

DAVID BALTO
**“SPIRITUAL CARE FOR JEWISH FAMILIES SUFFERING PERINATAL
LOSS”**
MAY 10, 2026 (MOTHER’S DAY)
FOR THE MASTERS IN ARTS IN SPIRITUAL CARE AND COUNSELING
JEWISH THEOLOGICAL SEMINARY

IN MEMORY OF
SHARON LEE BALTO (April 14, 1926-January 27, 2024)
CAROL ANN BALTO (June 14, 1951-June 19, 1951)

Prelude

A version of Psalm 23 for burial of a stillborn child

Adonai is now the shepherd of this child:
God, allow her to lie down,
Allow her to play in green pastures,
Allow her to feel the love of her parents and family,
Lead her and hold her and give her warmth and comfort.
Now we stand in the valley of dark, evil shadows; help us not to be afraid.
Comfort and support us with Your rod and staff.
Provide for us and bolster us when the world seems too much to bear.
God, we pray—allow the memory of goodness, mercy, and hope to remain with us
forever.¹

I. Summary and Introduction

This paper addresses the lack of guidance and resources for dealing with families suffering perinatal loss.² It describes a significant gap in guidance and literature for Chaplains on this subject and then tries to fill that gap by discussing the challenges these families face – emotionally, spiritually and psychologically. The paper attempts to give voice to the families suffering these losses through a

¹ Rabbi Jim Egolf, DMin, DDiv, ACPE certified educator. L’chol Z’man V’eit: For Sacred Moments (CCAR Press, 2015), 60. (he wrote this for the loss of his son).

² Perinatal loss, the death of a fetus or neonate between conception and 28 days after birth, is categorized as miscarriage (fetal death prior to 20 weeks’ gestation), stillbirth (fetal death after 20 weeks’ gestation), and neonatal death (death between birth and 28 days after birth). (Berry 2022). The paper primarily focuses on stillbirth or miscarriages after 20 weeks gestation.

series of interviews with Jewish families and Chaplains.³ It then describes how Jewish and Non-Jewish Chaplains approach providing spiritual care for these families based on interviews with Chaplains. It analyzes obstacles in the provision of spiritual care for Jewish families and inadequacies in preparing Jewish Chaplains and Rabbis in providing this care. It concludes with recommendations about how to improve education for Chaplains supporting families dealing with perinatal loss and recommendations for grappling with these issues in the Jewish community.

An overview of the project is provided in Section II. In Section III, it describes the problem being analyzed, in particular the lack of guidance for Chaplains. Section IV describes the mode of analysis for the paper. It explains how hermeneutic interpretive phenomenology is the tool of analysis. It provides a personal reflection about my relationship with perinatal loss and a statement of my commitment to the issue of perinatal loss and the purpose of the research.

The core of the paper is to provide a guide for Chaplains about the experience of families grappling with perinatal loss as guided by interviews of families and Chaplains and the literature on perinatal loss. Section V describes the experience of the families using a framework guided by disenfranchised grief and ambiguous loss. The study describes 8 forms of suffering: (1) shock and trauma, (2) sadness and grief, (3) alienation from the self, (4) guilt, (5) doubt and lack of meaning, (6) loss of faith, (7) stigma and shame, and (8) separation and isolation.

Section VI describes the approach of Chaplains in providing spiritual care. There are eight key principles in providing spiritual care: (1) being self-reflective, (2) being present and holding space, (3) being patient centered and a companion, (4) embracing parenthood and personhood for the baby, (5) the search for meaning and attachment, (6) the spiritual wilderness, (7) providing guidance on rituals, and (8) caring for both partners.

Section VII analyzes the obstacles to providing spiritual care for Jewish families.⁴ These encounters involve distinct challenges because of the status under Jewish law that the baby less than 30 days old is not a life to be mourned. It

³ Although the study focuses on the experiences of Jewish families and Chaplains the teachings are applicable to any faith.

⁴ A good deal of the discussion of Jewish practices refers to the requirements of Jewish law known as “Halacha.” Jewish observance varies a great deal depending upon whether people follow the Orthodox, Conservative, Reform or other movement. A great portion of Jews are unaffiliated with any movement. Orthodox Jews typically follow Halacha in a very observant fashion. Actual Jewish practices for other denominations may vary a great deal.

documents the lack of institutional tools to deal with these losses. It describes how this can increase the problems of disenfranchised grief and ambiguous loss.

