experiencing personal and r/s growth.

Attempting to Process the Loss

The news of the participants' losses came in different ways. Some learned in the doctor's office during a routine visit. Others had traumatic experiences leading up to them receiving even more traumatic news. But, whether intentional or not, the participants immediately tried to make sense of what was happening. One minute the participants were happily and cautiously expecting their babies, and the next, they faced the reality that they would not have a happy ending.

Lucy had experienced one early miscarriage. After a few years of trying for a baby, she and her husband had a daughter. Lucy's history made her anxious. Even though she was anxious,

Lucy was excited and started to accept that she and her husband would have another baby until the bleeding started. Lucy stated:

> I couldn't really wrap my head around it, sad to say. I had been sitting with the news that we were expecting for about a week, so I was cautiously excited. When I started bleeding and when the doctor actually confirmed that there was no more baby, I was crushed.

Rose had a high-risk pregnancy. She started a family later in life. One day, Rose felt something terrible was happening when she felt her baby's membrane sac while using the restroom. When she got to the hospital, some staff tried to prepare her for what was happening. She felt what was happening but tried to hold onto the little hope she had left. Rose stated:

> I was very traumatized. I think there was a part of me that knew what was going on but didn't want to accept what was going on. I was thinking, we could go in and you know, there's something that they could do. You know, I was just kind of; I think my emotions and feelings were all over the place; I didn't really know what to think. I didn't want to accept what inevitably I knew could happen; I was just hoping that once I got there, that there was going to be something that they could do to make the outcome different, but you know, as the hours went on, I soon began to realize, okay, I'm going to leave here and without my baby. And yeah, um, and I just had so many random thoughts, okay, in the hospital room, I kept looking at the incubator thinking, can't they just, when my baby comes, isn't there something they can do? Just different thoughts; I was all over the place, really.

Whitney's earlier chemical pregnancies were easier to process than her other losses. With the chemical pregnancies, she received communication from her doctor's office based on the lab work that prepared her for the losses. For the other losses, Whitney's attempts to process were

different. She tried living in a state of denial for one and the other. Finally, she tried to accept what had happened and reached out for help. Whitney said:

> The first time it was just complete denial and wanting to ignore the grieving process that I needed. I think that definitely was a hindrance for me. The second time, I processed the fact that we lost a baby. I reached out. I had much more support, but it just seems like it's been a longer process, you know.

Morgan and her husband were excited to start a family. She and her husband were elated to see their baby and hear the heartbeat for the first time. During their first ultrasound appointment, the ultrasound tech was expressionless and silent. Morgan had a suspicion that something was wrong. The ultrasound indicated a molar pregnancy. She said:

> And so, she then told us that she can't find a heartbeat, and we were like, OK, and I immediately started crying because I knew, you know, I knew kind of what that meant, and then later she told us that it was not a viable pregnancy.

Ella had an incompetent cervix. Her cervix dilated prematurely which caused her to go into labor with identical twin boys. While in the hospital, she tried to hold out until she reached a point of viability. She wanted to get to a point in her pregnancy where her children would have a chance at survival. Unfortunately, her labor resumed, and her babies died after being born. She said:

> I was really shocked because, you know, here I am, I've just given birth to these babies that I was expecting to give birth to, and there be a totally different circumstance. I was just really confused because I had no idea. I didn't know how to process this, really.

Elise had multiple losses, and each circumstance was different surrounding her loss.

During her first pregnancy and loss, Elise went in for a routine ultrasound. It was at that time she was informed that there was no longer a heartbeat. During her second pregnancy and loss, she had an emergency c-section. Unfortunately, her daughter died a week after being born. Attempting to process the first loss for Elise happened after she was wheeled out from her D&E. She stated:

> It was so odd because they wheeled me in, I was pregnant, and when they wheeled me out, I wasn't. So um, that was rough. It was really rough. Because how do you process that? Now you are, now you're not. I knew I wasn't technically pregnant, but my body was holding on to the pregnancy, so I don't know. As soon as they wheeled me out, I was a mess. I just could not believe this was real for us. I stayed in bed a lot. I didn't want to do things. I didn't want to hang out with friends; I didn't want, I didn't want to do anything, really.

Sarah unexpectedly gave birth to a stillborn baby at home. A year later, she experienced a miscarriage in the emergency department. Sarah recalled being dumbstruck as she described her first loss as a heartbreaking and chaotic. Before her losses, Sarah's obstetrical history was unremarkable. However, after delivering their baby, Sarah was transported to a local emergency department during her first loss and was soon discharged. She and her husband did not know how to understand what they had just experienced. Sarah stated:

> It was very difficult because this was uncharted territory. You've gone through hard things, but not on this level. The first loss, um, it was so surreal on many levels because it happened at home and when we got to the ER, which we, we'll call it an ER, but the doctor there was like, 'I don't know what to do with you, I'm not really sure how to handle this,' and I could have gone home. I didn't even need the ambulance ride, but um,

> we were discharged and sent home like nothing had happened, and we just sat in the parking lot probably for two hours because we have to home and tell our kids that, you know, 'mommy was no longer pregnant,' and it was difficult.

Monique had multiple losses as well. She learned about her first loss during a routine ultrasound. She mentioned feeling awkward while waiting for her D&C surgery because she was still carrying her baby. Her second loss was a result of PROM. Again, she described not knowing where to begin to process things. Monique stated:

> Well, I had a few ultrasounds, and everything was normal until I began leaking amniotic fluid. I was on hospital bedrest for a few weeks while I slowly leaked fluid. Eventually, labor started, and it was just, I don't have words, really. We were heartbroken. I mean, this was so unexpected; I was so confused. I was a wreck. I had to give birth which was excruciatingly painful.

Overwhelming Emotions

The participants' losses caused them to experience various emotions that consumed them for quite some time. Many participants were overcome with sadness and could do nothing but cry. Others were angry and confused. Some were bitter. The overwhelming emotions sometimes occurred in tandem with the participants' attempts to process the loss, while in other instances, the emotions came afterward.

Lucy's emotions were complicated for her to handle. Lucy spent a lot of time alone in bed. She did not have the desire to do anything and was a shell of her former self. She even had to take a leave of absence from work. Lucy said, "But I felt like I was in a dark space mentally. I just had consistent negative thoughts".

Rose's experience was challenging, and certain factors made it even more difficult for her emotionally. She was older and had spent time and money pursuing fertility treatments. This baby would also be her and her husband's first child together. A lot was riding on this pregnancy for Rose. After her loss, she was very sad and heartbroken. But she was also angry. Rose stated:

> I was like, why me? You know, I don't understand. So, I went through a lot of anger, you know. My faith got shook for a while, you know, just a lot of different feelings and emotions and just wondering going back.

Whitney's grief was full of emotions. Her situation differed in the fact that she suffered from infertility issues, so each loss was a reminder of the struggles it took to get pregnant in the first place. Whitney described it as being multidimensional. The multidimensional aspect was because she had to contend with infertility and loss. She tried to find the positive side but often felt sad and unworthy. Whitney explained:

> But, like yeah, I mean, some days were dark and hard to get through. Like the fertility aspect and feeling unworthy added another dimension to my grief. It was very back and forth. Like I said, some days, I'd be wondering if it would just be me and him, and then I'd get down about it. Then some days, I'd try to find the bright side of it. It's like, you know? What kind of life do we get to have without children? Really depressing days and thoughts.

Morgan was very emotional after learning about her loss. When the doctor confirmed the ultrasound tech's evaluation, Morgan cried and continued to cry. Every time she discussed what happened, she cried. She was even faced with difficult emotions when trying to decide the next treatment steps. After her medical procedure, Morgan had an emotional breakdown. She stated:

> So, like, this whole thing is just very uncomfortable for me, but I had that [a D&C] done, and you know, I remember one night just, you know, it's when I think everything just finally hit me, and I just, you know, wept. There's a difference in crying and weeping, and I just wept on the floor because you know that surgery, you go in pregnant, and then you come out, and you're not. And so, I was just weeping on the floor that I wasn't pregnant anymore because I was so excited. I remember my husband coming in and finding me, and we just sat on the floor, and just kind of cried together.

Ella described herself as being completely heartbroken. She was shocked and felt like the entire experience was a nightmare, something that she would never wish upon, even her worst enemy. After leaving the hospital, she went home and stayed in bed most of the time. She often cried, at least every day. She described one instance that seemed like she was on a rollercoaster ride. Ella stated:

> I was discharged. I came home, you know, and I went into the room that we had planned to be their nursery, and I just cried. My mama says that she'll never forget the way that I cried, like the sound that came from, like, the depths of my soul, basically. I don't know if I'm being dramatic, but she says like I wailed like a literal wail escaped my body. I was in a dark place; I cried every day. I was very depressed, and it was weird because I still felt like I could feel them moving in my body. It's weird, you know? I still had to contend with postpartum emotions, so postpartum depression on top of grief, on top of depression from grief, it was, it was awful, you know? I'm sitting around with cabbage leaves on my on my breasts because I'm leaking milk, and I just, oh, it was a bad place. I, you know, I contemplated killing myself because it was just too much for me to deal with. It was, it was emotionally difficult for me.

Elise was very emotional after her losses. After her first loss, she cried and spent a lot of time alone. She withdrew from her friends and stayed in bed. After her second loss, she described having dark days and a lot of crying. In addition to being sad, she was angry and bitter. Elise stated:

> During that time, I spent a lot of time at home, on the floor, crying. Weeping. I spent a lot of time being angry. I felt so alone. I blamed myself; I blamed myself for not going to the doctor sooner when I started feeling bad. I blamed myself for letting my blood pressure get so high when I know I didn't have anything to do to control that. I thought my husband hated me; I thought God hated me, which both I know weren't true. But it was a struggle. I blamed myself, and I felt like such a failure.

A lot of Sarah's emotional responses were subdued. This is because she felt as if she still had to be present for her husband and her family. Sarah wanted to give in to her emotions. At the same time, she felt obligated to still be a wife, mom, and household manager. Not expressing her emotions was difficult for her. Sarah explained:

> I knew that we both couldn't fall apart, and we both couldn't go crawl into a cave like we wanted to and just hide from the world. The kids still needed to be parented; they still needed to be homeschooled. They still needed to get to dance and to their different activities and still be around family and still eat, and so I just kind of went into robot mode. And I don't know if that's, you know, part of being the oldest; I've always tended to just brush my own emotions to the side and be more the caretaker and make sure that things get done regardless of how I may or may not be feeling.

Monique had multiple subsequent losses. It seemed like with each loss; her emotions grew more and more intense. After her first loss, she was despondent and spent much time

focusing on getting pregnant again. Her second loss was much more traumatic, after which she described herself as a "wreck." She described it as one of the more emotionally painful things she had ever experienced. After her third loss, she grew more despondent. She stated:

> Then after the third loss, I was just, you know, over it. I couldn't believe it was happening again. I grew angrier and angrier. I was angry at God, mad at myself, angry at random people who could get pregnant, angry at everyone. I was bitter. I was just spiraling into a dark ditch.

A State of Confusion

Going from the realization that you are going to have a new baby to the harsh realization that you are not is a tough pill to swallow. The news of their loss or impending loss left the participants with more questions than answers. Most participants struggled to wrap their minds around moving from one reality to their current reality. Some participants were confused about what was happening around them during their loss. Others were confused about navigating a loss like perinatal loss.

Lucy wanted to know what could have caused her to miscarry. Her doctors never gave her a reason. In her first miscarriage, she attributed it to the stress she put on her body by jumping into a pool to rescue a little boy. After her second loss, she wanted to find a concrete reason for her losses. She stated, "I guess, like anyone else that loses, I wondered why. I wondered what was wrong with my body. I had terrible cramps and cycles. I always had to stay in the bed. I wondered if that was the cause."

Rose was in the hospital. She was prepared for the fact that she was not going to leave the hospital with her baby. In the preparations, the nurses and other hospital care team members asked her what she wanted to happen once the baby was born. Rose was perplexed because she

was not prepared to answer any of the questions. She had not fully grasped that she would be charged with making these decisions. Rose said:

> Throughout the night, they were asking me all these questions, wanting me to make decisions, and I didn't know what I was supposed to say or do, and you know, I'm grieving a baby that's not here yet, so I wasn't focused on that. I was just so confused.

After Whitney's first loss, she was also confused. Her confusion stemmed mainly from not knowing to whom she could turn. She wanted someone with whom she could share and express her emotions and feelings. Her confusion kept her from processing her feelings, and from as a result, she suppressed them. She later realized was unhelpful. Whitney stated:

> With that first one, it was, I didn't want to deal with it, I didn't want to talk about it, I hadn't talked about our infertility journey at all, up to that point, so like, I didn't know who to go to. I was just really confused. I didn't know, so it was just kind of, like, push it to the side.

Morgan was perplexed about what had happened. Her confusion stemmed from not fully understanding what was happening with her body. Morgan felt her medical team did not answer her questions satisfactorily, especially when her midwife explained molar pregnancy. As a result, she did not know what had transpired to cause the molar pregnancy. So, she did not know how to grieve. Morgan stated:

> I just didn't know what to grieve, I guess, and so finally, I settled in on grieving just all the plans and ideas and thoughts we have of what the baby was going to be, you know, we had already talked about, like was it going to look like you know stuff like that. So we figured we just kind of grieved to like that because we didn't get to the point of like

> picking the name or anything, so like, and it's just a tough thing to grieve, let me just we just sat on it like that yeah.

Ella's confusion was a result of processing her new reality. Ella was hopeful that she would be able to save her pregnancy. She was determined to do all she could to prevent labor from resuming. However, she was caught so off guard by her loss. Additionally, the traumatic nature of it made it difficult for Ella to accept. She felt it was very surreal. Ella stated:

> It wasn't anything like how I wish, how I hoped that it would happen. You know? It was like they're, they're them dying was like the death of like all the dreams and the, the things that I planned, you know? I picked out, picked out a nursery for them. I picked out clothes, I picked out, you know, all these things, and here, here it is, you know that's not going to happen now. These dreams are dying with my babies. Um, I felt like it was, I was in such a daze. Like, is this really happening to me? This can't be happening to me, like how in the world is this something that I'm really living right now?

Elise gave birth at 25 weeks gestation. Unfortunately, her baby was born only one week past the viability mark. As a nurse, Elise prepared herself for a lengthy NICU stay. She was prepared for possible complications, and a long road full of obstacles before she could bring her daughter home. Unfortunately, Elise's daughter would never make it home, and this change left Elise at a loss. She was confused by the events that had taken place. Elise stated:

> I left the hospital with empty arms. I wasn't expecting to bring her home right away, but I had hoped that after a few months in the NICU that she'd be coming home. I was prepared for her to have some delays or what have you, but I knew I was having my baby. I was prepared, to one day, leave the hospital with my baby, but instead, I left with a few of the blankets they swaddled her in, a little onesie, some other keepsakes like

> prints and pictures, but I was empty-handed. I was just so lost after this. I was confused; I couldn't understand what was happening and why it was happening to us.

Sarah had a few different sources of confusion. One source of confusion was that her previous pregnancies were normal and without complication. So, when Sarah had her first loss, she was caught off guard and confused. After her second loss, Sarah was even more confused because she could not fathom two losses within a year after many normal pregnancies. She was also confused because she did not know who to talk to outside her husband. One big source of confusion for Sarah was trying to navigate the grief. She described the experiences as being "uncharted territory" for her. Sarah stated:

> But ummm, it's definitely a tricky thing because every experience is different and trying to navigate, there's not like a, you know, how to book that gives you a step by step on how to, how to go through these things because everything is different.

Monique was confused. She did not think a miscarriage could happen to her. She hoped that she would have normal pregnancies because of her difficulties conceiving. Unfortunately, that was not the case for her. She had multiple losses, and after her first loss, she described being confused because the loss was unexpected. She stated:

> So, with my first miscarriage, I was so sad. Sad isn't even the word for it. I think I was just disappointed. I mean, with every loss, I was disappointed, but I think I was disappointed especially with the first one, because I thought that, and this is silly, but I thought, "oh, since I struggled getting pregnant, there's no way that I would lose a baby." I mean, I knew it happened, but I didn't think it could happen to me.

Grieving What Could've Been

In addition to grieving the loss of their babies, participants grieved other aspects. The participants contended with grieving other aspects. Participants grieved their thoughts, dreams, hopes, and plans for their child. They grieved the life that they planned, and they grieved all the experiences they planned. In one instance a participant grieved ways that she did not get to honor her child's life.

Lucy had hopes of giving her daughter a sibling. She grew up with sisters and wanted her daughter to experience having siblings. Her husband also had brothers, and they had a close relationship. So, having close familiar relationships was an important aspect of them. Her husband also wanted to have a big family, so she grieved that she would not be able to do that. Lucy stated:

> I was grieving the loss of my baby. I was grieving the fact that I may not ever have another child; this was after the second miscarriage specifically. I grieved the plans and the thoughts that I had for this baby. I wanted to give my daughter a sibling. I wanted them to be best friends like me, and my sisters were. I just grieved a lot of things in that time period.

Rose grieved a few different things as well. One aspect was she did not have a memorial service for her son. She did not know what happened to his remains, and that is one thing that she grieved. Another aspect for Rose was grieving that she could not start her own family with her husband. She wanted to have her husband experience raising a child with his wife. Rose stated:

> I was really looking forward to us having a family. Because he had an older child, was never married to her mom, he was always there for his child, but this was his chance to, I

> feel like we both got robbed, raise a child from birth in a home with the woman that he loved. And he'd never been able to do that before.

Whitney also had hopes and dreams of how her family would look. Whitney's mother always spoke about being lonely as an only child. Her mother's statements were engrained in her brain. She and her husband have a dream of having three children. The fact that she has had miscarriages and infertility struggles make her grieve the plans she had and has. Whitney said:

> Going through that process was a little bit of grief in and of itself. You know, I had this image of what I would like my family to look like, and even before we were able to get pregnant the first time, I've always wanted to be a mom. It's like wondering are we going to be able to have kids at all. I grew up; my mother's an only child, so I grew up with my mother telling me how lonely she was growing up. So then, I didn't want to have an only child, you know! But now, it's the dream for us, you know? We've always said, for us, no judgment on any other family, that two is not enough, and four is too many, so like, so now that I'm at two, it's just like, "oh, I'm so close to like that perfect vision for us." And I wonder, like is that going to happen? So yeah, I mean, there's a grief in and of itself just going through the process of am I going to be able to have kids at all? And then, after going through so much to get pregnant, to lose a baby, that's heartbreaking. It's gut-wrenching.

Morgan's entire pregnancy experience had been less than ideal. Having a molar pregnancy was confusing to her. She grieved that her body started the pregnancy and then messed up. She grieved that she had to have a D&C because it was an abortive method to her. But, most of all, she grieved the hopes and plans that she had for her baby. Morgan stated, "I grieved, just thoughts and ideas that I had for the child I thought was growing, you know. I

didn't know. It was very strange, just this very strange situation that I really didn't know how to handle."

Ella described her loss as being different. Ella experienced that she grieved differently compared to other significant losses she had in her life. The loss made her feel as if she had lost out on what she anticipated happening. It was not like she pictured in any aspect. She also grieved the dreams of bringing her babies home and becoming a mom. Ella said:

> It's different, um, the feelings that I had when my, when my grandma or when my grandpa died or when you know, a close friend or loved one dies, they're completely different from the feelings that you experience when a child dies because, to me, it's not only the death of that child, but it's also the death of the dreams and the hopes and the wishes that you had for that child. So, my grief was not linear in any shape, state, or form.

Elise previously had a miscarriage before her second loss. After her first miscarriage, she was upset. She grieved that she was no longer pregnant but was excited when she became pregnant again. After losing her second child, Elise had more to grieve because she was preparing for her baby to come home with her. When her daughter did not come home, Elise was crushed. Elise stated:

> Everyone thinks that when you have your baby and that they go to the NICU, that it's automatic that they get to go home. But every baby doesn't leave the NICU to go home. Some leave the NICU and go to Heaven. For me, my baby dying after thinking and planning that she would come home with me was not only heartbreaking, but it was the worst thing I've ever experienced. It was like watching all my plans, hopes, and dreams

> go down in flames. I knew it would be a long road, but I knew we would come out on the other side, and for my hopes to just be crushed like that was, it was nightmarish.

Sarah also thought things would turn out differently. With her first loss, her midwife assured her there were no complications. She had no reason to think her baby would die. Then, when she lost a second time, she was shocked. Pregnancy complications and loss had never been part of her family's journey. In describing all that she felt, she stated:

> I'm grieving the loss of my child. I'm grieving the loss of, you know, this whole moment in time we thought was going to be, you know, turn out completely different, and now I'm grieving the loss of all the things that we thought were going to happen.

Monique's grief included her childhood dreams. She dreamt of being a mom and taking care of her children. Monique never imagined it would be difficult to conceive or carry a child. She was heartbroken after her losses. A reason for her heartbreak was that she never imagined that this could happen to her. Monique explained:

> I always wanted to be a mom. I don't know about you, but I always wanted to be a mom. I would play with dolls when I was younger and just take care of them. Feed them, change them, dress them. You name it; I was doing it. So, when we decided to start trying for children, and it didn't happen, that was heartbreaking. What hurt even more, was once we went through all of that to miscarry. I never thought that could be my life. I never thought I would hear a doctor say time of death for my child. These experiences destroyed the way I thought we would have a family. Destroyed my childhood dreams. I grieved that. I grieved the loss of what I planned. I grieved the fact that I had to experience that. No one should have to go through this.

Doubting Your Innate Womanhood

The participants all felt that getting pregnant and giving birth was one thing that they were automatically supposed to be able to do as a woman. However, their losses caused them to wonder, question, and doubt their womanhood. Some of the participants' doubts were intensified by struggles of infertility. Other participants' doubt stemmed from the desire to place blame on something to account for the loss. The doubt negatively impacted their self-esteem and feelings of worth.

Prior issues with her body image intensified Lucy's doubt. Lucy suffered from an illness during her childhood. This illness caused her to have some physical disabilities and deformities. When she struggled to get pregnant and then had her loss, the doubt about her body was re-ignited, along with the beginnings of feeling like less than a woman. These feelings also hurt her mental health. Lucy stated:

> I think the miscarriages, especially that second one, just made me feel like my body was a failure even more. With the first miscarriage, I blamed myself a lot because, you know, I thought it was because of me jumping in to save that little boy. I never really got an answer. After having my daughter, I was okay, but then, after it took so long for us to get pregnant again and then miscarrying the baby on top of that, I thought something was wrong with my body. I didn't know why I couldn't have just one thing go right with my body. On top of that, I felt like a failure of a woman for me and for my husband.

Rose wanted badly to have a child of her own with her husband. So, when she lost the baby, she felt like she had let her husband down. Rose and her husband had a lot of discussions about their grief. One frequent conversation was how hers differed from his. A significant aspect for Rose was feeling as if this was something she failed at accomplishing. Rose stated:

> This was my only biological child, and I said, as a woman, you can't understand certain things I'm feeling because, as a woman, carrying a child is just something that I should be able to do, but I didn't, and to have failed at that, and I have a competitive spirit, I like to excel at everything I do, so I felt like a failure.

Whitney's issues with infertility and her body image also played a role in her doubt. The losses impacted her thoughts about herself negatively. She did not feel worthy of love and affection. She mentioned that she felt unworthy and undeserving of having children. This feeling was because of her struggles getting and staying pregnant. She stated:

> You know, I went through the whole like I'm unworthy, I don't deserve kids thoughts. You know, I don't take care of myself the way I should. You know, it's questioning and wondering. Blame and doubt. I did go through the whole I'm being punished for things in my past. But it was really more of like an unworthy type feeling more than anything else.

A molar pregnancy threw Morgan for a loop. This form of perinatal loss was an entirely new concept to her. Additionally, her feeling like she did not understand what happened or why it caused her to doubt herself. Morgan's loss was troubling for her. It was also a blow to her self-esteem. Morgan said:

> And again, I felt like I failed as a woman. It's like, that's the one thing my body should do, and it couldn't even like start off right, like it didn't even, like couldn't even get the first step right, so OK, and like I'm a very confident person so like for it to hit me like that, it was pretty, you know personal to me because I've always been like perform at the highest level, you know like overachieve. And my body was like that, so I struggled with that, for you know, a long time, and again, I just couldn't understand why.

Ella had a few factors that made her feel like she was less than a woman. She struggled getting pregnant. She also struggled with having an incompetent cervix. This condition caused her to lose her twin boys. The name of the condition itself made Ella feel bad about herself. She said:

> It made me feel just like; it made me feel awful. Um, it's kind of difficult to describe because, as a woman, you feel like getting pregnant and giving birth are things that you should naturally be able to do. Um, so when I had trouble getting pregnant, it was just like, OK, you know, your body sucks. What's going on with you? And then, when they told me, "You've got an incompetent cervix," it's like when your cervix opens up too early, like always in the second trimester, but incompetent cervix, such an awful way to put it, huh? Incompetent makes you feel, it makes you feel like you are a failure at something, and certainly enough, I felt, you know, I blamed myself. I felt like I was a failure; I felt like I was less than a woman. I felt like it was this cruel joke, and I was, you know, I was the butt of the joke because here you are, you can't get pregnant naturally, and here you are now, you can't carry a baby the way you're supposed to, so um I felt awful. I felt like a failure. I felt like I was less than a woman. I felt like I had just failed not only myself but my babies and my husband.

Elise's multiple losses and the physical reminders of them caused her to doubt herself. The losses were also a blow to her self-esteem. In her mind, perinatal loss made her feel defective and like she was a failure. Those feelings caused her to be very hard on herself. She had a lot of negative self-thoughts and self-talk. The negativity led her to begin therapy. Elise stated:

> It was sort of like everything was a reminder of how I was a failure of a woman. I was feeling like a failure. Like I'm defective like I'm less than others, which is gut-wrenching. I've always been an overachiever; I've always been able to be successful at things I try to do and failing at that, in the magnitude that I failed, oh, it's hard. It's something that is hard to explain to someone who hasn't experienced it. I wondered what was wrong with my body. Am I paying for a sin? Is it because of this or that? What makes me so unworthy compared to these other people? So, it was a door opener a lot for self-deprecation, a lot of self-hate, and self-blame. At one point, my husband just said, hey, I love you, but you know you need to get some help. And he was right. So, I started counseling.

Sarah never experienced losses in any of her previous pregnancies. So, it was difficult for Sarah when she lost her daughter and then her son. She tried hard not to blame herself or doubt her ability to have children. She struggled with those feelings. Sarah also knew she did not feel best when operating in that mind state. Sarah stated:

> So, we just, we thought, you know, God allowed us to experience the joy of pregnancy, and you know, love on them while they were in my womb, and now, they're in a better place. And what do we get to learn from that? How do we get to take those moments and use them for His glory? So, my flesh wanted so badly to go into that state and stay there, with something must be wrong, or you know, my body failed me, or I failed as a woman, but I tried too hard to remind myself that those thoughts are not of Him and I can't allow myself to camp out there. Obviously, it's, you know, ok to have the thoughts, but I can't stay there because it's not a healthy spot to be.

Monique's doubts lead to insecurities about her relationship with her husband. She thought she was a bad wife because of their difficulties conceiving and losses. In addition, Monique felt like she failed as a wife because her duty was to bear and bring forth children. These thoughts were troubling for her. Monique said:

> It made me feel like I was defective. It made me feel like I was a failure and that I was a waste of a woman and a wife for my husband. I even asked him if he regretted marrying me because he didn't sign up for all this. The doubt took a toll on our relationship definitely. It hurt my self-esteem and me feeling my value as a woman.

Feeling Alone and Misunderstood

Perinatal loss is still very taboo to discuss in many social circles. As a result, many people do not understand why people who have experienced perinatal loss grieve a baby that was not born or a child that only lived for a few days or weeks. The participants felt lonely in their grief. All of the participants found that they did not have many people to whom they could turn. Additionally they found that if they had someone, they did not fully understand the magnitude of their pain.

While perinatal loss is discussed some, in the 1980s and early 1990s, when Lucy experienced her losses, it was uncommon to discuss the topic. As a result, Lucy felt alone. She felt lonely because she did not discuss her losses with people outside of her husband, mom, and sisters. Even in the instances when she did disclose, she still felt alone and misunderstood. For example, Lucy described an incident with a family friend. She stated:

> Then a family friend came over, and he was fussing and told me, "get your life together. Life goes on." I think he meant well, but he didn't know what to say. I felt this was

> common among people who knew about the miscarriage. They would feel like they had to say something encouraging. They had to try to be motivational. It fell flat most of the time and made me feel lonelier and more misunderstood.

Rose experienced feeling alone and misunderstood in different ways. She had friends who she assumed would reach out to her, but those friends did not. That caused her to feel hurt and upset. She tried to make herself feel better about the slight by saying that her friends may not have known what to say or do, so they did nothing. In other instances, when people tried to give support, they did not empathize but pitied her, which caused her to feel misunderstood and isolated. She stated:

> I really didn't want to commune with a lot of other people because I felt like people just felt sorry for me. Like, it wasn't empathy. It was just like sympathy and pity. And they were like, you know, you poor baby, and I would go to church a couple of times, maybe try to go to a grief group, but I just didn't feel comfortable in that community anymore. They didn't try to understand my grief or why I was grieving.

Whitney felt alone and misunderstood because she did not know to whom she could turn. She talked to her husband about her feelings, but that was it. Much of this was because Whitney chose to keep private about their struggles. Another reason Whitney felt alone and misunderstood was due to the lack of understanding from people at her job. She was expected to bounce back as if the medical aspect of miscarrying was all she would experience. Whitney stated:

> The harder side was at work, like needing to take like a week off. My very first miscarriage was the very first day of school that school year, and being a school

> counselor, that day is full of schedule changes, and everybody needs you that day. I like was just like, I have to leave, like a lot of people were mad. A lot of people, and like not only so like I felt a lot of pressure to come back, um because I knew what was happening there like, I like my job I but a lot of pressure to come back some from coworkers.

Morgan's molar pregnancy made her feel alone and misunderstood. A major part of this is because Morgan did not know anyone who had a molar pregnancy. She did not know anyone that could relate to that type of perinatal loss. The second is because of the nature of her loss. Morgan felt that her loss was different from other types of perinatal loss and that, in some way, it would "take away from someone else's grief." Morgan stated:

> I didn't really have anybody to like. I don't know that I couldn't because I didn't really know what, what to grieve or how to grieve again because, you know, there wasn't a little baby, you know like my body just messed up kind of, and I struggle with that.

In Ella's r/s community, she felt like she was an outcast. Ella was overcome with grief but still tried to be an active member of her "church family." However, she felt as if they did not understand her. She felt like people tried to appease her feelings by just saying what they thought would make her feel good. She did not feel like anyone truly cared. Ella stated:

> I felt like nobody at my church really understood how I felt, and even if they, even if they didn't understand, they, they may try to say something like, "well, you know, your babies are in a better place." And I'm like, OK yeah, yeah Sharon, that's good that my babies are in a better place, but I wanted my babies here. I wanted my babies with me. What you're saying right now is not really helpful to me. I'm sitting here, I'm grieving, I'm crying, I'm in pain, and you're telling me that it's better off. Like, I understand that people have, you know, good intentions when they make statements like that, but they

> really, they really don't know that it's actually not helpful, and you know, sometimes all you need to do is just, just say you know, "I'm sorry, I'm thinking of you, I'm praying for you" and leave it at that. If you don't know what to say or just give me a hug and walk off, don't say anything at all.

Elise had a similar situation to Ella. People and friends reached out, but their words often fell short. The comments made Elise feel like no one knew why she was upset. Eventually, Elise grew reclusive and spent a great deal of time alone. She even felt like her husband did not understand her grief. Elise stated:

> Um, so I spent a lot of time alone in my thoughts. People reached out, but they didn't know what to say. They either couldn't relate, or they just threw random scripture at me, which made me even madder. I'd rather you just leave me alone or give me a hug or something if you're just going to throw cliché statements at me like it's going to help. My husband and I spent a lot of time together. I feel like it was just us for the longest because no one in our circle of friends had experienced infertility, and no one had experienced loss. My husband was equally concerned about me because I went from an extroverted person to someone who just wanted to stay in the house and not go out and face the world. I think that this whole experience left me with really bad anxiety and depression and things that I've never experienced before. I felt really guilty because I wanted him to be able to grieve, but at the same time, he didn't fully understand what I was going through.

Sarah thought her r/s community would be a great support system for her and her family. However, she was shocked when they were not as supportive as she hoped. In one experience, she reached out to a r/s community leader and was hurt by their response. She did have some

support from her husband's co-workers and families. Unfortunately, she still felt alone in her grief. Sarah stated:

> But when we actually lost Jamie, we had more support from some people in his job community than we did from fellow believers. There were a couple that reached out and, you know, offered to bring a meal or, you know, sent condolences. But I wouldn't say that it was any help as far as navigating the grief or the healing process or any of that afterwards.

Monique struggled because none of her friends had experienced perinatal loss or infertility. In confiding in them, she often felt misunderstood based on their conversations. She knew they meant well, but it made her feel like she had no one in her corner. Monique also struggled with feeling alone and misunderstood because of her RSS. She felt like no one would understand the complexity of her grief if she shared it with them. Monique stated:

> Well, I think I mentioned it earlier, feeling the way I felt about myself, my feelings about each child I've lost, and the questioning of my faith, the testing of it. I just, it was hard. the hardest thing I've ever done or experienced, and you're literally navigating the grief of losing a child, the grief of losing those dreams you had for the child, and the complexities that come with it blindly. There's no guide to prepare you. There's no one in the hospital or the doctor's office that says, hey, you may have depression or anxiety. Here's what you need to know or be prepared for. So, you feel alone trying to process all of the things you're now faced with.

Uncomfortable Interactions with Others

In most instances, the participants experienced uncomfortable interactions with others based on the ambiguous nature of their loss and the disenfranchisement of their grief. For

example, people would unintentionally trivialize their loss and grief with statements and actions. In other instances, people would ask probing harmful questions. Those questions would remind the participants of their loss and struggles. Additionally seeing people who were pregnant or had newborns made for difficult interactions because of the participants' jealousy.

I previously shared one example of Lucy's uncomfortable interactions with others in a previous constituent. One of Lucy's family friends told her to get over it. He told her that life goes on. This trivialized the loss for Lucy. The statement from her family friend was not the only instance of an awkward interaction with someone she considered to be a confidant after her loss. Lucy stated:

> I had a few people make comments here and there, but I did not really talk about the pregnancy because it was so early. I had just tested with the first one, and I had not even been to the doctor yet for the second one. I had a few people say, well, you know, you have a healthy child or that we were young and could try again, but it did not help me. I think it hurt, but I just tried to get over it. One person asked me why I went to a funeral pregnant if I knew I was pregnant, and that hurt a lot because they were a family member.

Rose had many instances of uncomfortable interactions with others. When she returned to work, she met many people who meant well. Unfortunately, their words ended up being more harmful or laughable than helpful and reassuring. For example, someone told her that God knew how strong she was, which caused her loss. Another told her she was like a superhero, but these were unhelpful. Rose stated:

> I had a parent who was like, "God knows your strength, and that's why this happened because he knew you could handle it." I was like, "What? You're saying God took my baby because He knew I was strong?" That's ridiculous; I can't believe someone would

> say that to me. I had a close sorority sister ask, “Why don’t you keep the name? It’s such a strong, symbolic name of your love for one another, and why don’t you save it for another child?” I was like, “Because this is my child. This isn’t an imaginary fictional character; this was my child. I went through labor and gave birth to him; this is my son. It’s no one else’s name but his.” I don’t know what they were thinking or how they thought that would help. I had another young lady, one I mentored, who was a counseling student, so she should’ve known better. She made a comparison to me being strong like a superhero and was like even superheroes have their moments, and they break. The analogy was so crazy to me. I was like, “what? There’s nothing that compares, what?”

Whitney did not know how to respond to others when they said hurtful things or asked inappropriate questions. Her demeanor was typically cheerful. However, these comments and questions negatively impacted her. She would often become angry when people commented about her body or gave advice on what would help her situation. That aspect bothered her. She stated:

> What I didn't know was like how to respond to people. Grief counseling was actually like one of my favorite forms of counseling. I feel like that's a dark thing to say, but like I'm very familiar with that process and identifying my emotions, but like I'm a bubbly person, and so like the thing that I really struggled to navigate was when I felt angry because I don't, it’s not that I don't get angry but it's just like that would hit me so suddenly, and I didn't know how to approach it like especially when people would make comments. Again, I am not fit as a fiddle. I know I need to take care of myself, and that's all another journey that I am on. However, as you know, I have this Smith belly. Thanks, dad. And people will like just come ask me like “oh, are you pregnant?” And I like just did not

> know how to respond and struggle to not respond with anger, especially for people who I knew had gone through this journey, who understood infertility, who understood pregnancy loss, and knew like why you don't say stuff like that!

Morgan is a private person by nature. Certain aspects of her life, including her pregnancy and loss, were made public because of circumstances outside her control. Many of her uncomfortable interactions were because people felt like they had to say something. People tried to say things that were profound to "help." People would also use scripture or just make blanket statements. Morgan stated:

> I mean, like, and again, they're just trying to help, but like, there's no way to help somebody who's going through something terrible like personally, you know what I mean like, so I, I think people are real quick to just throw scripture at and it did it would make me mad like someone said like all things work together for good and I'm like yeah I know but you know like I know that scripture but right now this is this does not seem good so like I certain things turned me off.

Ella received hurtful comments from friends and family as well. People did not understand why she was still upset and grieving after a specific timeframe. It was as if people assumed that because the loss was over that the emotional part should be too. She was met with hurtful comments and questions when she did not "snap back" like they thought she should. Those comments and questions trivialized the loss for her. Ella stated:

> Oh, it hurt it definitely hurt and some of those statements that are received I got them from people that I considered close friends and loved ones it just seemed like the, the first couple of weeks it was just like okay, you know "take all the time you need. We're here for you," and as the months went by and I wasn't like snapping back to normal it was just

> like okay like “why are you still sad?” like “why are you still upset? Why are you still depressed? You shouldn't be doing this because it was you know you your baby was only like you know your baby wasn't going to survive anyway!” So, it was it was like a slap in the face so it hurt, it hurt my feelings and, and some of those people I have I still have not yet talked to this day. It made me feel like I was alone um that made me feel like there was nobody that understood what I was going through even though you know I know that there are people that have lost their babies I know that there are people that have lost their babies in terrible ways but in that moment in my grief in my despair I felt like I had no one I felt completely alone and it took me a while to pull to climb out of that out of that dark space.

Elise had her fair share of inappropriate questions and comments from others. Her anxiety made facing these situations almost impossible for her. Elise’s friend also felt like she should have been “over it” after a specific amount of time. Her friend’s comments inadvertently caused the fracturing of a friendship. These situations caused social anxiety for her. Elise stated:

> It’s awful. For the weeks after losing both babies, I had this baby belly that hadn’t gone away. So, I’d run into random people who didn’t know better who’d ask, “when are you due?” Or they’d say “congratulations.” Then I’d just burst out into tears and leave my shopping cart and go home. Or I’d run off and not even respond. I had friends who tried to make comments, but they just missed the mark completely. A lot of comments hurt my feelings like, I had a friend who was pregnant, and I told her, “congratulations,” but she got upset because I wasn’t planning on coming to her baby sprinkle. I lashed out at her and said, “I’m sorry, I don’t feel like celebrating you and your third baby’s father after

> me and my husband. I just lost our second baby. I'm sorry, I'm not in a space to deal with that right now."

Sarah's interactions came directly after losing her second child. The hospital staff was less than ideal and not empathetic to her situation. Their actions were hurtful. Some of the staff were very rude and dismissive. She also struggled with people not knowing what to say or do, making awkward interactions with others. Sarah stated:

> And to have a hospital worker, you know, shove a bucket in our face and act like it's not a baby! And then have another hospital worker come and say, "Oh well, I'm not sure if you're aware that our hospital has a disposal service if you would like for us to dispose," and I'm like, "What? What the hell are you talking about, woman? Umm, we already have a funeral home coming to pick up our child. You know he's not waste!" So that was frustrating to see the lack of empathy or sympathy or even just acknowledging that this is a difficult moment in someone's life and in someone's story, and the things that you say have power and can affect the very moment that they're experiencing. And, um, as far as other people in our circle, I just found people just didn't. They just didn't reach out.

Monique found being in public spaces difficult. It was difficult being in public spaces because of her strong desire to be pregnant and her jealousy toward other women who were pregnant or had just had healthy children. Her jealousy caused Monique to withdraw from her r/s community because it was a constant reminder for her. The instances were reminders of what she wanted but did not have. Monique stated:

> I remember going to church and seeing a girl with her baby who was a few months old and just crying so hard that I had to leave. I had to leave. I couldn't take it; I had to get out of there. That Mother's Day, I didn't want to go to church because all I wanted to do

> was be a mother and the opportunity kept slipping from my grasp. And then, there were times when I went back to work; I worked at the same hospital where I gave birth, and it was awful. I had to assess moms who had histories of doing drugs in their pregnancies, and I'm sitting here wondering why I can't have a baby, and these drug addicts have no complications. I was doing everything right, taking care of myself, you know. It was a hard pill to swallow.

Comparisons of Morality and Deservedness

It was common for the participants to compare themselves to others. They wondered why others received the things they prayed for while they struggled and suffered. However, all the participants stressed that they never wished harm or ill will toward others in these comparisons. They found it difficult to understand why they were being put through the trials of perinatal loss when they lived to a certain moral standard. These comparisons stemmed mainly from their r/s beliefs and values.

Lucy was an educator. She would have students whose parents were abusive and neglectful. Also, she often dealt with parents who could not adequately care for their children. They would keep having children even if they could not afford it. These situations were troubling for Lucy because she felt that her position was perfect for having children. Lucy stated:

> I definitely had confusion, and I wondered why God allowed this to happen to me. I struggled with that. I was married, I had a good job, I was able to take care of my babies. I worked in a school where the parents would just pop out babies without a pot to piss in, but it's me who has to struggle, and it's me who loses babies, and I really had a tough time understanding why them and why not me?

As an educator, Rose also had many interactions with parents and even students who were not in ideal situations to have children. One part that was very troubling to Rose was the fact that she was often privy to cases where students were not being taken care of properly. In addition to those instances, there were often news reports of children being abused and killed. These news stories and situations she encountered at work bothered Rose. It bothered her because it seemed like God looked past her and blessed someone else. She stated:

> You see all this news, and people are killing children, and then like, you've got people having 8, 10, 12 kids they can't afford to, you know, raise one child, you know? And it was just. I was just angry for a while.

Whitney also works in education. She has been the first person many students informed of their pregnancies. Whitney did not wish any complications on her students. However, she knew their living situations were not up to par. Additionally, she also struggled with people who are unfit parents that continue to conceive and give birth without any difficulty. Whitney stated:

> You know girls that will come, and it was not unusual for them I'd be the first person they tell! "Mrs. Horne, I'm pregnant. What do I do?" Umm, so that was definitely a challenge. It would cause me to question God. I would wonder why. Why are these babies getting pregnant when they are, they don't have the resources? They don't have stable homes themselves! So that was really challenging because I just don't get it! Not that those kids don't deserve to have families, but they're just not ready! They're not able to provide a home that a child needs! Some of them aren't being provided for themselves, so now their parents are trying to, you know, just make it. Along with my husband's sister who has lost custody of her kids and she's popped out three babies in, in three years so, so those two particular circumstances it was just like this isn't fair! Like I know the life I

> was going to provide with my kids. I knew that I was going to raise my kids to have and share mine and my husband's faith! We're going to, you know, we want them to love and follow Jesus like we do! But we're not getting that chance, and these people who, some of them are pieces of crap.