Section VIII provides recommendations on how to approach the problems identified in the study. It includes recommendations for hospitals and Chaplaincy organizations to improve the education of and involvement of Chaplains to deal with perinatal loss. On the issues related to the Jewish community it sets forward actions Jewish communal organizations, synagogues, social service agencies and Rabbinical schools to bring greater attention to the issue of perinatal loss and to improve spiritual care for these families.

II. Description of the project

Chaplains often play a critical role in providing spiritual care to families that suffer loss. Through a variety of approaches including presence, compassionate dialogue, prayer and rituals, Chaplains can help families grapple with these painful losses. In the world of perinatal loss Chaplains seek to comfort in the midst of deep trauma, provide a sanctuary where feelings are welcome as families bond with the child in the hours after death, and begin the process of making meaning.

Although there is substantial guidance on providing care for families suffering loss there is far less literature or guidance on how Chaplains can provide spiritual care to families suffering perinatal loss. Infant death is commonplace, but despite the high prevalence of pregnancy loss (25% of all pregnancies) and more than 27,000 stillbirths a year, these deaths are rarely discussed openly. (Petro 2015).

Perinatal loss is a life-changing event for families, a trauma with devastating, long lasting effects that may include severe depression, post-traumatic stress disorder, suicidal ideation, marital dissolution and “disconnectedness from friends and families and struggles with one’s faith.” (Cacciatore 2010). The parents’ grief often is underestimated or ignored by their social network who may never have met the baby and/or feel uncomfortable discussing the loss of a child. Families enduring perinatal loss experience profound grief, loss of the actual and imagined future for that child, and the baby who is never forgotten. Moreover, over 40% of parents will never know the reason for the stillbirth. (Star Legacy Foundation, “About Stillbirth,” <https://starlegacyfoundation.org/about-stillbirth/>).

The social impact of perinatal loss is substantial. Up to 60% of the parents suffering perinatal loss experience symptoms of posttraumatic stress five years after the loss. (Berry 2022). About 25-75% of parents suffering perinatal loss suffer

complicated grief, often resulting in depression, anxiety, suicidality, substance misuse, eating and sleeping disorders and premature death. *Id.* Two-thirds of parents experience persistent symptoms of trauma after the loss. (Berry 2023). (In comparison only 4% of the general population suffer complicated grief after the loss of a spouse, parent, friend, or older child.) Approximately 25% of women experiencing perinatal loss develop adverse psychosocial outcomes, which is one of the leading causes of disability in the United States. (Cole et al., 2017). Men also suffer from these losses.

The purpose of this paper is to provide a document that helps to guide Chaplains and other spiritual caregivers on the lived experience of families that suffer perinatal loss and approaches to deliver compassionate spiritual care. Based on surveys of families and Chaplains the paper will document the experiences of these families and offer guidance on approaches to providing spiritual care outlined in Section V.

III. Problem being analyzed

In spite of the significance of the problem there is modest guidance for Chaplains or other spiritual caregivers on the experiences of these families or how to provide spiritual support. There is limited research into the spiritual challenges faced by families suffering perinatal loss and little specific analysis of the roles of Chaplains. With so little known about a parent's spiritual experience of perinatal loss, the Chaplains interviewed in this study explained their approach is generally intuitive.

There is a general lack of guidance for Chaplains to provide spiritual care to families suffering perinatal loss. (Zwerling, Blake *et al* 2024). There is very little Chaplain-specific literature (if any) on this issue.⁵ I could not find any training courses for Chaplains on the subject, nor could I find it addressed in any Chaplain treatises. I did find less than a handful of training sessions at chaplaincy conferences.⁶ I could not find any courses provided by Chaplaincy associations.

⁵ I asked every Chaplain interviewed, leading Chaplain education experts, staff at the Chaplaincy Innovation Lab and scholars in perinatal loss and none could identify more than a couple Chaplain-specific articles.