Morgan's r/s beliefs are engrained in her being. Before she married, her vow of purity was important to her. She thought it would come easy for her when she married and wanted to have children. Unfortunately, having children did not come easy for her, but it did for others who were having children out of wedlock. Morgan struggled with this a lot in her grief. She stated:

> You know, that's when you start asking why. And I remember at the time one of my family members; I'm very strong in my faith, and so one of my family members, like it was really important to me growing up to maintain my purity, and so I'd waited till marriage, and you know I didn't; you know we- I did stuff I wasn't supposed to, but I did wait until marriage. But one of my cousins became pregnant around the same time I did, but it was out of wedlock, and you know her pregnancy went fine and normal and I, and then I just couldn't understand, you know why like I did this, and I did this correctly you know? And I struggled with that a lot, and I struggled. I didn't go to my friend's baby shower; I just couldn't. I sent her a present, but like I was so, it took me a while to be able to see a baby. My sister-in-law was pregnant like all my sisters-in-law had a bunch of little kids, so like it was just, you know, why can't I? You know you do that was when you type thing.

Ella also had trouble comprehending why living to a certain moral standard did not guarantee her life would go as planned. She went so far as to try and bargain with God. She tried to be perfect so that He might bless her with children. Ella could not understand why living a

pious lifestyle did not guarantee everything you wanted. That concept was difficult for her to grasp. Ella stated:

> I looked at the news and saw stories of kids being abused and people having kids they can't take care of, and here I am, married, employed, able to provide for kids, and I can't get pregnant naturally, and then I can't carry without complications. I couldn't understand what they did that I wasn't doing. I did a lot of trying to bargain with God, like, hey, if I do this and this, will you let me get pregnant and have a baby that gets to come home and live? And then I just stopped going to church. I don't think I stepped in church for at least six months after the loss. Even then, when I started going back to church, it was hard. I'd see moms and their kids and just start crying and have to leave. They had a baby dedication one Sunday, and I didn't know they were planning to do that, so when I saw all the babies and their parents up front, I just lost it, and I left. It was hard being around anybody that was pregnant or seeing people post about pregnancy announcements or birth announcements it was, it was really hard because it was like, I really want this; I want this so bad I can taste it, and I got so close, and then it was just snatched away from me like, it was just snatched from my hands, and I was so angry, and I was so bitter, and I was so hurt it was really hard for me.

Elise's profession caused her to see every walk of life. She would often see children who were abused and neglected. She frequently took care of pregnant women who used drugs and alcohol. It was easy for Elise to get caught up in comparing her situation to others. Comparing her situation to others cause Elise to question God. She stated:

> I couldn't see or understand why God would allow this woman who couldn't even love her baby enough to stop using drugs to have a healthy baby, and here I am, doing what I

> think is everything right, and I can't even make a baby, let alone have one make it to be born.

Sarah had no previous difficulties conceiving or staying pregnant. This aspect of grief was difficult for her to wrap her head around. She knew that it was natural to question and wonder why. She tried not to dwell in those thoughts or comparisons for her sake. She tried to redirect by focusing on her r/s beliefs. Sarah stated:

> I'm a woman, and I'm supposed to be able to do this, or I'm living this way; God, why is this happening to me? I refused to allow myself to go down that rabbit hole and fought tooth and nail to stay out of that mindset and just kept reminding myself that God is sovereign and while we don't understand everything that we experience on this side, He's still in control, and He allows things to happen. And rather than looking at it from the lens of what's wrong with me and why is my body screwed? I looked at it from the lens of why God allowed me to go through this.

Monique also compared herself to others based on her r/s beliefs and lifestyle. She felt like she was "doing everything right". Even with doing right, Monique was still not getting rewarded. Monique also struggled with thinking that she would not have to endure suffering if she tried to live a pious lifestyle. Her comparing herself to others worsened her grief. Monique stated:

> I would compare myself to other people and think, okay, God, you know I go to church, I believe. I do this and that; I don't do drugs; I don't drink. I'm married. You know, trying to paint myself as if I'm better than others who may have had a baby with no issue.

A Spiritual and Mental Battlefield

The spiritual and mental battlefield was common among the participants. They turned to their r/s beliefs and practices to cope but often chose negative coping mechanisms, often unknowingly. Interestingly, some participants wrestled back and forth with negative and positive r/s coping. It was as if they wanted to try and pull themselves out of whatever negative mind state they had. The participants described this aspect of their grief as a struggle between their r/s beliefs, thoughts, and feelings.

Lucy grew up going to church. Her grandfather was a minister, and she was married to a minister. But Lucy still questioned God and found her faith was tested. As a result, she stopped going to church for a short time while she processed her emotions. Based on her description, Lucy experienced divine and interpersonal struggles. Lucy stated:

> It was a tug of war. A mental battle of the minds. It was like the angel and devil you see in the cartoons. On one end, I knew it was okay to question, and on the other end, I had thoughts like it's not okay to do this. You're a bad Christian, and you're not really a believer. It was hard to come out on the other side of those thoughts and feelings.

Rose's loss made her very angry with God. Rose also stopped attending church. She felt that people were not empathetic but just felt pity toward her. Rose's RSS centered around her anger at God, but she admitted she never lost her faith. Also, based on her description, Rose's RSS were divine and interpersonal. Rose stated:

> I was just like, Lord, I know you know my strength, but you're really killing me. It's like, you know I'm, I'm still angry, and you're doing this to me. It's like he kept throwing it in my face. Well, they could have a baby, and they can have a baby, but Nope, not you, so yeah.

Based on her description, Whitney's RSS were primarily divine and moral struggles. She questioned why. She did not understand. Whitney also had issues surrounding her morality because she thought her losses were because of past transgressions. Additionally, she also had difficulties with feeling unworthy. Whitney stated:

> Umm, it made the process harder for sure it's; it's just it's the constant questioning of why? Am I not deserving? Why don't you want to give this gift to me, but you want to give it to these other people so easily? Like they didn't, it's like you know, and again the kids, especially they didn't even have to try! Like they had to perform an act, but they weren't trying for a baby like those kinds of thoughts. And it's again it went back to, like, what did I do wrong that I didn't get to do this? Don't I don't get to have the family that I want? So the questioning and wondering just made me feel worse about myself like God thought I didn't deserve the same blessings He was giving to everyone else, if that makes sense.

Morgan described her faith as being strong. As a result, she was reassured by Biblical examples of people questioning God and even being angry with God. However, that did not mean that she also did not struggle with these thoughts and feelings. Based on her description, Morgan experienced divine and moral struggles. Morgan allowed herself to feel how she did but tried to counter those thoughts and feelings with "Biblical truth." Morgan stated:

> I did but I, I guess I as you know look at Job a lot you know and he questioned God and so I knew I could question him and ask why I get angry but I knew that it also needed to drive me towards him not away from him because it's it you know push me away from him then I have no way to deal with you know what I mean like I knew that there's no way I'd be able to do anything and in the end I knew just like his characteristics and like

> again a lot of it was like a mental battle like in my head you know like a thought would pop in and I'd again have to say what was true like no Lord you're good like you're never changing and you have a reason for this but I wouldn't always win that battle in my head/ and I can remember being angry and being blunt like just randomly when I was talked to him just be like I just don't you know I don't understand why and I think I think that's part of grieving so I I think doing that actually helped me grieve instead of like trying to push it down like oh you shouldn't even be like questioning this you should just take it I don't think I don't think there's anything in the Bible that tells us to do that and, and said I do I think it helped me I think it helped me grieve and you know he would send scriptures to me like bring scriptures back to mind that I remembered or things that I learned and I think he really like he would really speak to me just in different ways even when I was having this terrible thoughts about him you know because they were they were not good thoughts but I do I think it I think it helped me grieve because I, I don't think the appropriate way to grieve is to stuff everything down you know.

Ella also struggled with RSS. Her loss caused her to be angry at God. Not only was Ella angry at God, but she was hurt. She had doubts and could not believe why God would allow this to happen to her. By her account, Ella experienced divine, interpersonal, doubt-related, and moral struggles. Ella said:

> I was angry at God. I had doubts. I had doubts about my faith, about His plan, about everything. I was questioning my Christian beliefs because how are you a loving God, but you allowed my babies to die in this manner.

Elise's RSS caused her great distress. She was conflicted by her questioning and anger. Even though she knew there were examples of people doing just as she did in the Bible, she still

felt like it made her a “bad Christian.” As a result, Elise experienced divine, interpersonal, doubt-related, and moral struggles. Elise was troubled by this experience. Elise stated:

> Well, I want to turn to my faith during bad times. I know that I want to run to a loving Father, but I was so angry at Him. Why take my babies, you know? I know that in certain books of the bible that they question God. They lament to God, they express their displeasure with the way things are going in their lives, so I know that it was okay to do that, but at the same time, I felt like God was punishing me for something, and it hurt. I felt like He didn’t think I deserved a baby. I felt that he thought I was unworthy of becoming a mother. I questioned His love for me if He could cause me so much pain. I questioned my beliefs, and my faith strayed.

Sarah’s faith was tested. During her moments of questioning, she always tried to bring herself out of that mind state by focusing on what she believed to be true based on her r/s beliefs. Sarah described going through difficult things before, but nothing of this magnitude. As a result, Sarah struggled with divine and interpersonal struggles. Sarah stated:

> Umm, I question God, why? Why let it happen that way? Because if you're in control of things, couldn't you have picked a different course couldn't you have chosen a different means to allow things to happen? But then I just kept coming, I just kept coming back to he's still God, and I don't understand why things happen other than the fact that this is just a very broken world; bad things are going to happen. And when it happened the second time, I questioned Him again, like why did we have to go through this twice? A year apart, no less!

Monique spent a great deal of her life in the church. She shared that she had family members in ministry. Also, her father was a pastor. So, dealing with RSS were difficult for her.

As a result of her loss, Monique experienced divine, doubt-related, interpersonal, and moral struggles. Monique stated:

> Well, I went in there, and I told the counselor that I'm angry at God and I'm bitter, and it scares me because I can't say that God is good because I don't see how a good and loving God can kill my babies. I don't see how God can take my babies away from me. I definitely kept questioning God and my faith, and that, in turn, made me feel like I was a bad Christian, and it made me even more depressed. My daddy was a preacher, and I grew up in church. I read the Bible, and I believed in His word, but I felt like I couldn't trust it because He said He'd give me the desires of my heart, and yet all I want to do is be a mom, and He's not letting me. It took a lot for me to get to the place where I realized that I may not understand why while I'm living, but that I need to trust God's plan.

Post-Loss Disruptions

The participants' losses and grief were not just temporary. Some aspects of the losses and grief have continued to impact the participants' lives and their grieving. For example, participants noted disruptions like new mental health diagnoses. Other participants experienced nightmares and panic attacks. One participant also expressed having issues being intimate with her husband.

Lucy had to take a leave of absence from her job after her loss. She returned to work but was soon overwhelmed by depression and anxiety. She thought she was alright, but in reality, she was not. Lucy felt it was best for her to take some time to focus, re-group, and heal. Lucy stated, "So, eventually, I went back to work. Shortly after that, though, I had to take a leave of absence from work for about three months. Because my nerves, the anxiety, and depression, it all, it was there."

Rose was overwhelmed and confused by all the questions the hospital staff was asking while she was preparing to deliver her son. Because of the lack of discussion and her confusion, she missed out on having a burial or formal memorial service for her son. She also does not know what was done with her son's remains. Rose often thinks about these things to this day. She stated:

> But we never did any kind of formal service. They asked me did I have a funeral home or a crematorium, and I was like, no; I mean, I didn't know what to do! And the last thing I remember them asking me was, do you just want us to take care of it? And I said yes, but I didn't know what that meant, and I think to this day, that's the hardest part for me. Years later, I mentioned it to my husband, and he was like, oh my God, you know, I don't know. My mom was like I'm sure they had different medical uses, and I think that's the one piece that is always going to bother me. I'm a woman of faith, and I do know that the body is just temporary, and the spirit is what's in heaven, but at the same time, I'm like, what happened after I left the hospital? I don't know.

Whitney's post-loss disruptions include daydreaming about the child she lost whenever she sees a young girl in her town. Whenever she saw the child, she would think about the child she had lost and get sad. The losses also impacted her intimate life with her husband. She described having a spark and then experiencing a loss and starting a cycle of not feeling genuine intimacy. Whitney stated:

> Because it's like the infertility aspect and then the perinatal loss aspect has really hurt our intimate life. I say that because sex just became a chore versus a way to connect, so that's been the hardest thing. It's like we go through all this timing intercourse and things so we can get pregnant, so it's very methodical and intentional, not just spur of the moment I

> want to be with my husband. Then we have a loss, and it's like it hits me to the core. It took me some time to get to the point where I felt like we had a spark in our relationship again, but it's like, you know, we finally got to a good place in our intimacy life, and then like I said, we got pregnant out of nowhere and then miscarried and then, and it's just it's like it just started right back over. I blame myself a lot for these issues. I feel like it's my fault. It's all me like he's still like, you know, ready to go! But I'm like, like, it takes me days to, like, get up the desire. I feel unworthy because of all the losses and the struggles getting and staying pregnant.

Morgan now has a son. However, she still thinks of what it would have been like to have had a normal first pregnancy. She wonders what it would be like to have two children instead of just one. She stated how she sometimes gets sad about her loss. Morgan stated:

> I still think about it even though I have a son now. I see moms that are around my age. I have two kids that would have been about the same distance apart, you know, and it makes you wonder again and flip back into why couldn't we have just, you know, like why couldn't have just went normally.

Ella was unfortunately plagued with anxiety and depression. She was a happy person but felt like she had a personality shift. After the loss, Ella felt like she was still pregnant. Ella also has panic attacks now and even has nightmares and flashbacks. The flashbacks and nightmares cause her to relive the entire ordeal. Ella stated:

> Well, you know, I had awful nightmares the first couple of months after it happened, like I would have nightmares reliving the entire experience, like from, from me feeling the sack in the bathroom from the ride to the hospital and me praying from me feeling them kick for the last time to feel in my, my water break and feeling the pain of pushing them

> out and then you know hearing the sound that I made when I was screaming and crying just replaying in my ears from the phantom movements of thinking I still felt them kicking it was it was like I was going crazy in a sense.

Elise also received new mental health diagnoses. She is even on a medication regimen. She was diagnosed with anxiety and post-traumatic stress syndrome. Elise has panic attacks and flashbacks of taking her daughter off of life support. Elise stated:

> Ever since the losses, I've had really bad anxiety, and she's diagnosed me with post-traumatic stress syndrome too. I have really bad flashbacks of taking my baby off life support. I have nightmares. It's just like the smallest thing can trigger me, and I shut down. I have panic attacks out of nowhere. So, it's been very difficult.

Sarah never experienced any mental health problems prior to her losses. After the losses, she felt like she has developed anxiety. Sarah stated that the smallest things would trigger her to have a panic attack where she feels as if everything is happening again. She has what she described as a psychosomatic experience. Sarah said:

> Just meditating on scripture, whether it be through anxiety because anxiety was not really an issue before any of this happened, but it's almost like random PTSD where little things will trigger anxiousness and fear and just reminding myself that God did not give us a spirit of fear but of power and of love and of a sound mind, and so I try to focus that verse has been used quite a bit over the past two years. Any little twinge or me feeling off will take me back to that moment with both of them, and my body will start to react as if something's wrong with me and I'm getting ready to drop dead, and that was never really a thought before.

Monique has been plagued with post-traumatic stress symptoms as well. For example, she has nightmares. She described the nightmares as being very realistic and troubling for her when she has them. She still has the nightmares and thoughts. However, she does have support from her counselor to work through reducing the number of times she has intrusive thoughts. Monique stated:

> I still have nightmares about giving birth and my daughter dying. Now that I know it's normal and now that I have support and plans in place, I think I'm making progress. It's all a journey, it's part of my story, and I'm growing through it all.

Finding Ways to Cope

Each participant coped in their own way. Some participants coped by positively turning to their r/s beliefs and communities. Others used their r/s beliefs in more negative ways. Some participants sought therapy, journaled, or turned to their spouses for support. Participants used r/s coping, both negative and positive, while most used both r/s coping and secular coping mechanisms.

Lucy's RSS caused her to take a step back from attending church. She also stopped reading the Bible and praying. She eventually started therapy and made progress. She got to a place where she began attending church again and resumed her r/s practices. She felt that these steps were positive steps toward her beginning to cope. Lucy stated:

> I think part of what helped was starting to pray and read the Bible again and going to therapy. My counselor had to help me see that those thoughts and feelings were normal and helped me develop a way to get through that patch.

Rose's coping consisted of finding ways to make memories that honored her baby. For example, she made a shadowbox of the clay molds of his hand and footprints and the outfit he wore. She also journals and collects Christmas ornaments in memory of him. One method of coping for her was also listening to his heartbeat and the scrapbook she created for him. Rose stated:

> I did go to grief counseling, and not a lot of sessions. I remember it wasn't a lot, but also, you know, as I said, the book, the scrapbook that I like created that was very, you know, meditative for me. I would just kind of reflect back on the process. I still have access I can whenever I get ready to, I can listen to his heartbeat, and I still every now and then I listen to, you know, the ultrasound because I have it saved and I listen to his heartbeat.

With Whitney's first loss, she did not process it well. Her method of coping was ignoring her feelings and pushing them to the side. After realizing that was not the healthiest method, she sought help and r/s support from her r/s community. Whitney found comfort in sharing her experiences with people in her r/s community. Whitney said:

> Yes, so definitely talking with other people who have gone through this my Bible study groups and just really challenging myself to find my acceptance through my studies, and like I remind myself of this over and over. Is that the way society, like I said, pieces of crap who get kids so easily that's the world's view of those two people, and that's not God's view of those people and like learning to accept that like in God's eyes, I am no more deserving of a child of those people are which is a hard thing to accept. Like I said, that is a really hard thing Umm, but I, it has helped that that thought alone has really helped me find some peace because not because it makes them deserving, but it just means that it doesn't make me any less, that I deserve those desires of my heart and God

> views me as being just as deserving, but that he might have a different plan for my life, and that I need to be OK with that.

While some participants craved the company of others and talking out their feelings with people who have had similar situations, Morgan was the complete opposite. She preferred to turn to her mother and others with whom she had a trusted relationship. She also turned to her r/s beliefs and read her Bible. Morgan said:

> I think that's kind of how I dealt with that and really and really to just fighting off thoughts that was a lot of it like just trying to keep those thoughts like at Bay and not letting myself like sit and think on those for very long because I knew I knew those were negative thoughts and I knew those were not you know you kind of ask yourself what's true I knew those things were not true, so I tried not to let myself like meditate on this too long when I know.

Ella tried grief counseling but did not feel it was helpful. So, she turned to her husband, journaled, and went for long walks. Ella turned away from her r/s beliefs and practices. She did not see the need to pray or read her Bible when she was so angry with God. Ella did have a turning point where she returned to her r/s beliefs to cope. Ella stated:

> I think the turning point was maybe a talk with a talk with one of the people who reached out to me after the experience kind of helped me see that yeah it's not it's not uncommon for you to question or to wonder or to even be angry at God and you're allowed to have those feelings you're allowed to feel the way that you do but at some point you have got to come up with a plan to work through those feelings so that you're not stuck and I just start it crying my face off like I just cried and I cried out to God and I said God I know

> that you love me and I know that you have a plan but I really just don't understand it and I know that you're sovereign but I just I don't get it help me to be OK with not understanding and it was like after that God maybe placed a special person in my life who would just send me scriptures that would read and I would meditate on those scriptures and I would start I started praying again and it was kind of like a an aha moment for me to where I I got to the point of saying you know I may not understand I may never understand on this out of earth but I know that everything the good and the bad it's just a way to bring me closer to you and a way to eventually bring glory to you so I'm I'm I'm at the point of of understanding that I may never understand and now I want to get to the point where I don't want their death I don't want this loss to be in vain.

Elise withdrew and isolated at first. Her entire demeanor changed. She got to the point where her husband was concerned and urged her to go to counseling. Her counselor has been beneficial in her developing positive ways to cope. Elise stated:

> The one [counselor] that I'm with now and the one that has just been absolutely amazing. She was able to help me verbalize my feelings, so I've been able to explain what I was feeling to my husband, which has been so helpful for us. She's helped me identify triggers and coping mechanisms. She's helping me realize that my negative thoughts and things aren't the truth, and I'm slowly finding ways to replace those thoughts with the truth.

Sarah knew her thoughts and feelings were normal, but she did not want to stay there, so she tried to solace in her r/s beliefs and practices. Sarah frequently prayed, read the Bible, and tried to find the lesson in all that happened. One aspect that really helped her cope was opening up to her husband about how she felt. Sarah said:

> We had less of a circle with the second loss really no circle as far as support goes and it's only been through taking every opportunity that I can to share what actually happened with different family members from start to finish that I've had more of an opportunity to grieve and it finally came to a head where I had to I had to tell James, "you know I'm not OK and I know you're not OK but I'm not OK either and I need to speak out loud what I'm thinking and how I'm feeling" and once I did that ,which was probably about four months ago, and there are last loss was last November we're coming up on and hopefully first November after these two of not going through something and saying and after sharing with him more real how I felt… and how the past couple of years have been, there was a sense of relief and you know him being able to really be even more honest with his emotions and what he's been going through and feeling like he's filling in the spot where he's starting to see the light again and not living in fear.

Monique's RSS kept her from being a part of her r/s community and from turning to her r/s beliefs and practices. After some time, Monique eventually started counseling and joined a support group at her church. One positive aspect of that for Monique was no longer feeling like she was alone. Monique stated:

> Having found the support I've found now has helped a great deal. I know that it was ok for me to feel what I felt, and now I'm working towards keeping those thoughts from consuming me again while still honoring the memories of my children while being the best mom I can be for my child that's here with me on earth.

Trusting God's Plan

At some point, the participants all had a moment where they decided that trusting God's plan would be more beneficial for them. As a result, they stopped trying to determine why their losses happened to them. This shift was often characterized by a return to their r/s beliefs and practices in a more positive way than prior. In instances where participants did not dwell on the negative aspects of r/s coping, this was marked by their constant self-reassurance of their r/s beliefs.

Lucy went through a cycle of questioning God, wondering why, and even withdrawing from her r/s community. After counseling and making progress, Lucy resumed reading her Bible. She also started praying and attending church again. For her, it was the realization that God was in control and her trying to control things would be futile. Lucy said:

> But I think it eventually strengthened my faith. I had to believe the scripture. I just had to. I had to believe that if it was meant for me to carry the pregnancies, that it would've been. He makes no mistakes, and I didn't get to the place where I was angry with God or bitter because it was very early and I had a healthy child, but I did wonder why I questioned Him.

Rose stopped attending church in person. After a series of events that made her withdraw from her r/s community, she did what she felt was best for her. Even though she did not attend church and was angry with God, she never lost her faith. Rose still does not think she has the r/s community she wants, but this experience caused her relationship with God to deepen and shift to a different level. Rose stated:

> I kind of kind of shifted the way that I, I practice my relationship with God. I've never totally lost it, but I was angry for a minute, but I, and then I just know, I mean, so many different things have happened in my life I'm like, what would my life be like if John was here and I was dealing with this so yeah I, I don't know where would I be right now who knows but I do know God has a plan and I do know I have to trust in it I was just really hurt at that time yeah.

Whitney's faith was also tested. However, even though it was tested, she never lost her faith in God. Whitney reflected on how she trusted God wholeheartedly with other aspects of her life but was conflicted with her struggle to trust God with getting and staying pregnant. Even though she realized this was what she should do, she still recognized it would be difficult. Whitney stated:

> It's like, why can't I take that same approach? Why do I have to control this area feel like I have anything to do with it, so very much relating it to the grieving process; I'm not going to be able to fully get over it. I just realize I need to let go and let him have control, but I still like just insist on picking it back up and be like, "nope, I got it." I don't know. I, yeah, I still haven't learned how to get past that that that's just one that's a that's a rough thing yeah that's a rough one.

Morgan's realization came in church service one Sunday. She sang along during praise and worship and had a realization that comforted her. She was by no means over what happened. But at that moment, she had resolved that no matter her emotions or feelings, she would trust in His will for her life. This moment was a turning point for her. Morgan said:

> Finally I just realized having in church one Sunday they're singing that song that's like, "You're a good, good Father" and it talks about "you've been so good to me" and then at the end they sang like for invitation they sang "It Is Well With My Soul" and finally you know I just I had to claim that because you know even if He never did anything else for me just what he did at the cross is enough like He never asked to do anything else for me ever again and so I finally just kind of settled on that and I could finally just saying you know even though I'm not like okay and I'm not happy and I'm not joyful still well with my soul because I know that about things you know work together for good and that's kind of how we you know you just it kind of gets redundant but you just keep telling yourself that and He's the Great Comforter and I fully believe that's the only way I was able to you know get through something like that and I don't know what I would have done if I didn't have that relationship part.

Ella also went through a rough period because of her RSS. In retrospect, she realized that she would never understand and that trying to understand was only a hindrance. Ella realized that God placed certain people in her life to help her. She started to trust in God and rely on her faith. Ella stated:

> I want to say that now looking back from like looking back, I can see that it's God orchestrating all these relationships and putting me into contact with all these women and these people and showing me that I'm not alone and helping me restore and strengthen my faith in ways that I can't imagine because now I can say that he has the plan and although I don't understand it I'm going to trust it and I'm going to trust in his word and I know that I will see my babies again one day

After finding a counselor and grief support group, Elise realized she would be okay with not understanding why the losses happened to her. She learned that every day would not be easy. She resolved to trust God's plan for her life. She knew this was the best for her. Elise stated:

> But, with this, I couldn't and still can't understand why God wouldn't give my babies a chance at life. So, trying to understand has been a stressor; at least, that's what me and my therapist came up with. I am working toward being okay with never understanding fully. I know it's His plan. I'll see my babies one day. I know that I have to accept that. One day at a time, though, one day at a time. I had to kind of get to the point of feeling comfortable of praying again and feeling like I can talk to God and that he hears my prayers and that whole answer my prayers. I was just so angry I was consumed with anger towards God, and don't get me wrong, I still have my moments. I just start it crying my face off like I just cried, and I cried out to God, and I said God, I know that you love me, and I know that you have a plan, but I really just don't understand it and I know that you're in control but I just I don't get it help me to be okay with not understanding.

Sarah used her questioning and wondering as a time to try and draw closer to God. While it may have been natural for her to want to stray, she knew that relying on God was what she was called to do based on her r/s beliefs. Sarah tried to remind herself constantly to trust in God's plan. She did this even when she questioned Him and wondered why things happened the way they did for them. Sarah stated:

I just kept asking why! I don't understand, and I still have those moments where I asked him you know I, I wish that I had a glimpse into the bigger picture of why. And I don't even know if this knowing the why would which help. I don't know; maybe it would, maybe it wouldn't. Umm, so I, I try not to focus on the why and just instead turn that why into what can I

learn? What can I do to be stronger coming out the other side of this? What does God want me to learn in all of this? And how can I, how can I use this? So, I definitely have my questions. I didn't. It didn't make me question my faith. That's one thing I will say didn't falter. I still trusted that He was who He says He is, and my belief that He was, you know, still who He says He is, none of that changed. But the "why" has come out quite frequently over the past two years. Umm, I, I definitely have leaned on those scripture and just different verses over the years that, you know, have meant a lot to us just, you know, always trusting that, that you know He's, He is working everything for good while we don't understand it, it's like you know He sees overhead we just see what's in front of us today.

Monique went through a journey from rolling her eyes in the church to saying she trusts God's plan for her life. Monique stopped singing praise and worship songs. Additionally, she stopped reading the Bible and became a recluse. She then came to realize that she had to trust God to get out of her despair. Monique's experience of getting to that realization was comforting for her. Monique stated:

> Well, it's comforting in a sense. Um, I guess it's one of those things where I'll never completely understand, but I know that I trust Him. I know what the Bible says about life after death, and I trust that my babies are in His arms. The feeling is bittersweet. You know, this whole world is scary, the fact that they don't have to deal with it is good, but I still selfishly wanted my children. I haven't carried a child that I haven't wanted. When I think of it that way, I can see that my spirituality has maybe grown a bit because I'm not in the place where I once was, but I didn't think I'd come out on the other side of the grips that grief, anger, depression, and all of the other things I experienced had on me. It was like one thing stacked on top of another.

Transitioning from Struggle to Growth

Each participant grew following their loss. While they may have had areas personally where they grew, they all grew in their faith following their loss. The participants described the experience as a struggle for their faith, but ultimately, they said it was strengthened. While some participants may still be actively grieving, they still feel that their faith has strengthened from their loss and grieving process.

As the oldest participant, Lucy has had more time to recognize how she grew from her experience. In addition, Lucy's daughter is grown and has children of her own, which for Lucy, is an excellent opportunity to reflect on her growth and what peace she felt from trusting God. Lucy can now look back at the pain and struggles she experienced and see how God orchestrated every aspect of her life thus far. She feels that the experience only prepared her for more difficult times, like her husband's death. She stated:

> It's good. It helps me see that He has a plan. I have to trust it. I don't have to understand it. People who don't have a spiritual belief or faith in God will never understand. But, if you surrender and submit to Him, you know that it's His plan; you're not in control. He gives and takes away, but He's still good and worthy of praise. It helps me see nothing is my fault and that I need to trust that He'll work it out for my good and His glory. I think in my old age, I'm able to see that and embrace it, and it gives me peace.

Rose found fulfillment in other ways than having a child. Her work in education and with other children has helped her realize that maybe her purpose in life was different than how she thought. Rose resolved to continue moving forward, determined to have joy. She and her

husband still honor the memory of their baby, but she is at peace with what happened, even though it hurts and still hurts sometimes. Rose stated:

> I guess blaming you know someone other than myself you know you like you know you took my child from me you did this I don't know like I, I definitely just went through those phases of grief but I just think I stuck there and hung out for a while because I just didn't understand why, why me Lord you know it's kind of like that why me no you know and it's one thing to have your faith tested but I felt like mine was just like I don't even know I won't say my faith was destroyed because I never totally lost my faith but it was it was pushed to like the ultimate limit I felt like during that time and I just didn't understand why so it was just and I know I never will you know like I said I know there's a plan and I just don't understand why that was the plan for me why that happened and I think that that was the most significant thing it's just it shook me pretty hard I was just saying it really shoot my face but it was such a strong foundation of part of my life that eventually I just said okay I've got to accept this or I'll. I'll never move on, I'll never, you know, experience joy, I'll never be happy.

Whitney believes that her experiences strengthened her faith and her trust in God. Through the complexities of her journey with infertility and perinatal loss, Whitney realized that she would be much more at ease if she put her trust in God. She reflected and realized that she felt like she would not have made it through some days of her grief without her r/s beliefs. Whitney also believed she grew even though she still struggles with trusting Him entirely in this aspect of her life. Whitney stated:

> I would say that it challenged and strengthened my faith. Challenging in the way that it's God doesn't see me as I see myself. God doesn't see others as I see them, and he is God,

> and I am God, but at the same time, how somebody gets through this without faith in the Lord, I do not know because there were days that those darker days those tunnel days that I don't know how I literally. After all, I'm not a morning person; how in the world did I get my tail up every day driving to Charlotte, take hormone shots, get blood draws, and be at work by 8:00 AM with a smile on my face for those kids I don't know how I did it other than, other than Him.

Morgan knew that this experience could either challenge her faith or strengthen it. She chose to allow it to enhance her faith and relationship with God. She feels like not suppressing her thoughts and feelings, even the uncomfortable ones, helped her rely on God even more. She even thought that she had experienced growth. Morgan stated:

> I just wish I wish I could, could have seen into the future that like God was gonna bless me with a, a son and you know it was going to be good and but still looking back, if I would have known that it wouldn't have required any faith you know, to know that he's good it wouldn't have required me to claim that he is good even though the situation was bad um. So I'm kind of thankful that I didn't know because it did give me a more intimate relationship with the Lord just, I guess, just more because there is a lot of feelings that I couldn't that nobody else could empathize with, so I had to turn he was the only one that I could pour out to so yeah I do kind of wish I knew that, but I don't kind of do that so, but that's really about the only thing I can think of. Um, it’s all His plan.

Ella described her grief journey as being a very dark experience. She only started to feel relief once she began counseling. However, once Ella started counseling and found the help she needed, she transitioned from being in a dark place consistently. Ella described it as finally being able to see the bright side. Ella stated:

> I would say that the experience challenged my faith definitely it challenged my faith because I went through all of those things, and I think that they really played a part in my grief think that they, it calls me to have more intrusive thoughts. I think that it calls me to be angrier be more bitter. I think I'm finally making some progress, some headway, and I mean, like it's been two years, and I still have moments where I'm like, "you know God why, why me? like what, what did I do to deserve this?" Or, "what did my babies do to deserve this?" But I, I try, try my best to block out those thoughts and to, to keep from spiraling back down into a really dark place I, I'm able now to, to I'm able now to still say you know God is good in spite of and for a while there I was not able to say that.

Elise realized she had grown when she stopped trying to understand. Elise found that trying to understand why was causing her more harm than good. In working with her therapist, she has come to a place where she is okay with not understanding. She also got to a place where her anger toward God no longer consumes her. Elise stated:

> But, with this, I couldn't and still can't understand why God wouldn't give my babies a chance at life. So, trying to understand has been a stressor; at least, that's what me and my therapist came up with. I am working toward being okay with never understanding fully. I know it's His plan. I'll see my babies one day. I know that I have to accept that. One day at a time, though, one day at a time. I had to kind of get to the point of feeling comfortable of praying again and feeling like I can talk to God and that he hears my prayers and that whole answer my prayers. I was just so angry I was consumed with anger towards God, and don't get me wrong, I still have my moments. I just start it crying my face off like I just cried, and I cried out to God, and I said God, I know that you love

> me, and I know that you have a plan, but I really just don't understand it and I know that you're in control but I just I don't get it help me to be okay with not understanding.

Sarah tried to remain positive even while dealing with her grief. She tried to find the lesson God wanted her to learn through her losses and grief. While she has experienced difficult things before, she felt that this was on a different level of difficulty. But, throughout the grief experience, she could see how God moved in her life, and she had joy. Sarah stated:

> But then when you go through something that's really hard on a different level, different kind of hard and difficult and painful, it's just it's like it activates a totally different area of faith that hadn't been touched before—just solidifying that He is capable of bringing anybody through anything. There's nothing that we will ever go through that God isn't capable of giving us peace and giving us a joy in the midst because we have joy. You know, as believers, it's the fruit of the spirit; it's not something that we have to earn or that you know we have to work on; if it's freely given, it's just a matter of us choosing to operate in it. And seeing over the past two years, you know, the ability to take what was a very difficult and dark situation times two and still find the joy in the midst of it all has brought us closer to Him has brought us closer together, it's, you know, affected some of the ways that we parent because you look at your kids differently when you go through those moments. And so, I definitely feel like my faith is stronger coming out the other side of both experiences.

Monique found the support she needed. She turned to her r/s beliefs positively to cope and had a breakthrough. Monique eventually realized that the only way to move forward was to completely trust God’s will for her life. It was at this point that Monique realized she had grown. Monique stated:

> I mean, me questioning God and being confused and doubting my beliefs just sent me down a tailspin. I know you can question God; Job did. But I still felt bad for doing it. I don't know why, exactly, but I just did. Um, I'd also say there was a spiral of depression and anxiety; I was just consumed with grief and anger. At the same time, I tried to read the Bible and try to pray that God would help me understand. I mean, I'm still grieving, and I'm still working through my feelings, but I think it's a bit easier now that I know that I may not understand why it happened. I guess I just have to continue to trust His word and know that He will use this for my good. I think my losses pushed me away from my faith, but eventually, I worked my way back to it. I'm still a work in progress. I'm still in counseling, and I'm still going to my support group meetings, and that helps me so much. I think also being able to see that God has a plan and that I will see my babies again one day gives me something to look forward to.

Research Question Responses

This section contains the answers to the research question that guided the study using the constituents generated from the data analysis. The research question was: How do women with r/s beliefs describe their lived experience of grief from perinatal loss? While each grief experience was different, each participant's grief had certain qualities that could not be varied and was necessarily true of all individual entities. The identified constituents attempting to process the loss, overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, comparisons of morality and deservedness, a spiritual and mental battlefield, post-loss disruptions, finding ways to cope, trusting God's plan, and transitioning from struggle to

growth provide a detailed description of the grief of women with r/s beliefs related to perinatal loss.

General Structure of Lived Experiences of Grief After Perinatal Loss

The participants lived experience of grief includes attempting to process and make sense of their loss. For example, Ella had a second-trimester loss and was immediately trying to process her reality. She stated, “To just kind of be so scared of what was going on like I had an idea of what was going on, but I didn't really fully accept it, because you know I'm sitting there like trying to find ways to keep the inevitable from happening it was painful; physically, mentally, emotionally.” Trying to process the loss led to the participants having many emotions that often consumed them.

Participants experienced an overwhelming variety of emotions. They described their feelings as being something similar to a rollercoaster. Some participants expressed that all they could do was cry. Others said they felt like they were in a dark tunnel or spiraling into a dark ditch. Monique stated, “I’ll never forget the feeling of being wheeled out of the hospital with a little box in my arms instead of my baby in my arms. Like it was heart-wrenching, terrible, something I wouldn’t wish on my worst enemy.” A state of confusion exacerbated the overwhelming emotions.

The participants were confused because they had to navigate a problematic grief experience without knowing what to expect. Many participants expressed confusion about why it happened, why it happened to them, and how to move forward. For example, Sarah said, “There was no paperwork given to us saying hey, you need to follow up with anybody. Here are some signs of depression that you might experience, and these are some things that you need to, to do.

Like, zero was talked about like I was given instructions as far as my health goes, and then I was sent packing, and that was very frustrating." The loss caught them off guard, and due to the disenfranchised nature of grief associated with perinatal loss, they were often left not knowing what was going on or to whom they could turn.

In addition to grieving their children, the participants grieved other aspects of pregnancy and childbirth. For many, this was evidenced by wanting to give their living children siblings or wanting to have a certain number of children to fit their ideal family. Whitney discussed the hopes and dreams she imagined for the children she lost. Whitney shared, "I think with the loss of a baby, whether you know about it for three days or eight months, there's the loss of, um, the potential that that life the love of, um, you imagine with that. You think of the child, the memories you'll make with that child, the life of that child. It's different; it's, it's, it's the loss of the potential versus just the loss…." Not only did participants grieve other aspects, but they doubted their womanhood.

Experiencing perinatal loss caused the participants to doubt their innate womanhood and have negative thoughts about themselves. The participants blamed themselves, felt guilty, and felt less than a woman because of their losses. Many had preconceived notions about how a woman's body was supposed to work. For example, Morgan stated, "Like I felt like my body has failed like it's the one thing a woman supposed to do, and my body didn't do it right." Participants also felt lonely and that no one understood what they were experiencing.

Based on the nature of the loss, participants often felt alone and misunderstood. They thought they had no one to turn to, and no one understood their grief or why they were so upset. For example, Elise tried to share her thoughts with people only to be dismissed by them or have her emotions trivialized. She shared, "I felt really lonely. I felt like I felt alone. I felt like I had no

one to turn to." Other participants did not hear from loved ones that they thought would reach out, and others received insensitive feedback from people regarding how long they should grieve.

The nature of the loss and their grief also made participants uncomfortable with others. People would say things that seemed appropriate, but they were harmful. Ella had numerous occasions where she felt like this. She said, "I understand that people don't know what to say, but it, it, it, it didn't help with how I felt at the time. It certainly didn't make me feel any better, and it certainly didn't say make or help me to snap out of, of whatever depression or grief I was going through at the time. If anything, it made me have questions and doubts; even more, I feel like the statements trivialized what I was going through." Participants also experienced a moral struggle when they compared themselves to others based on their r/s beliefs.

In their attempts to understand why they experienced a loss, participants compared themselves to others or tried to refrain from comparing themselves to others based on their moral standards as an attempt to reconcile who deserved to have children. Elise had one experience on her first day back at work following her first loss. She said, "I couldn't see or understand why God would allow this woman who couldn't even love her baby enough to stop using drugs to have a healthy baby, and here I am, doing what I think is everything right and I can't even make a baby, let alone have one make it to be born." None of the participants wished ill on anyone, but they could not understand why certain people and not them. In addition to the moral struggle, participants experienced other RSS in their grief.

The participants experienced one or more RSS in their grief experience that impacted their grief and mental health in various ways. For example, Monique vividly described her experiences in her r/s community following her loss. "I mean, I was rolling my eyes in the

church. I would hate being in there because I didn't feel I had anything to be thankful for. I would see everyone else have what I wanted, and I couldn't figure out why me. What have I done wrong? What have I done to deserve this? Now I'm able to say and believe that He is good in spite of my circumstances. I mean, I stopped going to church. I stopped reading the Bible. I stopped singing gospel music and praise songs. I just stopped. Oh, those doubts and anger at God and the questioning, I honestly think, made my grief worse. I mean, I hated myself, and I was even more upset and angry with God. I won't dare say I hated Him, but I was so confused, and I felt like He hurt me so badly." This description was just one example of the battles participants described having between their r/s beliefs and their thoughts and emotions.

In many instances, the participants' losses impacted their lives. These post-loss disruptions manifested in ways like anxiety, post-traumatic stress disorder, nightmares, and projecting onto other children who would be the same age as the child/ren they lost. One participant's intimate life was impacted, while another's professional life took a hit. For example, Lucy shared that she had to take a leave of absence from work due to her mental health. She stated, "… I felt like I was in a dark space mentally. I just had consistent negative thoughts." In some way, participants tried to cope with their grief.

The participants tried to find ways to cope. Their coping mechanisms were either r/s or secular, positive or negative, to help them work through their grief. Elise shared that she started to read the Bible to help, "I started using the scripture to help when I feel unworthy or like a failure or like I'm defective. I actually started going back to church and reading the bible again. I'm praying now. It's been a long struggle. A long road. But this is part of the journey…." Other participants used secular coping mechanisms. A few started grief therapy or found a perinatal loss support group. One used journaling and scrapbook making to help cope.

Eventually, participants worked to resolve their RSS. They found a way to strengthen their r/s beliefs, trust God's plan, and accept His will for their lives. Lucy shared her journey by saying, "I think it weakened my faith and then eventually strengthened my spiritual journey because when you go through something like that, a trial, a trauma. When you go through that and realize that there's nothing that you can do, you have to believe in the One who is and who has and will do." All participants recognized that, based on their r/s beliefs, relying on God would be better for their grief and mental health.

Finally, participants worked through their complicated grief and their struggles and transitioned to grow from their experience. Participants grew personally and spiritually. Monique shared that she felt like she saw the light at the end of the tunnel. This is because she found the proper support. She said, "I think I'm making progress. It's all a journey, it's part of my story, and I'm growing through it all." Others saw growth in their spirituality and their view of God. In every form, the participants saw personal growth.

The participants experienced different circumstances surrounding their losses. Their grief experiences were different, but there were shared qualities that were determined to be invariable aspects of grief related to perinatal loss for r/s women. These qualities are thirteen constituents identified through the eidetic analysis. These constituents are the common experiences that captured the participants' lived experience of grief. Each participant experienced these commonalities through their experience in grief related to perinatal loss. Together, these constituents are the general structure of the participants' lived experiences.