⁶ The only ones I found were at Association of Professional Chaplain conferences. See <https://www2.apchaplains.org/forms/store/ProductFormPublic/perinatal-loss-supporting-the-patient-their-loved-ones-and-the-staff-after-a-fetal-demise> (presentation by Julie Cecil); <https://www2.apchaplains.org/forms/store/ProductFormPublic/the-silent-crisis-of-perinatal-grief> (presentation by Dani Helm).

In my interviews with Chaplains few mentioned having formal training on spiritual counseling in these situations. None mentioned taking any outside courses or relying on literature on the subject. There is some literature and training but it is not targeted to Chaplains. At most some Chaplains mentioned having a short didactic on the subject in their clinical pastoral education program.

In the Jewish community these problems are even more significant. Under Jewish law the baby⁷ is not treated as a human being, for the purpose of the obligation to mourn, unless he or she lives for 30 days. Traditionally the baby would just be taken to be buried in an unmarked grave.

Because the baby is not recognized as a human life:

- There is very little in prayers or memorialization for perinatal loss. The Jewish faith has a strong set of rituals and traditions for dealing with grief, but because the baby is not treated as a human life, almost none are applied to perinatal loss. There is very little liturgy to deal with these losses and none in major denomination prayer books.
- There is very little guidance from the religious denominations to Rabbis and the communities about how to handle these losses. There are very few resources on how to deal with these losses.
- The subject is shrouded in silence with very little literature and few sermons or Rabbinic writings on the subject.
- The latest Rabbinic teachings on how to address these losses under Rabbinic law (“responsas”) are over 25 years old.
- Training in Rabbinic schools on these losses is sparse and not fully developed. Hebrew Union College and Yeshivat Chovevei Torah are the only significant seminaries to address the issue in some depth.⁸ In most seminaries, the education focuses more on issues of Halacha (Jewish Law) rather than pastoral care.
- The only book on providing rituals for these losses – Tears of Sorrow, Seeds of Hope is from 1998.⁹

⁷ In this paper I refer to the loss as a “baby.” Almost all of the families interviewed referred to the loss as a “baby.” As described *infra*, Chaplains need to be sensitive to how the family characterizes the loss and follow the family’s lead on whether the loss is a “baby” or a “fetus.”

⁸ Hebrew Union College addresses it in their Lifecycle Counseling Course in sessions on “ambiguous loss” and “when birth is not joyous.” As described *infra*, Yeshivat Chovevei Torah addresses it in a one-week seminar every four years on beginning of life issues.

⁹ Cardin, Rabbi Nina Beth, Tears of Sorrow, Seeds of Hope: A Jewish Spiritual Companion for Infertility and Pregnancy Loss (1998).

- There are very few Jewish family service entities and one synagogue in the U.S. had support groups for families suffering perinatal loss.¹⁰ There are several perinatal loss support entities, which are voluntary entities with little support from the established Jewish community.¹¹
- I could find only two studies of Jewish families grappling with perinatal loss, both involving Ultra-Orthodox families in Israel¹²

Overall, perinatal loss is shrouded in deep silence.

Questions Presented

- a. What are the spiritual challenges faced by families suffering from perinatal loss and**
- b. What are the most effective ways of providing spiritual care?**
- c. What are the obstacles in the Jewish community to providing this spiritual care?**

IV. Mode of analysis

A. Overview of the scope of the study

Interviews with families and Chaplains. The core of the study was interviews with families and Chaplains (described below). I interviewed twenty Jewish families¹³ who suffered perinatal loss.¹⁴ I limited my study to instances of stillbirth, deaths after 20 weeks gestation.¹⁵ I interviewed twenty Chaplains and

¹⁰ The Network for Jewish Health Service Agencies could identify only two local agencies provided perinatal loss support.

¹¹ For a listing of these groups see National Jewish Healing Center, “Resources – Perinatal Loss” at <https://jewish-healing-center.org/perinatal-loss/>.

¹² See (Hamama-Raz et al 2014)(Levitan et al. 2022); Ultra-Orthodox Jews are distinct and have much more strict views about faith and religious practice. About 7-8% of U.S. Jews are Ultra-Orthodox. The beliefs and practices of Ultra-Orthodox Jews are very different than the general population so these studies have limited utility in dealing with the general Jewish population.

¹³ I included Orthodox, Conservative and Reform families. Three of the families are Orthodox, four are Conservative, four are Reform, and one is unaffiliated. Three parents were same sex couples (both female) and there were no gender non-conforming parents.

¹⁴ Perinatal loss included both stillbirth and miscarriages after 20 weeks.

¹⁵ I included both unintentional deaths and Terminations for Medical Reasons. A pregnancy could be terminated for medical reasons including the fact that the baby would be unlikely to survive after birth or had a severe disability. These can be different situations in some respects from unanticipated stillbirth since the families chose to end the pregnancy. The families I interviewed who chose termination for medical reasons appeared to suffer very similar trauma to those who did not choose termination. They saw it primarily as a loss and not a termination. Studies have demonstrated that families choosing to end pregnancies for medical reasons suffer trauma and complicated grief.

Rabbis who have dealt with perinatal loss (Chaplain interviews included non-Jewish Chaplains).

Comprehensive Literature Search. I began with a comprehensive literature search looking primarily for articles addressing the psychological, emotional, and spiritual challenges faced by families suffering perinatal loss. (A listing of the articles is attached). I spoke with the leading academics in the field and asked them to identify key articles. Based on these interviews and my own literature searches I believe there is a robust literature on the psychological and emotional needs of these families, but less than a handful of articles addressing (in part) the spiritual needs of these families.

Training on perinatal loss for nurses. I recognized that although there was very little training for Chaplains on perinatal loss, nurses, social workers and therapists receive training on the subject. I attended programs for nurses by Association of Women's Health, Obstetric and Neonatal Nurses -- AWHONN, the leading educational venue for nurses on perinatal loss. I received the Perinatal Bereavement Certificate from AWHONN. In addition, I attended the session on perinatal loss for new nurses at the hospital I work at – Holy Cross Hospital, the largest delivery hospital in the state of Maryland.

Training for Social Workers and Therapists. I also attended a two-day course by Postpartum Support International on the emotional challenges from perinatal loss for social workers and therapists. In addition, I attended programs by Star Legacy Foundation, International Partnership for Perinatal Excellence, Institute for Reproductive Grief Care and the Pregnancy Loss and Infant Death Alliance which addressed the broad social, emotional and psychological needs of the families.

Learning from Nurse Educators. I spoke with nurse educators at several hospitals about nurse education for perinatal loss.

Jewish Support Groups for Perinatal Loss. I spoke with practically every significant Jewish organization that assists families with perinatal loss to get their input about the study. Those included I Was Supposed to Have a Baby, NechamaComfort, Our Love Continues, Knafayim, Jewish Grief Groups, ATime, Uprooted, National Council for Jewish Women, and Pregnancy After Loss Support. These conversations provided guidance about specific issues that arise for Jewish

(Kersting, Anette 2012). To some extent families dealing with termination for medical reasons may face somewhat different psychological and spiritual issues because they chose to end the pregnancy.

families and guidance how to interact with families in a compassionate and sensitive fashion.

Social Workers dealing with Jewish families suffering perinatal loss. I interviewed several social workers who focus on perinatal loss. Many of the social workers were identified by the Network for Jewish Health Service Agencies which surveyed its member agencies to identify social workers who focus on perinatal loss.

Therapists dealing with Jewish families suffering perinatal loss. I spoke with four of the leading therapists who serve families dealing with perinatal loss to get their perspective on the emotional, social, and psychological challenges these families face.

Progressive Mikvaot.¹⁶ I spoke with the directors of two of the leading progressive Mikvaot – Mayyim Hayyim in Newton, Massachusetts and The Soul Center in Baltimore, Maryland about their work with women dealing with perinatal loss.

Catholic guidance on spiritual care and perinatal loss. I spoke with Abigail Jorgenson the author of [A Catholic Guide to Miscarriage, Stillbirth, and Infant Loss](#) about the project and the Catholic approach to providing spiritual care in these situations.

Input from Jewish Hospital Chaplains. I led a discussion about my study and the issues of providing spiritual care to the Hospital committee of Neshama: Association of Jewish Chaplains.

Study of cultural bereavement practices. I studied the bereavement practices of several cultural and religious groups focusing on a treatise -- [Perinatal Bereavement Rituals and Practices Among U. S. Cultural Groups](#). I spoke with the authors of the chapters on Jewish, Christian, and African-American practices.