Summary

This chapter contained the findings of the lived experiences of grief of women with r/s beliefs who experienced perinatal loss. There were 8 participants in this study who all identified as

women with r/s beliefs and part of a r/s community that experienced perinatal loss. As a result of their losses, the women all had difficult grieving periods and experienced one or multiple spiritual crises. The responses from the participants were obtained using unstructured interviews with one guiding question and probing questions that followed. There were thirteen constituents identified: attempting to process the loss, overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, comparisons of morality and deservedness, a spiritual and mental battlefield, post-loss disruptions, finding ways to cope, trusting God's plan, and transitioning from struggle to growth. Responses to the research question were also outlined in this chapter. Each participant's interview answered the research question, which was further expounded upon through eidetic analysis to distill the essences.

Chapter Five: Conclusion

Overview

The purpose of this study was to understand the grief experienced by women with r/s beliefs related to perinatal loss. This study is informative to mental health, medical personnel, and clergy. Moreover, this study is also an important addition to the literature on grief related to perinatal loss. This chapter consists of an overview and a summary of the findings. These findings are discussed in light of the relevant literature and theory. Methodological and practical implications are discussed. There is also an integration of the Christian worldview perspective. Finally, delimitations and limitations are outlined and recommendations for future research are provided.

Summary of Findings

The focus of this study was to describe the lived experience of grief of r/s women who faced perinatal loss. In chapter four, I presented the thirteen constituents that emerged from the data analysis using an eidetic analysis. There could be a question regarding the number of constituents, whether too few or too many. According to Giorgi (2009), the constituents are contingent upon the participant and the researcher as the participant shared with the researcher how they "lived through each of the essential constituents of the structure" (p.209). The constituents represent the essential elements of grief related to perinatal loss for women with r/s beliefs. The constituents were left after all the individual features of the participants' experiences were eliminated to reveal the essence. The constituents are attempting to process the loss, overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, comparisons of morality and deservedness, a spiritual and mental battlefield, post-loss

disruptions, finding ways to cope, trusting God's plan, and transitioning from struggle to growth. One research question guided this study: how do women with r/s beliefs describe their lived experience of grief from perinatal loss? The constituents were the answer to the research question.

Attempting to process the loss portrayed how participants worked to make sense of the news that they would be or had already experienced perinatal loss. The participants went from preparing for a new addition to their families to preparing to adjust to the reality that a new baby would no longer be joining their family. The constituent, overwhelming emotions, refers to the various emotions participants experienced that were often crippling and debilitating. Participants experienced bouts of crying and weeping, while others were angry, confused, and hurt. Many participants felt they only wanted to stay in bed, do nothing, or hide from the world and responsibilities.

Each of the participants experienced a state of confusion. The confusion was common because their loss was nothing they expected to happen. The participants did not anticipate losing a child, did not think it would happen to them, and were left with many questions. The participants wondered why it happened to them, how it happened, and how to navigate their grief. In addition to grieving the loss of their child, the participants grieved other aspects related to pregnancy and childbirth. For example, participants grieved the hopes and dreams they placed on the child or grieved not being able to have a child with their husband.

Suffering perinatal loss is something that happens to a couple. However, all of it happens to the woman physically. This experience is because she carries the child in her body. The participants believed that because they were women, that pregnancy and childbirth should come

easily for them. However, when pregnancy and childbirth did not come easily, the participants doubted their womanhood and felt less than a woman.

The participants also felt like no one understood them and that they had no one to whom they could turn. Some participants turned to their spouses, but they felt that their spouses could not understand from where they were coming. Others had friends and family members that neglected to reach out or did not know what to say, so participants did not feel like they were there to support them. In addition to feeling alone and misunderstood, the nature of the loss made participants feel like people trivialized their loss. Participants had uncomfortable interactions with others because people often said inappropriate things under the guise of being uplifting or encouraging. For example, someone told one participant, "life goes on," while someone else told another participant that "God gave this battle to her because she was strong."

Participants tried to understand why they experienced perinatal loss. They compared themselves to others based on their own r/s beliefs, values, and morals. For example, one participant was bothered by the number of people who had a history of being unable to care for their children properly but had no difficulty getting pregnant and having healthy children. Some participants talked about the number of people who abused or neglected their children. Another participant wondered why God allowed someone to use drugs to have a healthy pregnancy but not her.

While the comparisons of morality and deservedness were examples of moral struggles, participants experienced other RSS like divine struggles, doubt-related struggles, and interpersonal struggles. For example, some participants doubted their r/s beliefs. In contrast, others had difficulties being around their r/s community and withdrew, and others wondered if

God was angry at them or punishing them for a past sin. These were not the only things that caused the participants distress following their loss.

Post-loss disruptions were instances in the participants' lives that were altered after their losses. Many participants were diagnosed with or had symptoms consistent with depression, anxiety, and/or post-traumatic stress syndrome. Others had nightmares and flashbacks of their losses, and one participant's intimate life with her husband has suffered. The participants turned to various methods to try and cope. Most participants turned to their r/s beliefs and/or practices, but they had a negative impact. Some participants turned to their r/s beliefs and/or practices, and they had a positive effect. Other methods were journaling, exercising, and meaning-making.

At some point, the participants decided to trust God's plan based on the tenets of their r/s beliefs. The participants realized that trying to understand why or make sense of what happened would not bring closure to their pain. One participant realized that trusting God would be the only reasonable thing. Another kept trying to rely on what she knew to be true based on her r/s beliefs whenever negative thoughts came, while another participant realized that God always provided. Finally, participants moved from their struggles of RSS and complicated grief to growth. Many participants thought that their faith grew stronger because of this. Others realized that this experience was a part of their story or journey and that to move forward, they have got to try to find joy in other things.

Discussion

This section contains the study findings in relation to the empirical and theoretical literature reviewed in Chapter Two. The findings from this study support previous research on the grief and CG that often accompanies perinatal loss, thereby extending the body of literature

on this topic. Also, this study further supported the theory of religious coping, showing that r/s beliefs and practices can be used in negative and/or positive ways and impact mental health.

Empirical Literature

Several of the constituents derived from this study align with existing literature on grief and complicated grief. Researchers agree that perinatal loss negatively affects women's mental and emotional health (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Cumming et al., 2007; Farren et al., 2016; Hamama et al., 2010; Isguder et al., 2017). They also state that bereaved parents are more likely to experience persistent grief (CG) (Boynton, 2018; Cassaday, 2018; Christiansen et al., 2014; Gold et al., 2014; Huffman et al., 2015; Isguder et al., 2017). CG is associated with adverse mental health implications (Burke & Neimeyer, 2013; Burke et al., 2011). The participants' experiences were oriented toward the literature based on their interviews. This section contains a discussion on how the study confirms the previous research.

Perinatal loss is a common occurrence in the United States. Boynton (2018) noted that 1 in 5 pregnancies would end in loss. Bereaved parents are likely to experience a numerous variety of feelings and emotions. Grief is a normal reaction to loss. Many factors influence the grieving process, indicating a likelihood of CG developing (Gold et al., 2014). The study's findings confirm previous research on grief and CG related to perinatal loss. The following constituents corroborate and extend empirical research on grief related to perinatal loss: attempting to process the loss, overwhelming emotions, and finding ways to cope.

Grief

For many, learning that they are expecting a baby is an exciting time in their lives. People begin to plan for their lives to change and to welcome a new baby into their families, but they

never think perinatal loss is in their future. When the loss occurs, the expectant parents are devastated and experience deep sorrow or grief related to their loss.

There are many theories on grief. There are Kubler-Ross' (1969) five-stage model of grief, Bowlby's stage-theory model of describing grief (1980), and Worden's (2009) four tasks of grieving are just a few. The study confirmed research done on grief. All of the participants went through some 'stages' of grief, whether it was trying to accept the loss, denial, processing the loss, feeling numb, experiencing disbelief, being depressed, confusion, seeking a new connection, or other aspects of grief (Bowlby, 1980; Kubler-Ross, 1969; Worden, 2009). For example, Whitney recalled being numb and ignoring the emotions she needed to process her first loss. In another instance, Rose described trying to seek a new connection by having mementos and little things to honor the memory of her baby boy. In perinatal loss, the attachment theory is often used to explain the grief reaction.

Perinatal grief is often explained in research by the attachment theory, specifically the MFA, which stems from Bowlby's Attachment Theory. The theory explains that women and men are emotionally invested in the pregnancy and their child's life when they learn they're pregnant (Kohan & Salehi, 2017; Ussher et al., 2020). Researchers found that women are often initially met with shock, anger, disbelief, anger, and fear (Boynton, 2018). All participants shared that they were shocked and disbelieving when they learned about their loss. For example, Monique stated, "I mean, this was so unexpected; I was so confused." Learning of this or impending loss was difficult for the participants to process.

Some participants miscarried but did not know it or learned of their miscarriage during a routine scan. These participants had a D&C to remove the baby from their wombs. These were typically scheduled and not done on the same day. Boynton (2018) noted that women often

struggle to process the fact that they still carry their deceased baby. Elise stated, “It was so odd because they wheeled me in, I was pregnant, and when they wheeled me out, I wasn’t. So um, that was rough. It was rough. Because how do you process that? Now you are, now you’re not. I knew I wasn’t technically pregnant, but my body was holding on to the pregnancy, so I don’t know.” Not only was that aspect of processing difficult, but so were the emotions that came with the loss.

Perinatal loss is emotionally taxing. According to Cassaday (2018), women face agonizing pain once the initial shock and processing occur. This pain was true for each study participant. Boynton (2018) listed several perinatal loss's emotional outcomes, including distress, emotional turmoil, anger, fear, panic, despair, denial, and sadness. The participants shared a variety of emotions that they experienced following their loss. Rose mentioned her “emotions and feelings were all over the place” she described ranges from denial and sadness to anger. Elise described crying frequently and being angry. She said, “I spent a lot of time at home, on the floor, crying. Weeping. I spent a lot of time being angry.” Some participants’ emotions were so bad that they just wanted to escape. Sarah noted wanting “crawl in a cave … and hide from the world”.

Some participants used secular coping mechanisms in addition to r/s coping mechanisms, which is why this is discussed in this section. For example, rose mentioned journaling, scrapbooking, and having special keepsakes from her son to help her cope. She attempted grief counseling but only went to a few sessions. Lucy, Whitney, Ella, Elise, and Monique all used counseling to help cope. Ella, Elise, and Monique also attend a perinatal loss support group. Based on the literature, people have different methods to get to the point of acceptance,

reorganization, and/or adjustment in their grief (Bowlbly, 1980; Kubler-Ross, 1969; Worden, 2009). These findings are aligned with the literature on grief.

The constituents attempting to process the loss, overwhelming emotions, and finding ways to cope were characteristics of grief related to perinatal loss that the participants had in common with one another that specifically corroborated and extended the existing literature on grief. The participants described their lived experiences of grief by expressing the difficulties they had attempting to process their loss and the various emotions that consumed them during their grief. Another aspect of grief related to perinatal loss is that of CG. The study's findings also corroborate and extend empirical research on CG. The following constituents confirm previous research on CG related to perinatal loss: overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood uncomfortable interactions with others, and post-loss disruptions.

Complicated Grief (CG)

Participants' responses correlated with the research on factors that led to prolonged grief or CG. For example, participants with earlier losses had less intense emotional reactions than those with late-term losses. Cassaday (2018) found that late-term losses are more likely to result in more emotional distress and intense grief. This distress and grief were evident throughout the participants' interviews. For example, Morgan had a molar pregnancy. While upset and saddened over her loss, she felt uncomfortable saying her loss was similar to other losses. She said, "I don't want to take away from someone else's grief either that grieved a baby." On the other hand, Monique experienced a late-term loss and physically delivered her baby. She stated, "I'll never forget the feeling of being wheeled out of the hospital with a little box in my arms instead

of my baby in my arms. Like it was heart-wrenching, terrible, something I wouldn't wish on my worst enemy." Monique experienced CG, as evidenced by her intense emotional responses.

Other factors that are predictors of CG in perinatal loss are a history of infertility. Bhat and colleagues (2016) noted that infertility is related to psychological distress following perinatal loss. Five participants experienced infertility and planned pregnancies: Rose, Whitney, Ella, Elise, and Monique. Ella was suicidal following her loss. She said, "Oh, it was a bad place. I, you know, I contemplated killing myself because it was just too much for me to deal with." Whitney felt like her grief was prolonged. She stated, "…it just seems like it's been a longer process, you know". Gestational period and history of infertility are not the only factors that impact CG in perinatal loss.

There are other factors that are predictors of CG in perinatal loss. According to research, having prior children and social support are also high predictors of CG in perinatal loss (Huffman et al., 2015). Sarah had prior children before her loss, but her perception of the social support she had caused her complicated grief. She stated, "We had less of a circle with the second loss, no circle as far as support goes." She discussed how she finally started to have some semblance of normalcy in her life two years after her first loss, but she still has difficulty processing that it actually happened to her. Elise has yet to have a child. She described feeling alone. "I felt really lonely. I felt like I felt alone. I felt like I had no one to turn to." Also associated with feeling alone and misunderstood are disenfranchised grief and ambiguous loss.

Even though perinatal loss is prevalent, people still have difficulties discussing it and understanding why bereaved parents experience grief the way they do. Researchers found that CG is related to ambiguous loss and disenfranchised grief (Blood & Cacciature, 2014; Lang et al., 2011). The results of this study also substantiated this existing research in this area. Research

shows that the grief is disenfranchised because of a lack of acknowledgment or validation of the grief of the bereaved and the absence of social support (Lang et al., 2011). All participants indicated feeling alone and having no one to whom to turn. Rose shared that she felt alone and that the people she expected would reach out did not. She said, "There were people that I thought would reach out to me and check on me but didn't, and that hurt, and I, and I know it's probably they didn't know what to say or do, and maybe that's why." Ella reported feeling like no one understood why she felt how she felt. "I felt like nobody at my church really understood how I felt."

Another aspect of disenfranchised grief is negative interactions with medical personnel and other people. Researchers found that women expressed displeasure with the service they received from hospital staff and felt confused by the lack of assistance after their loss (Smart et al., 2013; Stratton & Loyd, 2008). Sarah had a disconcerting encounter with medical personnel on both occasions. After her first loss, she described Emergency Medical Services personnel stepping over her baby on the bathroom floor. During her second loss, she described the insensitivity of a hospital staff member who offered to "dispose" of her child. She stated, "…we already have a funeral home coming to pick up our child. You know he's not waste! So, that was frustrating, to see the lack of empathy or sympathy or even just acknowledging that this is a difficult moment in someone's life and in someone's story…." All participants noted being confused about how to proceed with navigating their grief or being confused as to why the loss occurred. Monique stated, "There's no guide to prepare you. There's no one in the hospital or the doctor's office that says, hey, you may have depression or anxiety; here's what you need to know or be prepared for. So, you feel alone trying to process all of the things you're now faced with." Lucy expressed confusion as to why the loss occurred. She wondered if it was due to her heavy

menstrual cycles or saving a drowning child. Morgan was perplexed about molar pregnancy and felt that her provider did a poor job of explaining what and how it happened. She stated, “I had no idea what that meant, and the midwife, she didn’t really do just a fantastic job like explaining it, so we were kind of in the dark.” Another condition of disenfranchised grief, circumstances surrounding the death, was highlighted through the constituent grieving what could have been.

Perinatal loss is an ambiguous loss, and the grief is typically disenfranchised. The ambiguity and disenfranchisement can contribute to CG (Lang et al., 2011). Each of the participants not only grieved the loss of their baby but the constituent grieving what could have been highlighted some additional characteristics of grief related to perinatal loss that are not widely acknowledged because of the disenfranchisement of grief (Doka, 2002). Every participant also grieved some aspect of their planned life and their dreams for the child/children they lost. For example, Rose lamented not being able to give her husband a child of their own, while Whitney thought about the hopes and dreams she poured into the child even during the beginning stages of her pregnancy. She said, “…the loss of, you know, all the hopes and the dreams and the things that you would hope to pour in.”

Interactions with other people are also related to CG and disenfranchised grief. Harris (2010) found that people act in ways that trivialize the loss because of the social and cultural norms related to grief and bereavement. Every participant was uncomfortable interacting with another person who said something that inadvertently trivialized their loss. For instance, Rose had someone tell her she had lost her baby because she was strong. She stated, “I had a parent who was like, “God knows your strength, and that’s why this happened because he knew you could handle it.” She also had another person suggest not naming her son so that she could save the name for another baby. She stated, “I was like because this is my child. This isn’t an

imaginary, fictional character. This was my child; I went through labor and gave birth to him; this is my son." In another example, Monique experienced her friends trivializing her loss. She said, "My friends would say, 'well, at least you can get pregnant, and you guys can try again when you're ready.' It's not that easy."

Additional characteristics of uncomfortable interactions and CG deal with the bereaved women finding it hard to be around pregnant women and/or those who have been pregnant without complications. Lin and Lasker (1996) found that this also contributed to CG. Six participants reported uncomfortable interactions in the form of difficulties being around pregnant women. Elise stated, "…It seemed like everyone there got pregnant easily and had babies with no difficulties. Like it was shoving it in my face that it was a badge of honor that I had yet to earn…." Morgan and Ella found it hard to go to the baby shower of a loved one. Morgan stated, "…I didn't go to my friend's baby shower. I just couldn't." Other feelings, like feeling the desire to blame oneself or feeling like less than a woman, are other aspects of CG that are validated by the study.

Feeling guilt or feeling like less than a woman or even feeling like a failure is a common grief reaction in perinatal loss. According to research, when becoming pregnant, expectant mothers typically undergo a process of development wherein they seek safe passage and other important tasks before birth (Rubin, 1975; Rubin, 1984). Studies of CG in perinatal loss report guilt, self-blame, feeling like a failure, and feeling like they are less than a woman is common (Lin & Lasker, 1996; Frost & Condon, 1996; Stirtzinger & Robinson, 1989). All of the participants reported these feelings. For example, Morgan stated, "…I felt like my body has failed like it's the one thing a woman is supposed to do, and my body didn't do it right." Ella reported blaming herself and feeling like a failure after being diagnosed with an incompetent

cervix. She stated, “It makes you feel like you’re a failure at something, and certainly enough, I felt, you know, I blamed myself; I felt like I was a failure. I felt like I was less than a woman….” CG is also manifested through post-loss disruptions.

Psychological aspects of perinatal loss extend beyond being sad or angry. CG is associated with mental health conditions like depression, anxiety, and PTSD (Shear, 2015). Farren and colleagues (2016; 2021) found that depression and anxiety were prevalent among those who experienced perinatal loss one month after the loss. Lucy described her emotional state as being crushed. She said, “I went through depression. I stayed in the bed a lot.” Elise also described herself as being depressed. She said, “I was depressed. I was very bitter, very angry.” In some cases, the depression, anxiety, and other mental and emotional impacts continued to impact the participants’ livelihoods.

Lucy had to take time off work because of ongoing mental health issues. “Shortly after, though, I had to take a leave of absence for about three months. Because my nerves, the anxiety, and depression, it all, it was there.” Elise was prescribed medication and was diagnosed with PTSS. Sarah, Elise, Monique, and Ella reported having flashbacks and/or panic attacks. Sarah described her experiences with panic and anxiety by saying, “…it’s almost like random PTSD where little things will trigger anxiousness and fear…any little twinge or me feeling off will take me back to that moment with both of them, and my body will start to react as if something’s wrong with me and I’m getting ready to drop dead, and that was never really a thought before.” CG also impacts relationships. Lang and colleagues (2011) reported marital strain. In addition, researchers indicated that CG could affect intimate relationships (Hutti et al., 2015). Grief impacting an intimate relationship was true with one participant. Whitney reported having intimacy struggles with her husband. She said, “It took me some time to get to the point where I

felt like we had a spark in our relationship again, but it's like, you know, we finally got to a good place in our intimacy life, and then like I said, we got pregnant out of nowhere and then miscarried and then, and it's just, it's like it just started right back over."

The constituents overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, and post-loss disruptions were characteristics of grief related to perinatal loss that the participants had in common with one another that specifically corroborated the existing literature on grief. The participants described their lived experiences of grief by expressing the various emotions that consumed them during their grief; feelings of confusion, doubt, blame, and loneliness; difficult interpersonal interactions; and other prolonged aspects of their grief. In addition to corroborating the previous research, the study adds novel contributions to the field.

Theoretical Literature

The theory that guided this study is The Theory of Religious Coping. The theory originated from the work of Kenneth Pargament and others who were interested in the relationship between religion and coping (Pargament et al., 2011). Researchers proposed that when a trauma or life stressor occurs, that religion/spirituality are often used in the search for significance (Pargament, 1997). The theory's assumptions are that religious coping can have different purposes; it involves emotions, behaviors, thoughts, and relationships; it changes over time, situation, and setting; it leads to either beneficial or harmful outcomes; and it adds something to the coping process (Pargament et al., 2011). This study supports and extends existing research on religious coping. The constituents comparisons of morality and

deservedness, a spiritual and mental battlefield, finding ways to cope, trusting God's plan, and transitioning from struggle to growth confirm and extend several aspects of this theory.

The theory of religious coping has frequently been applied to studies on trauma, grief, and mental health. Regarding perinatal loss, one study found that negative religious coping puts women at risk for developing CG (Cowchock et al., 2011). Every participant experienced some aspect of negative coping, whether they realized it or not. According to Pargament (et al., 2011), examples of negative religious coping methods include thinking the stressor is a punishment from God, thinking a stressor is an act of a demonic force, expressing confusion and dissatisfaction with God's relationship in the situation or with members of the r/s community, and trying to control the situation individually without help from God. Several participants mentioned being angry with God. Participants expressed confusion and wondered why God would allow them to experience the loss. For example, Whitney wondered why God did not want to bless her with another child. "…the questioning and wondering just made me feel worse about myself like God thought I didn't deserve the same blessings He was giving to everyone else…". Many of the difficulties with r/s coping came from participants wondering why and comparing themselves to others based on their r/s beliefs.