Examination of training from Jewish Chaplains and Rabbis. The project seeks to determine the training and resources available to Rabbis and Jewish Chaplains in dealing with these losses. I did comprehensive searches looking for any resources and there was nothing significant written on the subject. I interviewed

¹⁶ A “mikva” is a is a specialized ritual bath used by Jewish people to achieve spiritual purity. Its primary purpose is to transition a person from a state of ritual impurity to purity, rather than for physical cleanliness. Some women go to the mikva after a miscarriage or stillbirth.

the former President of Neshama: Association of Jewish Chaplains and searched through their website and the websites of other Chaplain organizations.

For a perspective on Rabbinic education, I interviewed educators in the Orthodox, Conservative, Reform, Reconstructionist and Renewal movements about how they approach providing spiritual care for perinatal loss and how Rabbinical students are educated on how to care for these losses. I attended a one-week seminar at Yeshivat Chovevei Torah, a modern Orthodox Rabbinical school, that dealt with halachic, spiritual and emotional issues surrounding the beginning of life, that addressed perinatal loss.

Finally on Halachic issues I reviewed some of the leading Orthodox authorities on the subject and the responsa¹⁷ of the Conservative and Reform movements. I spoke with the author of one article of the Orthodox position and the author of the Conservative responsa.

B. Methodology for the Study

The interview process was approved by the Institutional Review Board of the Union Theological Seminary and the Jewish Theological Seminary. Interviews with families were secured by word of mouth and reaching out to groups that deal with perinatal loss (e.g., National Council for Jewish Women) and social workers who deal with these losses.¹⁸ Confidentiality protocols were used and interviews were recorded with recordings destroyed at the end of the project. Subjects were informed the interviews were entirely voluntary and they could decline any question. The subjects received the outline of questions beforehand. (The interview outline is at Appendix A). Because of the sensitive nature of the discussions the subjects were offered counseling at the end of the interview.

The subject pool focused on families suffering a stillbirth defined as a loss after 20 weeks of gestation. It included some cases of termination for medical reasons, as that can pose different psychological, emotional and spiritual issues. The study excluded families that suffered losses within the past 6 months, since a shorter period may raise more difficult emotional issues. Since there is some greater sensitivity to how loss is handled in the past decade, the study limited subjects to

¹⁷ A “responsa” is a written legal opinion.

¹⁸ The subject pool was not necessarily representative since these were all families willing to speak about their loss. Three of the subjects had already been public about their losses authoring articles or participating in public interviews. Three of the subjects are Rabbis.

those who suffered loss within the last ten years. There were no limits by denomination.

For Chaplain interviews members of the Hospital Committee of Neshama: Association of Jewish Chaplains were solicited.¹⁹ Chaplains were also secured by word of mouth. Non-Jewish Chaplains were secured by reaching out to academics who have studied perinatal loss and non-Jewish support groups for families suffering these losses. The Chaplains received the questions beforehand. (The interview outline is at Appendix B).

The approach taken to the research was hermeneutic interpretive phenomenology. Hermeneutic interpretive phenomenology is a qualitative research approach that seeks to understand the lived experience and hidden meanings of human phenomena. It rejects the “bracketing” of researcher bias, instead embracing the “hermeneutic circle”—the continuous, reflexive interpretation of participant narratives, context, and the researcher’s own background.

Hermeneutic interpretive phenomenology is different than traditional research in several respects. It is meaning focused and attempts to interpret the meaning of lived experiences. It assumes the researcher's background and preconceptions are part of the interpretive process, aiming for transparency through reflexivity rather than detachment. Hermeneutic interpretive phenomenology is particularly well suited for situations of human challenge and suffering and has been used in numerous psychology and nursing studies. It has been used to interpret the impact of perinatal loss on families.

Unlike other methods of study there is not a need for saturation for hermeneutic interpretive phenomenology. The depths of phenomenological meaning can never be fully explored, so saturation is irrelevant. When one achieves an understanding of the phenomena and can identify the meaning the participants apply to their lived experience, there is sufficient data. Typically, eight to twelve interviews are considered necessary using methods consistent with this approach.