Seven participants explicitly expressed comparing themselves to others based on their moral standards. In contrast, one expressed having those thoughts minimally but trying not to allow herself to dwell in that mindset. Whitney and Rose mentioned having difficulties understanding why God would allow others who abuse or cannot care for their children to have children constantly. Yet, at the same time, they struggled to conceive and carry a child. Elise mentioned difficulties with patients who were pregnant drug users and not understanding why God would allow their pregnancies to continue healthily but for hers to end tragically. Morgan

spoke of her purity before marriage and wondered why others who may have conceived out of wedlock could carry without difficulty. Finally, Sarah mentioned having those thoughts but using r/s coping positively to escape that mind state.

The studies on r/s coping related to perinatal loss highlighted, in large, the divine struggles experienced by the study participants. The constituent comparisons of morality and deservedness could fall under the category of a moral struggle. People who are r/s often try to hold themselves to a standard of morality. For example, professing Christians believe that sexual intercourse before marriage is a sin. This belief is why Morgan struggled and wondered why a pregnancy out of wedlock was without complication while she experienced a loss. While this is not explicitly defined as a moral struggle, the aspect of the participant trying to live up to the moral standard of her r/s beliefs and holding others to that same standard and using those standards as a justification of why they are worthy of receiving certain things, seems to fit with other examples of moral struggles. This aspect of moral struggles is one extension of the theory and should be explored further.

The constituent, a spiritual and mental battlefield, highlighted the various RSS participants experienced during their grief. Every participant experienced a RSS. For example, Whitney wondering if her loss was because of past sin is an example of a divine struggle. Rose, Monique, Ella, Elise, and Morgan's anger with God is another example of a divine struggle. Sarah and Lucy's examples of questioning God and wondering why are also instances of divine struggles. In addition to divine struggles, some participants experienced interpersonal struggles. Sarah's feeling of alienation from her r/s community, Rose, Lucy, Monique, Ella, and Elise's examples of stopping church attendance are other interpersonal struggles. Elise, Ella, and

Monique all experienced doubt-related struggles because they had questions about their faith and doubts about what they believed. Table 4 shows the RSS participants experienced in their grief.

Table 4

RSS Participants Experienced

	Divine	Demonic	Interpersonal	Moral	Doubt	Meaning
Lucy	x		x	x		
Rose	x		x	x		
Whitney	x			x		
Morgan	x			x		
Ella	x		x	x	x	
Elise	x		x	x	x	
Sarah	x		x			
Monique	x		x	x	x	

Participants experienced spiritual crises due to their grief related to perinatal loss, which is consistent with the literature. The constituent, a spiritual and mental battlefield, highlights the CSG the participants experienced. CSG is defined as a form of distress in grief characterized by the presence of RSS, like wondering why God is punishing them, questioning God's love, doubting r/s beliefs, feeling like an outsider in the r/s community, and more (Burke et al., 2011). Based on this definition, all of the participants not only experienced grief and CG, but they experienced CSG as well. There is a gap in the literature on CSG and perinatal loss. Thus, this study contributes to both the theoretical and empirical literature by providing information on the experiences of grief, religious coping, and spiritual crisis in the population of women who have had perinatal loss. The constituents finding ways to cope, trusting God's plan, and transitioning from struggle to growth supported and expanded the theoretical literature.

All participants used r/s coping in both positive and negative ways during their grief. Sarah and Morgan used both positive and negative r/s coping mechanisms in tandem. For

example, while Sarah would question God and wonder why (examples of negative r/s coping mechanisms), she would still turn to her r/s practices and beliefs for comfort, like reading the Bible and praying (examples of positive r/s coping mechanisms). Sarah stated, "I question God, 'Why? Why let it happen that way? Because if you're in control of things, couldn't you have picked a different way? Couldn't you have chosen a different means to allow things to happen?' But then I just kept coming back to He's still God." Morgan and Sarah's experiences are examples of finding ways to cope and trusting God's plan. The participants used r/s coping mechanisms, both negative and positive, but decided to trust God's plan, ultimately choosing to rely on positive r/s coping mechanisms.

The remaining six participants used negative r/s coping mechanisms and then had a turning point where they turned to positive r/s coping mechanisms. For example, Monique described rolling her eyes and hating being in the church because of her anger. At a certain point, she decided to trust God's plan after employing secular counseling and support group coping mechanisms. Lucy stopped attending church and reading the Bible after a certain point. Then once she made some progress in therapy, she returned to the church and returned to positive r/s coping mechanisms. She stopped trying to understand; instead, she trusted God and His plan. She stated, "I have to trust it. I don't have to understand it."

Participants moved through a cycle or process of their grief and eventually moved toward trusting God's plan and transitioning from struggle to growth. Each participant had an instance of deciding to trust God's plan based on what she knew to be true from her r/s beliefs. For example, Ella described a moment when she talked with a friend who encouraged her to return to her r/s beliefs. She eventually got to the place of being content with not understanding why she experienced her losses. Sarah and Morgan described using their r/s beliefs to bring them out of

negative self-thoughts and anger or frustration with God for their predicament. Each participant said that their faith was challenged and strengthened due to their experience, indicating growth.

Transitioning from struggle to growth highlights the participants' experiences of moving from a place of struggle and crisis to acceptance. For example, Whitney described realizing how much she relied on her faith, and Morgan described realizing that turning toward God instead of turning away made a difference in her grief experience. The different outcomes based on the type of primary r/s coping align with the fourth assumption of the theory of religious coping, that religious coping can lead to beneficial or harmful outcomes (Pargament et al., 2011). All of the participants ultimately had a strengthened faith or relationship with God.

Contributions to Empirical and Theoretical Literature

Perinatal loss is a widely researched topic. Unfortunately, because of its widespread, common occurrence, so many aspects of perinatal loss should be explored. In the prospectus stage of this study, I learned that research on specific aspects of grief is lacking in the literature. For example, as noted earlier, the literature highlights an association between CG and CSG, but regarding perinatal loss, there is little to no information (Burke et al., 2011). In addition, perinatal loss is considered a traumatic loss. Still, little research has been done to describe the experiences of grief, religious coping, and spiritual crisis in the population of women who have had perinatal loss.

This study contributed to this area by highlighting aspects of spiritual crisis and CSG in the population of women who have experienced perinatal loss. For example, all participants experienced one or more RSS in their grief. They also used negative methods of r/s coping. When the participants used negative r/s coping and experienced their RSS, their grief was elevated and complicated. Participants mentioned a variety of CG responses, such as depression,

anxiety, PTSD, and suicidal ideations. When participants used positive r/s coping, they could work through their grief symptomatology instead of being consumed by it and focus on moving toward acceptance.

Another contribution to the field is that a spiritual crisis does not equal a weak faith. For example, the two participants that used positive r/s coping in tandem with the negative r/s coping mechanisms highlighted that experiencing CSG does not indicate a weak faith. Researchers noted that views of God and attachment to God were factors in the type of r/s coping mechanism to which an individual will gravitate (Kelley & Chan, 2012; Klausi & Caudill, 2018). Negative views of God and insecure attachments to God are related to weak spiritual life and negative religious coping. While these were only two instances, it warrants further research, especially concerning perinatal loss, grief, and religious coping.

Implications

The purpose of this section is to address the implications of the study. This study is helpful to clinicians and mental health professionals, medical personnel, and clergy. These implications are examined from several contexts, namely empirical, theoretical, and practical. Christian worldview considerations are also discussed in this chapter. There is a discussion on how the Christian worldview informs an interpretation of the findings of this study.

Theoretical Implications

This study has theoretical implications for researchers exploring the theory of religious coping related to perinatal loss. The theory of religious coping is based on the premise that individuals desire significance, and when that significance is threatened, the need for coping arises (Pargament, 1997). People use r/s coping to deal with the sacred (Pargament, 1997). The act of conceiving and giving birth to a child is sacred. Thus, with the prevalence of perinatal loss

and individuals with r/s beliefs, this theory served as an appropriate framework to examine the grief of r/s women who experienced perinatal loss.

The assumptions of the theory of religious coping align with this study's findings. First, religious coping had different purposes for the participants. Some used religious coping to search for meaning, while others used it to quell their anxiety (Pargament et al., 2011). Religious coping involved emotions, behaviors, thoughts, and relationships (Pargament et al., 2011) for the participants. The participants' emotions, behaviors, and thoughts were integral to their religious coping. Third, religious coping changed over time, situation, and setting (Pargament et al., 2011). The participants either used positive and negative r/s coping in tandem, or they used negative and gradually gravitated toward positive methods. Fourth, religious coping led to beneficial and harmful outcomes (Pargament et al., 2011) for the participants. Amid their negative r/s coping, participants had harmful consequences. These outcomes impacted mental health, emotional health, and interpersonal relationships. Contrariwise, positive r/s coping led to beneficial effects. Every participant reported spiritual growth. The fifth assumption is that religious coping adds something to the coping process (Pargametn et al., 2011). Once again, participants were able to grow from their experience. The final assumption is that religious coping can help our understanding of religion (Pargament et al., 2011). Some participants spoke of knowing they could be upset, and lament based on their r/s beliefs, while others noted learning more about what it means to trust God truly.

The theory of religious coping is an appropriate framework within which to examine the grief of women with r/s beliefs related to perinatal loss. The theory explained the participants' CG and CSG responses. For the participants, their method of r/s coping, be it positive or negative, had a relationship with their grief. Those who employed negative r/s coping techniques

were depressed and/or anxious, experienced difficulties with interpersonal relationships, and even struggled with CG and CSG. Participants reported spiritual growth and a deeper understanding when they switched to using more positive r/s coping mechanisms. The theory of religious coping created a deeper understanding of the lived experience of grief related to perinatal loss for women with r/s beliefs.

Empirical Implications

There are also empirical implications for this study. For those researching grief related to perinatal loss, this study examined the psychological impact that grief, specifically CG and CSG, have on the lives of women who experienced perinatal loss. It was found that women with r/s beliefs who experienced perinatal loss experienced CG and CSG. Both the CG and CSG impacted their grief in many ways. Participants reported feeling angry, depressed, bitter, and disappointed. Some were confused and hurt. They wondered why they were subjected to experience perinatal loss and wondered somehow if they were to blame. They also felt flawed, diminished, and inadequate in their own eyes. It was difficult for them to find support because of a lack of understanding of grief related to perinatal loss. It was also difficult for them to find support in their r/s communities because of their grief and spiritual crises. It should also be noted that the grief and the intensity ebbed and flowed. It was not a linear process at all times. The participants moved through certain aspects of their grief and stayed in some others for longer periods. Additionally, the spiritual crisis aspects of their grief impacted the duration of their grief intensity. While all participants noted that they felt they had grown, they still grieved the loss of their child.

The findings from this study help create awareness of how the mental and emotional health of women who experienced perinatal loss can be impacted by r/s coping, CG, and CSG.

The current issue is that although there are numerous studies on perinatal loss and its psychological impact, very few examine the experience of grief, coping, and spiritual crisis. This study helps fill the gap in the literature on the grief experience of grief, coping, and spiritual crisis in women with r/s beliefs who experienced perinatal loss.

Practical Implications

This study has practical implications for clinicians, mental health professionals, medical personnel, and clergy. This study can help create awareness of the grief experienced by women with r/s beliefs who have experienced perinatal loss by providing more information to develop treatments, interventions, and programs that suit the needs of these women. Some participants mentioned difficulty finding a counselor that understood their grief. One participant went through several before finding a perfect fit, while another quit going to grief therapy altogether. Based on their experiences, clergy and counselors were not equipped to deal with the grief of these women. It could be reluctance on behalf of the participant, but counseling is typically the first thing recommended when dealing with grief and loss.

In the case of this study, the CSG aspect of grief further complicates grief. It adds another dimension to clinicians' skillset when working with clients with r/s beliefs who are experiencing grief from perinatal loss. Counselors should already be empathetic to the difficulties of perinatal loss. They should work to treat clients holistically, and for some, this includes their r/s beliefs. Counselors must be aware of the impact that r/s beliefs, r/s coping, and RSS have on grief related to perinatal loss.

All participants expressed frustration with the lack of information or assistance for navigating the grief experience with perinatal loss. In addition, they were unsatisfied with the lackadaisical responses given by medical personnel. Several participants described how they

were not given any materials on what to look for mentally and emotionally in the days following their loss. Medical personnel's bedside manner and lack of empathy were also highlighted. In one disturbing instance, one participant described how she was offered disposal services for her son's remains and how callously hospital staff threw his remains in a plastic bin to show her after she completed her miscarriage. Another participant expressed that she missed out on providing a proper burial for her son because hospital staff bombarded her with questions she was unprepared to answer. Medical personnel should respect that the experience of perinatal loss is one of the most traumatic and heartbreaking things a family can experience and that empathy and compassion are necessary.

In this study, several participants mentioned feeling their pastor did not understand how to help them navigate their grief experience. Furthermore, one participant's pastor's response caused her to shut down and not seek pastoral support. Another interesting aspect is that many participants felt that their anger or frustration with God was not allowed and that it was sinful. However, in the Bible, many instances of people lamenting to God. Clergy and church leaders should work to help people experiencing spiritual crises come to terms with what they feel and let them know that it is normal and that it is also not always equated with weak faith. Churches should develop perinatal loss support groups to support the needs of this population of women. This action could affect instances of women feeling misunderstood by their r/s communities. Additionally, clergy being better educated on aspects of r/s coping, spiritual crises, and CSG and the impact on mental and spiritual well-being would also help this population of women.

Christian Worldview Perspective

Christians who experience perinatal loss are often confused because they do not understand how a loving God could allow something of that magnitude to happen. Some of the

participants expressed this confusion and anger in their interviews. For example, Monique said she would roll her eyes in the church because she could not understand why God allowed her to experience perinatal loss. However, one common misunderstanding is that being a Christian does not automatically mean one will not experience heartache or pain. Pain and suffering are not a betrayal by God. There are many instances of bad things happening to Christians in the Bible. Job lost everything, the Israelites wandered in the wilderness for forty years, and David's infant son died after being born. Even though people will face pain, God promises to be a refuge in the time of trouble (Psalm 46:1). The Bible says in John 16:33, "I have said these things to you, that in me you may have peace. In the world you will have tribulation. But take heart; I have overcome the world" (English standard version Bible, 2001). One participant noted terrible things happening as a direct result of living in a fallen world. According to the Bible, "For we know that the whole creation has been groaning together in the pains of childbirth until now" (English standard version Bible, 2001, Romans 8:22). This means that we will experience pain and heartache. Still, Christians have hope that Jesus will return, and when He does, all will be restored (English standard version Bible, 2001, Romans 8:23). This means that we will experience pain and heartache. Still, Christians have hope that Jesus will return, and when He does, all will be restored (Romans 8:23). For women like the study participants, this is good news. The study participants eventually saw how God could turn a heartbreak into a testimony of his greatness. They allowed Him to redeem the situation and accept His grace.

Integrating Scripture in Psychological Interventions

Women with r/s beliefs who experienced perinatal loss might seek help from a counselor who integrates a Christian worldview into their practice.Several participants found support from a Christian-based counselor. According to Pearce (2016), using cognitive behavioral theory-

derived methods is best to integrate scripture into psychological interventions. For example, in the book of Romans, it is said that thoughts impact actions and that personal transformation and growth can occur through changing those thoughts (English Standard Version Bible, 2001, 12:2). For example, two participants tried to counter their negative thoughts and replaced them with uplifting scripture references. Christian women can work to change their negative thoughts by focusing on what the Bible says.

Some participants noted how meditating on and recalling specific scripture was helpful when they became overwhelmed by their negative thoughts. Pearce (2016) recommended scriptural memorization to integrate the Bible into practice. Specifically, memorizing scripture helped Sarah because it reinforced positive thinking. (Pearce, 2016). Incorporating scripture can help foster discussions about struggles and loss and helps answer questions like 'Why do good things happen to bad people?' (Pearce, 2016). Morgan used scripture to help her find new perspectives about pain and suffering (Pearce, 2016). Integrating a Christian worldview into psychological interventions, like grief counseling or CBT for women grieving perinatal loss, can address the potential spiritual crises that women might experience and may be too scared to admit. Integrating Christianity into psychological treatment is a way to treat women who have experienced perinatal loss holistically.

Delimitations and Limitations

Delimitations are purposeful decisions the researcher makes to limit or define the study's boundaries. Delimitations are necessary because the study results are influenced by the boundaries that I set in the study. Limitations are potential weaknesses of the study that cannot be controlled. They may be related to the design, the analysis, or the sample. It is important to

discuss limitations because they give credence to the study. The information in this section is the rationale behind decisions made to limit or define the scope and focus of the study.

The study methodology and design are important delimitations to the study. By choosing a qualitative, descriptive phenomenological study, I decided what would be the best option to capture the lived experiences of women with r/s beliefs who experienced perinatal loss. Another delimitation was the age range for the participants, women between the ages of 21-65. I chose this range because of the topic's sensitive nature, and it was best that participants were adults who could make autonomous decisions and give informed consent to share highly personal aspects of their lives. I also selected the age range because people start families at various times in the life cycle. Another delimitation is requiring the participants to be English-speaking U.S. citizens. This requirement made scheduling and completing interviews and compensating participants easier. Other important delimitations were requiring the women to have experienced perinatal loss, have r/s beliefs and be a part of a r/s community, and have had a difficult grieving period and spiritual crisis following perinatal loss. These were important because they ensured that the aspects of religious coping and spiritual crisis would be explored by the study and described by the participants.

The limitations of the study are potential weaknesses in the study that were outside of my control. Researchers often critique qualitative research as biased or lacking rigor (Anderson, 2010). In addition, there are certain limitations based on the study's methodology. One limitation is my experience with perinatal loss, CG, and CSG. It is possible that my personal biases could influence the research. To negate this, I engaged in bracketing. I also used a reflective journal and continued sessions with my counselor. Another limitation is difficulty analyzing and interpreting data (Anderson, 2010). Based on the in-depth interviews, I had a large volume of

raw data to transcribe, read, analyze, and interpret. To lessen the chance of errors, I made sure to member-check after transcribing the data. I also read, analyzed, and interpreted the data in a quiet space away from any interruption. Sample size could be considered a limitation, but with a recommended sample size of 5-25, 8 was within that range. It also allowed me to gain relevant information applicable to the study's research question. Some might consider the unstructured interview a limitation of the study (Corbin & Morse, 2003). However, I made sure to use the same guiding question and probing questions for each interview.

Other examples of this study's limitations are the participants' diversity. There was no diversity in the r/s beliefs of the participants—all of the women identified as Christian. Also, most participants were at least middle class, so there was no variety in socioeconomic status. Therefore, the grief experiences of women with other r/s beliefs were not explored, and the grief experiences only came from a specific socioeconomic demographic. Additionally, participants could have been deceitful in signing up and participating in the study because they only wanted compensation. Participants could also have exaggerated explaining their experience or scaled back their experience because they were fearful.

Recommendations for Future Research

The current study focused on grief of eight women with r/s beliefs who experienced perinatal loss. This study adds valuable information to the literature on grief and perinatal loss. Still, considering the study findings, limitations, and delimitations placed on the study, there are multiple recommendations and directions for future research. The participants all identified as Christian; the only perspectives explored were those of Christian women. Studies should be done with a more diverse group of participants to add to the literature. Another recommendation for future research is to study men and/or couples who experienced perinatal loss and have r/s

beliefs. Creswell (2007) noted that qualitative research shows how an issue impacts a group of people. These studies can and should be qualitative because it is an attempt to understand the human experience better.

In this study, the participants struggled with understanding why they were experiencing perinatal loss. Still, others who may not have lived up to their moral standards based on their r/s beliefs and values could go on to have perfect, normal, and healthy pregnancies. In the study, I classified this as a moral struggle because it dealt with issues of morality and r/s beliefs. It would be beneficial to consider extending moral struggles to cover instances like what was described in the study and also to study the impact of moral struggles in light of grief related to perinatal loss. To do this would require revisiting the development of the RSS scale. Additionally, moral struggles are typically examined in studies of military veterans or criminals (Farnsworth et al., 2014; Pargament & Exline, 2022). Therefore, it would be beneficial to consider moral struggles and their relation to perinatal loss.

Another recommendation for future research is to explore the relationship between r/s coping, CG, and CSG following perinatal loss. The literature indicates links between perinatal loss and adverse mental health conditions, but there are still gaps in the literature relating to r/s coping, CG, and CSG related to perinatal loss. This study's findings added to the empirical and theoretical literature on perinatal loss, grief, CG, r/s coping, and CSG. However, this was only a small, qualitative study to provide insight into the lived experience. Researchers could add to the literature by considering what moderates the association. Participants should be adults who have experienced perinatal loss and have some r/s affiliation. Participants should be assessed using the Brief RCOPE, Perinatal Grief Scale (PGS), Inventory of Complicated Grief (ICG) Scale, and the Inventory of Complicated Spiritual Grief 2.0 (ISCG 2.0) Scale using a quantitative study and

survey research approach. Using Hayes' Process for SPSS, researchers should analyze data to see if the independent focal variable of perinatal loss and the dependent variables of CG and CSG will be moderated by r/s coping.

Summary

This qualitative, descriptive phenomenological study examined the grief experiences of women with r/s beliefs who experienced perinatal loss. Thirteen constituents emerged from the study: attempting to process the loss, overwhelming emotions, a state of confusion, grieving what could have been, doubting your innate womanhood, feeling alone and misunderstood, uncomfortable interactions with others, comparisons of morality and deservedness, a spiritual and mental battlefield, post-loss disruptions, finding ways to cope, trusting God's plan, and transitioning from struggle to growth. The findings from this study describe the experience of grief, coping, and spiritual crisis in women with r/s beliefs who experienced perinatal loss. It was found that r/s coping impacts CG and CSG. Notably, positive r/s coping impacts grief and spiritual well-being positively, whereas negative r/s coping harms grief and spiritual well-being.

The implications of this study extend to various stakeholders like mental health professionals, medical personnel, and clergy. In the words of Sarah, "It made me want to just like scream from the mountaintops, 'can you all not just open your eyes and realize that this is something that needs to be talked about?'" The topics of perinatal loss, CG, and CSG should not be so taboo. This taboo nature could be changed by starting the conversation. Mental health professionals need to learn how to provide support to women with r/s beliefs who experienced perinatal loss is important. There are many complexities to the grief experience, and mental health professionals must be competent in their services. It is also imperative that medical

personnel are more empathetic in their dealings with women who have experienced or who are experiencing perinatal loss.

Furthermore, healthcare professionals should better prepare people experiencing perinatal loss for what to expect in their grief. While it is true that one size does not fit all, some form of preparation and a list of potential resources is better than nothing. Clergy should also recognize how to address spiritual crises in grief. Clergy learning how to address spiritual crises could alleviate some of the emotional distress from the CSG. The lived experience of grief from perinatal loss in women with r/s beliefs has many struggles. There are struggles with emotions, beliefs, self-esteem, and self-worth, but it is also a part of the journey for many women who emerge from their struggle to a place of acceptance and growth.

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Appendix A: IRB Recruitment Flyer

Research Participants Needed

Grief After Perinatal Loss: A Descriptive Phenomenological Study

- Are you a woman between the ages of 21 and 65?
- Are you an English-speaking, US citizen?
- Are you of sound mind and do you have the ability to make autonomous decisions?
- Have you experienced perinatal loss (e.g., early term miscarriage, late term miscarriage, chemical pregnancy, ectopic pregnancy, molar pregnancy, stillbirth, neonatal death, vanishing twin syndrome)?
- Do you have religious/spiritual beliefs and are you a part of a religious/spiritual community?
- Did you have a difficult grieving period and spiritual crisis following your perinatal loss?

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.

The purpose of this research study is to describe the experiences of grief, coping, and spiritual crisis in the lives of women who faced perinatal loss.

Participants will be asked to describe their experience with perinatal loss in a virtual interview via Zoom and review their interview transcripts. Interviews will be audio-recorded and transcribed.

Participants will receive a $20 Amazon Gift Card following the completion of the study.

If you would like to participate, please scan this QR code and complete the survey. You may contact the researcher at the phone number or email address provided below.

A consent document will be emailed to you.

Marlena Baxter-Dunn, a doctoral candidate in the Department of Community Care and Counseling, School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact Marlena at [redacted] or [redacted] for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

Appendix B: Consent Form

Title of the Project: Grief After Perinatal Loss: A Descriptive Phenomenological Study
Principal Investigator: Marlena Baxter-Dunn, MSW, MS, Doctoral Candidate Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be a woman, must be between the ages of 21-65; must be an English-speaking, US citizen; must be of sound mind and have the ability to make autonomous decisions; must have religious/spiritual beliefs and be a part of a religious/spiritual community; and must have experienced perinatal loss. As a result of your perinatal loss, you must have had a difficult grieving period and experienced a spiritual crisis. For the purposes of this study, perinatal loss is considered early term miscarriage (during the first trimester), late term miscarriage (after the first trimester), chemical pregnancy, molar pregnancy, vanishing twin syndrome, ectopic pregnancy, stillbirth, or neonatal death. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to describe the experiences of grief, coping, and spiritual crisis in the lives of women who faced perinatal loss. In many instances, perinatal loss and the impact of grief is not discussed. This study aims to describe the experiences and provide an opportunity for women to share their stories.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in one, 60–90-minute interview via Zoom. The interview will be audio-recorded and transcribed afterwards.
2. Review the interview transcript to ensure that what has been recorded accurately reflects the experience that was discussed. This should require 10-15 minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include creating awareness in the counseling and mental health profession of the negative impact that can ensue from perinatal loss, complicated grief, and complicated spiritual grief, thereby helping counselors and clergy tailor their interventions to suit the needs of women who experienced perinatal loss. Additionally, this study will fill a gap in the counseling literature and add to the growing body of research on the grief associated with perinatal loss.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of being

emotionally triggered, resulting in distressing feelings. If you become emotionally triggered and experience psychological distress, you can refuse to answer the question that triggered you, reschedule the interview for a later date, or withdraw from the study. You are free to opt out of this study at any time. You are not obligated to answer any question with which you are not comfortable. The researcher will provide participants with a list of mental health resources that they can use, should they feel the need to do so.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms. Participants will be asked to choose their pseudonyms at the beginning of the interview. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer, flash drive, and locked office cabinet. After three years, all electronic records will be deleted, and all physical records will be shredded.
- Interviews will be audio-recorded by the researcher. Following the interviews, the researcher will download the interviews off the Zoom platform server and onto a secure flash drive. The researcher will transcribe the interviews. Recordings will be stored on a password-locked computer and flash drive for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study in the form of a $20 Amazon Gift Card. The gift card will be emailed once participants have completed the study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Marlena Baxter-Dunn. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or [redacted]. You may also contact the researcher's faculty sponsor, Dr. Jason Ward, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher[s], **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix C: IRB Exemption Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

October 5, 2022

Marlena Baxter-Dunn
Jason Ward

Re: IRB Exemption - IRB-FY22-23-229 Grief After Perinatal Loss: A Descriptive Phenomenological Study

Dear Marlena Baxter-Dunn, Jason Ward,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix D: Perinatal Loss Support Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

1-800-622-HELP (4357)

SAMHSA's National Helpline is a free, confidential, 24/7, 365 day-a-year treatment referral and information service for individuals facing mental health disorders. They provide referrals to local treatment facilities, support groups, and community-based organizations. Send your zip code via text message to 435748 to find help near you.

The Crisis Text Line

www.crisistextline.org

In a crisis? Text HOME to 741741 to connect with a Crisis Counselor. It's free and available 24/7. You text HOME and you will receive confirmation and a trained crisis counselor will respond to help you through your crisis.

National Alliance on Mental Illness

www.nami.org

800-950-NAMI (6264)

NAMI HelpLine is available.

You can text, chat, call, or email (helpline@nami.org) the HelpLine M-F 10 am-10 pm. Text HelpLine to 62640.

If you're in a crisis text NAMI to 741-741 for free, 24/7 crisis support via text message

NAMI Helpline is a free, nationwide peer-support service providing information, resource referrals, and support to people with mental health conditions. Staff and volunteers are experienced, well-trained and able to provide guidance.

The National Suicide Prevention Lifeline

988lifeline.org

Call or text 988

The National Suicide Prevention and Crisis Lifeline provides trained counselors that will listen, support, and connect to resources if necessary.

Perinatal Loss Specific Resources

The National Institute for Trauma & Loss in Children Hotline: 1-877-306-5256

Share Pregnancy and Infant Loss Support
www.nationalshare.org
800-821-6819

Visit the website to find resources for perinatal loss in your state. Share is a national organization with over 75 chapters in 29 states. Their services include bed-side companions, phone support, face-to-face support group meetings, resource packets, private online communities, memorial events, training for caregivers, and much more.

SIDS Alliance/First Candle

www.firstcandle.org/bereavement/online-support-groups

1-800-221-7437

This organization offers online peer-to-peer support groups and supportive places for individuals and families to share information and experiences regarding perinatal loss. Visit the website for more information.

Rachel's Gift

www.rachelsgift.org

470-278-1956

Pregnancy and Infant Loss Support Groups meet virtually via Zoom. Registration is required. These services are free.

Perinatal Loss Support Group: Thursdays-7:00 pm

Men's Only Support Group: 2nd Tuesdays - 7:00 pm

Couple's Support Group: 4th Tuesdays - 7:00 pm

Visit the website to learn more information.

Star Legacy Foundation

www.starlegacyfoundation.org

952-715-7731

Star Legacy offers virtual support groups that are led by trained mental health professionals with first-hand experience and/or practice emphasis in perinatal loss. Registration is required. All groups are free to attend. Visit the website for more information.

Bereaved Parents Group: 1st and 3rd Monday - 7:00 pm and 2nd and 4th Thursday- 8:00 pm

Pregnancy After Loss Group: Every Monday- 8:30 pm

Dad's Grief Group: 2nd Monday of each month - 7:00 pm

Appendix E: Audit Trail

Date	Action Item
8/24/22	Proposal Defense with Dr. Ward and Dr. Simmons, virtually
8/28/22	Submitted and certified IRB Application
9/01/22	IRB Application certified by Chair, Dr. Ward, and officially submitted
9/30/22	Received email from IRB requesting clarification
9/30/22	Emailed Dr. Ward to ensure I was proceeding in the best way
10/03/22	Received response from Dr. Ward to proceed
10/03/22	Emailed requested information to IRB
10/05/22	Received IRB Initial Exemption Email
10/06/22	Began recruiting on social media with official IRB approved materials
10/06/22	Posted recruitment flyer on public bulletin boards around my community
10/07/22	Received responses from interested participants, followed up with emailing consent forms
10/07/22	Received Whitney's consent form, scheduled interview
10/08/22	Received Rose's consent form, scheduled interview
10/08/22	Received Lucy's consent form, scheduled interview
10/11/22	Previously scheduled therapy call
10/11/22	Received Monique's consent form, scheduled interview
10/11/22	Received Ella's consent form, scheduled interview
10/12/22	Received Elise's consent form, scheduled interview
10/14/22	Interview with Lucy
10/14/22	Received Sarah's consent form, scheduled interview
10/14/22	Lucy's Transcript Completed
10/14/22	Emailed encrypted transcript to Lucy and separate email with passcode.
10/15/22	Passed out flyers at 2 Perinatal Loss Awareness Events, one in my community and one in a neighboring town
10/15/22	Lucy identified no changes necessary
10/15/22	Emailed Lucy $20 gift card
10/21/22	Interview with Rose
10/21/22	Rose's Transcript Completed
10/21/22	Emailed encrypted transcript to Rose and separate email with passcode
10/21/22	Rose identified no changes necessary
10/21/22	Emailed Rose $20 gift card
10/22/22	Interview with Monique
10/22/22	Interview with Ella
10/23/22	Interview with Elise
10/23/22	Monique and Ella's transcripts completed
10/23/22	Self-reflexive journal entry regarding the first 5 interviews
10/23/22	Emailed encrypted transcript to Monique and separate email with passcode
10/23/22	Emailed encrypted transcript to Ella and separate email with passcode
10/23/22	Monique identified no changes necessary
10/23/22	Emailed Monique $20 gift card
10/24/22	Ella identified no changes necessary

10/24/22	Emailed Ella $20 gift card
10/24/22	Elise's transcript completed
10/25/22	Emailed encrypted transcript to Elise and separate email with passcode
10/25/22	Elise identified no changes necessary
10/25/22	Emailed Elise $20 gift card
10/25/22	Received Morgan's consent form, scheduled interview
10/26/22	Interview with Sarah
10/26/22	Sarah's transcript completed
10/26/22	Emailed encrypted transcript to Sarah and separate email with passcode
10/27/22	Sarah identified no changes necessary
10/27/22	Emailed Sarah $20 gift card
10/28/22	Interview with Whitney
10/28/22	Whitney's transcript completed
10/28/22	Emailed encrypted transcript to Whitney and separate email with passcode
11/01/22	Interview with Morgan
11/01/22	Whitney identified no changes necessary
11/01/22	Emailed Whitney $20 gift card
11/02/22	Morgan's transcript completed
11/02/22	Emailed encrypted transcript to Morgan and separate email with passcode
11/03/22	Morgan identified no changes necessary
11/03/22	Emailed Morgan $20 gift card
11/03/22	Self-reflexive journal regarding the final 3 interviews
11/04/22	Prescheduled therapy call
11/04/22	Began reading transcripts while listening to the interview audio-recordings
11/04/22	Self-reflexive journal regarding reading the transcripts and listening to the recordings
11/05/22	Continued reading and immersion of data
11/06/22	Continued reading and immersion of data
11/06/22	Self-reflexive journal prior to delineation of meaning units
11/07/22	Delineation of meaning units for transcripts of Lucy, Whitney, and Morgan
11/08/22	Delineation of meaning units for transcripts of Ella and Elise
11/09/22	Delineation of meaning units for transcript of Sarah
11/10/22	Delineation of meaning units for transcripts of Rose and Monique
11/10/22	Self-reflexive journal following delineation of meaning units
11/15/22	Transformation of meaning units for Lucy and Whitney
11/16/22	Transformation of meaning units for Morgan
11/17/22	Transformation of meaning units for Ella and Elise
11/18/22	Transformation of meaning units for Sarah
11/19/22	Transformation of meaning units for Rose and Monique
11/22/22	Prescheduled therapy call
11/30/22	Self-reflexive journal prior to beginning imaginative variation
12/01/22	Began process of imaginative variation
01/10/23	All constituents identified
01/10/23	Self-reflexive journal following identifying constituents
01/11/23	General structure of participants experiences constructed

01/16/23	Emailed Chapter 4 Rough Draft to Dr. Ward for review
01/16/23	Self-reflexive journal following completion of Chapter 4
01/16/23	Began working on Chapter 5
01/18/23	Received response from Dr. Ward regarding Chapter 4
01/20/23	Conference call with Dr. Ward
01/20/23	Emailed Chapter 5 Rough Draft to Dr. Ward for review
01/21/23	Self-reflexive journal following completion of Chapter 5

Appendix F: Self-Reflective Journal

10/23/2022

Ahhh! Big feelings here. I've completed my first five interviews. I had therapy on the 11th, and I told my therapist that I was a bit anxious about starting the interview process because I was worried about my ability to remain in the role of researcher. It wasn't as difficult as I thought it would be once I got in the swing of things conducting the interviews. I struggled with wanting to make my participants as comfortable as possible and with trying to give them enough time when they were visibly emotional, so I tried my best to follow their non-verbal cues. I want to write about the major thoughts that I had after each interview.

Lucy: Lucy was my first interview. I was worried at first how much she would remember, but shockingly, she remembered a great deal from her losses, which occurred in the late 1980s and the mid 1990s.

Rose: Rose was my second interview. Things went well. It brought back some emotions for me when she stated that she would be leaving without her baby. I had to make note that her experience was not mine regardless of the fact that we both left the hospital without our babies after giving birth.

Monique: I think with Monique's interview I got more comfortable with the interview process.

Ella: Ella was unknown to me before the interview. It was odd hearing someone share a story similar to my first loss experience. I struggled with not responding, "I understand." I also struggled with not wanting to say "yes, girl! Just like mine." This was a tough interview.

Elise: I knew of Elise, but this was the first time I've actually heard her story. She was visibly emotional during the interview, so I struggled with wanting to give her breaks as needed, but not wanting to interrupt the flow of our conversation. Once we got off the recording, I asked her if I needed more breaks, but she was pleased and thought that I was respectful and sensitive to her emotional needs.

11/03/22

I am done with my interviews. This feels like a big accomplishment. I'm proud of myself, but I'm really hoping that I can let my participants' stories shine through in my paper. I'm having a lot of self-doubt about my ability to remain objective and non-biased throughout. I do have a therapy call tomorrow and it's right on time! Some of the interviews were very emotional for my participants, so I was doing my best not to cry. I'm a crier, so when I see people cry, it's so hard for me to not want to cry along with them.

Sarah: I actually knew Sarah prior to the interviews, and I recall being jealous of her seemingly easy conception and pregnancy stories. So, I felt guilty during her interview. I felt guilty when she was discussing her losses. I don't know why, because I never hoped that she'd experience what she did, but I remember thinking I wish I could get pregnant as easy as she and I wish I could carry a pregnancy without complication like she does. Ouch, that hurts. I did personally

reach out to her after her first loss and her second loss, but as she was talking, I found that I had to stop myself from thinking, I should've done more.

Whitney: Whitney's infertility impacted her grief experience a great deal. It was evident through the interview that a large part of her grief experience was centered on the fact that she had concerns with the ability to ever have children.

Morgan: While Morgan's loss is completely different from others, I still think that her perspective and her experience was important to highlight. Her perspective was surprising in some respects.

11/04/22

I've been reading transcripts and listening to the interviews.

Here's things I keep telling myself.

1. Their experiences are not my own.
2. While we have similarities, the experiences are different.
3. Their stories are their stories.

I don't really have much to journal about with this entry.

11/06/22

I'm starting the meaning unit step of the analysis process. I don't know why, but this feels like a strange step. A lot of my participants give some in-depth information about their loss and I don't know if that should be included. I know I'm only writing about the grief, coping, and spiritual crises. I'm not writing about their individual loss experiences. I'm going to email Dr. Ward for some clarification before I start.

11/10/22

So, I've finished delineating meaning units. It took from the 7th until today (the 10th), working the entire day on the meaning unit identification. I'm double guessing some of the units, but I'm trying to focus on the fact that it's not absolute. Dr. Ward's reply was helpful. Now I'm preparing to go through to the next phase which is transform everything to third person. This is going to be a tedious task, but I hope to finish it in a timely fashion.

11/30/22

I plan on starting my imaginative variation soon. I took a longer than planned break because I found out I was pregnant. It's been rough, honestly, sitting with this data and dealing with a new pregnancy. As someone who has experienced perinatal loss, I am so anxious to find out that I'm pregnant because I can't bear to experience loss again. Granted, I'm in a different headspace than I was with my last loss, but it's still a loss and it would be absolutely awful. In my process of trying to immerse myself in the data and become one with the data, I had to take a break because I did not want to impose my doubts, worries, fears, and feelings on anything that my participants

shared with me. I had therapy on the 22nd of this month and I think that was really helpful for me to get my thoughts and feelings bracketed aside. I'm even more motivated to knock this out of the park! Here are the thoughts I'm keeping at the forefront when I start this imaginative variation.

1. These are their stories.
2. Each experience is truly different, however there are certain aspects that are common and invariable to each participant's story. Let's try to bring those out.
3. This is not your experience.

01/10/23

Things are going great. After a much-needed break, I was able to start the process of imaginative variation last month and I finally identified all the constituents. There are thirteen of them. I feel confident in my process and analysis. What has been helpful has been making sure that I'm not projecting my thoughts and feelings onto the data. I think by taking a break and being aware of that risk, that it's been helpful for me.

01/16/23

I sent Dr. Ward my rough draft for Chapter 4. I worked really hard on this, so I'm hoping that it's only a fix here and there. I am going to go on and begin Chapter 5 so that I'm not waiting idly. I have a few questions, so I'm going to reach out to Dr. Ward soon.

01/21/23

I finished my Chapter 5. That's just all I really have to write about. I'm going to focus now on being able to defend my research. Being able to defend the choices behind my methodology, the constituents I identified, and making sure that I am doing justice to the stories that were entrusted to me by my participants.

Appendix G: Constituents Meaning Structure

Participant	Constituent Meaning Structure: Attempting to Process the Loss
Lucy	Lucy found it difficult to process the fact that she was possibly having another miscarriage. When the doctor confirmed the loss, she was devastated.
Rose	Rose had a very traumatic experience leading up to losing her baby. She did not want to accept what was going on and kept trying to think of ways that could change the outcome.
Whitney	Whitney processed her chemical pregnancies better than she was her other losses. With the chemical pregnancies, Whitney was prepared for the loss by her doctors. Whitney did not process her first loss, instead of allowing her grief to naturally process, she pushed her emotions to the side. She processed her second loss by talking with others, sharing her feelings, and allowing herself to experience her grief.
Morgan	Morgan immediately had an emotional response to learning that she was not pregnant with a viable pregnancy. Morgan was confused by the nature of the loss and kept her from processing it, initially.
Ella	Ella was shocked after giving birth to her sons because she was not prepared to give birth to babies that would not survive. She did not want to accept the fact that her babies would not make it. Her birth experience was not how she imagined she would have her babies. Her loss felt surreal and was difficult for her to process.
Elise	Elise's loss was hard on her because she was not prepared to no longer be pregnant. During a subsequent loss, Elise knew that giving birth so early would be risky, but she was never prepared for her baby to die.
Sarah	Sarah's loss was difficult for her to process. Between the way in which the loss happened and the medical treatment she received afterwards; Sarah was confused. Her experience was surreal, largely because she felt like she had to suppress her grief to be there for her children. She did not fully process the emotional impact of her first loss and was left with anxiety and fear afterwards.
Monique	Monique struggled processing her loss because she was still pregnant, even though her baby died in her womb. After the procedure, when she was no longer pregnant, she was overcome with sadness. When she learned she would have another loss, she was heartbroken and confused.

Participant	Constituent Meaning Structure: Overwhelming Emotions
Lucy	Lucy was devastated and in a depressed state. The effect of the loss negatively impacted Lucy's mental state. Her mental state was comprised severely.
Rose	Rose was distraught following her loss. She was angry and confused. She felt guilty and blamed herself even thought her doctors told her that it was not her fault.
Whitney	Whitney's emotional state was impacted by her losses. She was distressed. She had random crying outbursts and depressive episodes that were troubling for her.
Morgan	Morgan was very tearful and spent a lot of time crying. She experienced strong emotions. Morgan had an emotional breakdown after her loss and wept on the floor with her husband after coming to accept the reality that she was no longer pregnant.
Ella	Ella's experience was very traumatic and painful for her. Her heart was broken. Ella experienced a depressive episode. In addition to this, she had suicidal ideations. Her emotions were distressing for her.
Elise	After her first loss, Elise was heartbroken. She stayed to herself and had no desire to do anything. Her second loss experience was horrendous, and she had a variety of emotions. She was depressed. She had distressing emotions and negative thoughts.
Sarah	Sarah and her husband wanted to withdraw, but she knew that she had to be there for her family. She wanted to fall apart but brushed her emotions to the side.
Monique	Monique was disappointed. She was overcome with sadness and heartbroken. Her second experience was painful emotionally and physically. Monique was depressed after her second loss and then repeated losses negatively impacted Monique causing her depression and anger. She experienced emotional and mental distress.

Participant	Constituent Meaning Structure: A State of Confusion
Lucy	Lucy did not have any answers around the circumstances of the loss. She did not know who or what was at fault. She found herself confused by the lack of answers.
Rose	Rose experienced confusion during the process of laboring and birthing her son because she was not prepared for what was happening and what would happen afterwards. This was further complicated by Rose already experiencing grief over the fact that her baby would not survive. She did not have a memorial service for her son because she did not know what to do when she was asked about her plans during her labor. She was not prepared for making arrangements after giving birth.
Whitney	Whitney was confused on how to navigate her grief with her first loss, so she pushed her feelings to the side. She struggled with interacting with others after her losses because she was confused on how to handle her feelings and emotions, especially her anger.
Morgan	Morgan was confused because she did not know what was happening. The nature of her pregnancy and loss were confusing to her and her healthcare provider did not do a good job of explaining what happened. She was confused about what to grieve and how to grieve because of the characteristics of a molar pregnancy.
Ella	Ella was confused because she never thought she would give birth to babies that would not survive.
Elise	Elise knew that giving birth early would be risky, but she was confused and caught off guard by her daughter dying. She did not know what to expect from her grief process, so she was confused by the impacts of her grief.
Sarah	Sarah was confused. She found it difficult to explain what happened to her children. After her second loss, Sarah could not imagine what could have caused her to have another loss, given her obstetrical history. She did not know how to handle or navigate her grief because there was nothing to prepare her for what to expect.
Monique	Monique was confused. She never thought a loss could happen to her because of her history with infertility. After she lost a second time, she was even more confused.

Participant	Constituent Meaning Structure: Grieving What Could Have Been
Lucy	Lucy not only grieved the loss of her baby, but she grieved her hopes and dreams that she imagined for herself and her family that were no longer happening.
Rose	Rose not having a memorial service for her son and not knowing what happened to his remains is one thing that Rose has grieved in addition to grieving his loss. Additionally, Rose was looking forward to having a child of her own flesh with her husband. She felt that she was robbed of that experience and that her husband was robbed of raising a child with his wife.
Whitney	Whitney's entire family planning hopes and dreams are what she grieved in addition to grieving the losses of her children. Her experience with infertility made her grief experience different. She wondered if she would ever be able to conceive. She always had a desire to have her version of an ideal family. In a sense, Whitney grieved the way she thought expanding her family would be.
Morgan	Morgan grieved the thoughts, dreams, and feelings she had when she first learned she was pregnant. She grieved what she hoped her pregnancy would look like. Her confusion around her loss and what exactly happened caused her to settle on grieving the idea of having a baby.
Ella	Ella's birth experience was not how she imagined she would have her babies. She grieved not having the experience she dreamt of and also grieved the plans and hopes she had for her children.
Elise	Elise planned on bringing her baby home from the NICU. She never allowed herself to get to the point of thinking that her baby would die, but after she did, she felt as if all of her hopes and dreams were destroyed.
Sarah	Sarah grieved the hopes and dreams and plans she had for her children. She grieved the plans she had for her family and for the life pictured for them all.
Monique	Leaving the hospital after giving birth was nothing like she anticipated or planned. She imagined how growing her family would look and she was devastated when her plans did not happen. Monique thought she missed out on her hopes and dreams.

Participant	Constituent Meaning Structure: Doubting Your Innate Womanhood
Lucy	The miscarriages made Lucy question her body and her status as a woman because of the difficulties she experienced conceiving and staying pregnant. She blamed herself. She thought of herself as a failure of a woman. Lucy's losses caused her to have thoughts that were damaging to her self-esteem and self-worth as a woman.
Rose	Rose blamed herself and felt guilt after her loss, although she took precautions, she felt like it was her fault. She felt that she failed as a woman because she did not carry her child to term and give birth to a healthy baby. She blamed herself and her body, she felt like a failure.
Whitney	Whitney felt like she was less than a woman and that she did not deserve to have children or have an easy path to having children. Her struggles with infertility further complicated her self-image. The losses negatively impacted her thoughts about herself and feeling worthy of love and affection. She felt defective.
Morgan	Morgan felt like a failure because of her loss. She felt that she was less than a woman. She thought that because she was a woman, that she should be able to conceive and carry. As a confident woman, this was a blow to her self-esteem. She struggled with feeling like her body failed her and feeling like less-than.
Ella	Ella's loss made her feel like she was less than a woman. She felt like a failure. She believed that because she was a woman, she should automatically be able to conceive and carry without an issue. She also felt like she failed her husband and her babies.
Elise	Elise felt like she was a failure of a woman and a mother. She felt as if she were to blame for the loss. She felt like as a woman, it was her responsibility to carry the children and give birth, and Elise's not being able to do that, negatively impacted her self-esteem and view of herself as a woman. She felt like less-than a woman which caused her to have a lot of negative self-thoughts and self-talk.
Sarah	While Sarah had thoughts of doubt surrounding her ability to carry children again, she tried her best to keep from letting those negative thoughts consume her.
Monique	Monique's losses made her feel like she was less than a woman and a wife. She questioned her ability to be a mom and felt inadequate as a woman and a mother.

Participant	Constituent Meaning Structure: Feeling Alone and Misunderstood
Lucy	Lucy felt like no one understood why she was upset and so depressed after her loss.
Rose	Rose was disappointed when people that she thought would reach out did not. She felt like people did not empathize with her, instead they pitied her, which made her feel alone.
Whitney	Whitney felt alone and as if she had not one to talk to or no one that understood what she was experiencing. She felt like she had no support or anyone who understood her loss while she was at work. People pressured her to bounce back and act like nothing happened w
Morgan	Morgan felt as if she did not have anyone to talk to because of the type of loss she had. She struggled with feeling like she had no one who understood her emotions or why she was upset about her loss.
Ella	Ella felt like no one understood her pain or her grief or even why she was so upset. Even her family and friends did not try to understand why she was upset. This made her feel alone.
Elise	Elise withdrew and spent a lot of time alone. She did not want to interact with others because she felt that there was no one that she could talk with about her experience. She felt like her husband did not understand because he did not have the physical reminder of the loss. She felt that no one extended her grace and understanding in her grief.
Sarah	Sarah felt like she had no one to turn to after her losses, especially her second loss. She felt like her r/s community and her family and friends did not know how to be there for her after her loss. She also felt like people did not reach out.
Monique	Monique felt alone and like she had no one to support her. She felt as if she was alone in specific characteristics of her grief and that she was an anomaly for having those feelings and thoughts.

Participant	Constituent Meaning Structure: Uncomfortable Interactions with Others
Lucy	Lucy's family and friends said things that diminished her loss. She experienced insensitive comments and people trivializing her loss.
Rose	Rose dealt with some uncomfortable interactions with others when they made statements that were intended to be helpful, but instead were harmful. These instances disenfranchised her grief experience.
Whitney	Whitney struggled with interacting with others and their statements that meant well but were harmful. She also struggled with seeing pregnant women and being jealous of their ability to get pregnant and stay pregnant.
Morgan	In Morgan's experience of grieving, some people tried to be helpful by providing her with Bible verses and saying other blanket statements. To Morgan, these instances were not helpful. One stressor for Morgan was people offering advice, condolences, and well-wishes that were tone deaf. Morgan also found it hard to be around women who were pregnant, including family members, without being jealous.
Ella	Being around pregnant women or new babies was hard for Ella. Ella also felt like people said things that were tone deaf and that were not helpful even though they may have intended for them to be. Her interactions with other people were difficult because people would say things that were hurtful. Even her family and friends made statements that were hard for Ella to deal with. They trivialized her loss and did not try to understand why she was so upset.
Elise	Elise was jealous of others who were pregnant or who had normal pregnancies and childbirth experience. Her physical reminders of her pregnancies and losses made it difficult in her interpersonal relationships. She also experienced people who trivialized her losses and could not extend grace and understanding to her in light of their own good news.
Sarah	Sarah's experiences with the healthcare professionals and with family and friends after her losses were difficult because no one knew how to address the losses. Healthcare professionals were not empathetic and did not show compassion. Their actions trivialized her losses and further added to her distress. Family did not know how to handle it, so it was tense.
Monique	Monique experienced insensitive comments from her friends and family that trivialized her loss and experienced. People made comments or statements that were harmful and impacted Monique's grief. Monique also struggled seeing people who were pregnant and people with babies.

Participant	Constituent Meaning Structure: Comparisons of Morality and Deservedness
Lucy	Lucy struggled with an aspect of spiritual pride. She compared herself to others and could not figure out why she had to suffer while others did not.
Rose	Rose found it difficult to accept what happened to her when there would be news stories of children dying. She also struggled with personal knowledge of people having children that they could not adequately care for, so she was angry that it seemed like everyone was getting what she wanted. She compared herself to others and wondered why she could not conceive easily or carry a baby to term. She found it difficult to understand when she saw people who abused children and could not understand why God would allow them, but not her.
Whitney	In Whitney's profession, she often sees young teenagers who are pregnant. This is difficult for her because she cannot understand why they are getting pregnant so easily and carrying without issue when they are in no position to raise a child. Whitney struggled with wondering why she was not given the same opportunities when she was stable and in position to raise a family. She also struggled people living in certain situations and wondered why not her.
Morgan	Morgan compared herself to others and wondered why them and not her. Her purity before marriage was important to her and she looked at others who may have had children out of wedlock and could not understand why she had to experience what she did.
Ella	Ella compared herself to others and could not understand why she was unable to have what she wanted in life. She saw stories of children being mistreated and abused and wondered why them and not her.
Elise	Elise would see people and compare their situations as if she was living better than them and deserved to have children easily like others. She looked at her situation and compared it to others' and could not understand why the blessings she prayed for were taken from her. She lived her life a certain way and thought it would be different.
Sarah	Sarah tried not to allow herself to fall into the trap of comparing herself to others. She recalled getting a lot of hate from other women about her ability to get pregnant and carry easily that when she experienced her losses, she realized that she did not need to stay in that mind state. When she felt like that, she tried to turn to scripture.
Monique	Monique compared herself to people who were doing the wrong things and wondered why they got what she wanted. She compared herself to others based on her r/s beliefs and found it hard to see why they had what she wanted.

Participant	Constituent Meaning Structure: A Spiritual Mental Battlefield
Lucy	Lucy struggled with doubting her faith. She felt like her faith was tested and it caused her to question everything she knew to be true. The RSS for Lucy were difficult because of her relationship with God. She questioned Him and wondered why god allowed the losses to happen. She even stopped attending church, reading the Bible, and praying. She felt as if the RSS were a battle between her spirituality and her mental health.
Rose	Rose was angry with God following her loss. She stopped attending church. She was confused and hurt and wanted to know why God would not allow her to have a baby. Rose never lost her faith, but she wondered why God would test her that way.
Whitney	Whitney questioned God and wondered why. She wondered why she had to try and control every aspect of her life and struggled with wanting to control things instead of turning it over to God. Whitney thought that God was punishing her for things she did in her past and that she was unworthy.
Morgan	Morgan experienced RSS and struggled because she knew that the thoughts and feelings she was having were normal but not Biblical, so she found a way to counter those thoughts and feelings. In the midst of her struggles, she turned to r/s beliefs and practices. She struggled with anger and even though she knew she could question God and feel the way she felt, it was still difficult to deal with those thoughts.
Ella	Ella experienced RSS. She was angry and God. She had doubts about her faith. She had doubts about everything. She could not understand why God would allow her babies to be taken from her if He was a loving God. She stopped going to church. The RSS made her feel unworthy and like she was not a "good Christian".
Elise	Elise experienced RSS and thought God hated her. She had difficulties with her r/s beliefs and the negative thoughts. She wrestled with knowing that she could be upset with God and actually being upset with God. She felt like she was punished. She struggled with what she believed to be true based on her r/s beliefs and her own thoughts and feelings. She even stopped going to church. Elise believed her RSS made her grief worse.
Sarah	Sarah knew that the negative thoughts and feelings were normal, but she did her best to turn to her r/s beliefs whenever she found herself going down a path of negative thinking. She experienced a struggle between what she knew to be true based on her r/s beliefs and what she was feeling because of her grief about her losses. She continued to turn to her r/s beliefs when she would question and wonder why. She tried to find how she could grow from the experience.
Monique	Monique experienced RSS. She was angry at God. She questioned her faith, and her view of God was changed. She stopped going to church. She would roll her eyes during church and turned away from her r/s practices. This negatively impacted her mental health. The RSS negatively impacted her r/s

	beliefs and practices. She felt that these experiences negatively impacted her grief.
Participant	**Constituent Meaning Structure: Post-Loss Disruptions**
Lucy	Lucy's grieving negatively impacted her and her mental health. She attempted to go back to work but had to take a leave of absence from work after only a few weeks back.
Rose	Rose was still plagued with not having a memorial service and not knowing what was done with her son's remains. This is one thing that has always bothered her since her experience.
Whitney	The losses have had a negative impact on Whitney's intimacy with her husband. The feelings of being unworthy, less than, and a failure have negatively impacted her desire to be spontaneous and intimate with her husband. Whitney blamed herself and doubted that she was worthy of love and affection because of the losses. She also projected her hopes and dreams she had for one of the children she lost onto a young girl in the county where she lives. This child is the same age as the first child she lost. She sees her and wonders what could have been.
Morgan	Morgan also thinks about the child that she lost and what life would have been like for her and her family. She often thinks about how her life would look if she had the child she lost, in addition to her son.
Ella	Ella had intrusive thoughts and nightmares consistent with signs of experiencing a trauma. Her experience caused her to have intrusive thoughts and feelings, in addition to new mental health conditions, she never experienced before.
Elise	Elise was diagnosed with PTSS. Her losses were traumatic for her, so she has negative, intrusive thoughts. She has been prescribed medication for her depression and anxiety, which was something Elise never thought she'd have to do. The lasting impacts of her grief, and the prolonged nature were troubling for her.
Sarah	Prior to her losses, anxiety was never a problem for Sarah. She now has to deal with the mental and emotional impact of her loses. She has intrusive thoughts and anxiety which are hard for her to deal with. She even has flashbacks that will trigger a psychosomatic reaction.
Monique	Monique suffers from depression and anxiety after her losses. Her anxiety of experiencing another loss is crippling for her. Monique also has trauma reactions like nightmares after her loss.

Participant	Constituent Meaning Structure: Finding Ways to Cope
Lucy	Lucy's RSS led her down a path of using negative r/s coping mechanisms. She had spiritual discontent and a punishing God reappraisal. Lucy started finding positive ways of coping by seeking professional help from a professional counselor and found it to be beneficial. She also turned to friends, but her biggest source of comfort was talking to her husband. After a certain time, Lucy incorporated her r/s beliefs through the means of positive r/s coping to help. She utilized spiritual connection by seeking God and collaborative religious coping by trying to work with God to solve her problem. She eventually returned to religious focus and used r/s activities to shift her focus and then actively surrendered by trusting God.
Rose	Rose's RSS also led her down a path of using negative r/s coping mechanisms. She had spiritual discontent and interpersonal religious discontent. She went to grief counseling but stopped shortly after she started. She used things like memory making to help cope. She had a scrapbook, she kept ultrasounds and recordings of his heartbeat. She also made a shadowbox with precious mementos. Rose eventually used active r/s surrender by doing her best to trust God.
Whitney	Whitney used negative r/s coping mechanisms at first. She had spiritual discontent and a punishing God reappraisal. She questioned why and wondered if she was being punished for her sins. She eventually turned to her r/s beliefs and used positive r/s coping mechanisms. She sought a spiritual connection and spiritual support through her church Bible study group and asking for prayer. She also had religious focus, because she turned her focus to God. Currently, she is still working toward active r/s surrender, which is her ultimate goal.
Morgan	Morgan's coping was different wherein she used positive and negative r/s together. When she was experiencing spiritual discontent through her anger and displeasure with God, she then turned to r/s forgiving and looked to God for help letting go of her anger and negative feelings. She also sought a spiritual connection and knew to turn to God when her negative feelings became overwhelming. Whenever she would try to make sense of what was going on without God, she stopped and used active r/s surrender and turned it over to God. Whenever she felt that she was wondering why she used benevolent r/s reappraisal and tried to see how God was using her through it.
Ella	Ella was also angry at God and questioned why he allowed her to experience what she did. She had spiritual discontent. She also felt like God could not answer her prayers, so she redefined His power in a negative fashion. Ella tried counseling but she did not think it helped. She talked to her husband and went for long walks. She eventually turned to her r/s beliefs and positive r/s coping mechanisms. She tried looking for a stronger connection with God through spiritual connection. She also turned to the Bible and prayer to shift her focus through r/s focus. She sought spiritual support and started trusting God and

	eventually engaged in active r/s surrender by deciding to trust God even though she would not understand.
Elise	Elise had a lot of spiritual discontent. She was angry with God, she was displeased, and felt as if He was not answering her prayers. She thought God was punishing her and used a punishing God reappraisal. She eventually started counseling and attending a grief support group at her church. She turned to positive r/s coping mechanisms like seeking spiritual support by seeking comfort from God through prayer. She used r/s focus and prayed to get her mind off of the things she was facing. She looked for a stronger connection with God through spiritual connection. She sought support from her r/s community and eventually actively surrendered because she decided to trust God's plan.
Sarah	Sarah also used her positive and negative r/s coping mechanisms together. When she was experiencing spiritual discontent through her anger and displeasure with God, she then turned to r/s forgiving and looked to God for help letting go of her anger and negative feelings. She also sought a spiritual connection and knew to turn to God when her negative feelings became overwhelming. Whenever she would try to make sense of what was going on without God, she stopped and used active r/s surrender and turned it over to God. Whenever she felt that she was wondering why she used benevolent r/s reappraisal and tried to see how God was using her through it.
Monique	Monique experienced spiritual discontent through her anger and displeasure with God. She felt that she could no longer trust God and redefined His power in a negative fashion. Monique's repeated losses caused her to grow angrier at God, further exaggerating her spiritual discontent. Monique started counseling and began addressing her RSS. She eventually turned to active r/s surrender and turned it to God. She sought spiritual support by looking to Him for support. She prayed and read the Bible to get her mind off of her problems through r/s focus. She looked for a stronger connection with God and sought support from her r/s community.

Participant	Constituent Meaning Structure: Trusting God's Plan
Lucy	Lucy felt like she had to rely on the fact that God's Word is true. She tried to work it out on her own but realized that trusting God would be the better option for her. She trusts that it was all a part of God's plan and found comfort in trusting His plan and believing in that plan and on His promises.
Rose	Rose could not and still does not understand why she experienced this, but eventually came to trust God's plan. She realized that her emotions and feelings were valid, but that she ultimately trusts her faith and what she knows to be true. She knows that God has a plan and she vowed to trust it even though she did not understand.
Whitney	Whitney turned to her r/s beliefs and practices and worked through her issues with feeling unworthy and undeserving. This helped to reassure her and helped her see that she needed to trust God's plan. She still struggles with completely surrendering, but knows that surrendering every aspect of her life, even this one, is what is best for her.
Morgan	Morgan turned to her r/s beliefs and practices in a positive way more so than she did in a negative way. She relied on God to help get her through her grief. She realized that even though she was upset, hurt, and did not understand what was going on, that she needed to trust in God and rely on Him.
Ella	Ella eventually started to feel like she was not an anomaly and began to move toward strengthening her personal relationship with God. She felt like her view of God was restored and she learned that trusting God's plan gave her hope for the future.
Elise	Through counseling, support groups, and use of positive r/s coping mechanisms, Elise realized that she had to trust God's plan. Even though she did not understand why it happened, she realized she might never understand and that she needs to trust His plan and accept His will for her life.
Sarah	Sarah turned to her r/s beliefs and practices in a positive way more so than she did in a negative way. She realized that her losses were a part of her story and that the losses, while difficult, should not and will not keep her from trusting in God's plan.
Monique	Monique eventually realized that she had to trust in God's plan as being the best for her and as being a way to have meaning for the lives of her children that she lost. She worked through her RSS and resolved to trusting God and His plan even if she does not understand.

Participant	Constituent Meaning Structure: Transitioning from Struggle to Growth
Lucy	Lucy was comforted in trusting in God and believing in His plan. She came to a place where she could look back on her experience and see that she grew. She trusts that it was all a part of God's plan and made meaning by knowing that she will see her children again one day. While the experience, especially the RSS she experienced were difficult, she believed it helped strengthen her faith and relationship with God.
Rose	Rose felt like her faith was tested in a difficult way, but she never lost her faith. Through her trials she felt like she grew stronger in her faith and found a way towards acceptance of her situation. Rose saw that her purpose may have been fulfilled in other ways, instead of having a biological child. She resolved that she had to focus on the future and focus on the fact that she will see her baby again in Heaven.
Whitney	Whitney thinks this experience challenged and strengthened her faith. Through the challenges, she learned to trust God and rely on Him for strength. She was reassured that His plan is the best plan for her life and saw that the only way she was able to come to peace is through Him.
Morgan	In hindsight, Morgan realized that her loss brought her closer to God and strengthened her faith. The struggles and difficulties helped her grow and trust in His plan. She felt like her RSS helped her grieve by causing her to turn towards Him and move toward healing and growth.
Ella	Ella worked through her RSS and began to strengthen her personal relationship with God. Her experience challenged and strengthened her faith. She turned to her r/s beliefs in a more positive way and restored her view of God. Her r/s beliefs were strengthened and she found hope for the future.
Elise	Elise worked through her RSS and turned to her r/s beliefs in a more positive way. She feels like she is making progress and is at a place of acceptance even though she does not understand. Her foundation was broken and she had to piece it back together and once she did, she realized that she would not have made it through the darkest parts of her grief without God.
Sarah	Sarah described her faith as strong but thinks that this experience activated a different level of faith. She relied on her faith and r/s beliefs and tried to learn how she could grow from this experience. Her faith was challenged, but in the end, Sarah felt that it was strengthened because she knows that she can get through the most difficult things in life when she relies on God.
Monique	While Monique described herself as "still a work in progress," she felt that her spirituality was strengthened. She realized that trusting in God was the only way for her to have any sense of peace about the situation. She worked her way back to her faith and found hope for the future.