C. Disclosures and personal reflection

Hermeneutic interpretive phenomenology research assumes the presence of the self in the research and interpretation of the research (unlike other methods which

¹⁹ The subject pool was not necessarily representative. Almost all the Chaplains interviewed were individuals recognized as having expertise in perinatal loss.

seek to bracket the self). A researcher cannot separate prior experience and knowledge from personal interpretation of meaning. (Bynum & Varpio, 2017; Sokolowski, 1999). Thus, it is necessary to disclose one's personal experience to evaluate its impact on a study. (Spence, 2017).

Perinatal loss is part of my family story. As a child I always believed and was told I was the first born. As a teenager I learned that my mother ("Sharon") had a baby girl fourteen months before my birth ("Carol Ann"). On the fifth day after birth a nurse came into my mother's room with a large syringe and my mother asked "what is that for?" And the nurse replied "to keep you calm; the doctor will see you soon." The doctor came in and told her that her daughter was dead. My mother never had the chance to see or touch her daughter. When she returned home, she received little comfort from her family because they also had experienced child loss and their implicit response was "it's time to move on." (Unfortunately, as those interviewed attested, this is not an unusual response from well-meaning family or friends).

My sister is buried in the very small baby section of the cemetery in an isolated corner reserved for infants and very young children. There is a tombstone. The fact there is a tombstone is very perplexing because typically religious families do not acknowledge the death of a baby under 31 days old. In our community monuments are not placed unless the baby lives for at least 3 years. There are no other babies (a child under three years old) in the cemetery with a tombstone.

I reflect that my sister has a tombstone because my parents decided that regardless of Halacha or community custom, they wanted their daughter remembered. Even though her life was painfully short they wanted her life recognized and acknowledged. They wanted a place they could mourn.

My sister's death was clouded in silence. Our family never spoke of her loss, although myself and my siblings would often visit her gravesite. My mother would acknowledge the anniversary of her death but rarely spoke of the circumstances or her feelings. My mother was an extremely empathetic person and could be close to people who faced suffering; I reflect that her ability to be so empathetic may have been nourished by the silent suffering she endured.

There was only once occasion where my mother spoke of the loss in my presence. When I was in my early 30s, I asked her to join me in an appointment with my psychotherapist. The therapist asked her how she was and she told him that she had always been fairly depressed and then revealed the story of the loss of Carol.

I was amazed at her willingness and ability to be so vulnerable about something that caused so much silent sorrow.

Since my mother became pregnant with me so soon after the loss I wonder whether I (in utero) absorbed her silent grief. There is a strong emotional connection between a mother and her baby to be. Feelings, especially those unexpressed may impact the baby. (See Vollman and O’Leary, Born Into Loss: Shadows of Deceased Siblings and Family Journeys of Grief (2025).) A good deal of my spiritual journey has involved being present with death – for example, I have been a member of our chevra kadisha for over forty years -- perhaps because of this intimate relationship with grief.

I am a hospital Chaplain and a good deal of my time is spent in the NICU where I deal with families with deaths soon after birth. I also on occasion deal with perinatal losses. Our hospital has a “Little Lives” ceremony every year to remember babies that have died in the hospital. Well over one hundred families attend. For the past six years I have delivered care in the “spiritual care room” and assist families in telling the story of their lost children and how those children are integrated into their families.

D. My commitment and the purpose of the research

I have a longstanding interest in perinatal loss. These situations are very challenging because of the enormous grief. And I realize that it is a grief that was fundamentally hidden in the Jewish community. Although Jews have a rich tradition for remembering the dead there are very few prayers or rituals for a loss by miscarriage or stillbirth.

The traditional Jewish advice upon perinatal loss was to do nothing. A newborn was not considered a human life unless it lived for thirty days. As Rabbi Jack Reimer observed the traditional advice was “[d]on’t give the baby a name, don’t sit shivah, don’t say Kaddish for it will only add to your pain.” (Reimer 1995) Babies who died would simply be taken away and buried in unmarked graves. It was a loss that was denied words or presence. For Jewish families the lack of ritual may feel like “a great robbery – stealing the traditional forms of bereavement when they are needed most.... There was no yahrzeit, no Yizkor, no memorials. It’s as if the tradition wanted the memory of the experience to be wiped out completely, as if it never happened.” (Wolfson p. 264)

About six years ago I was the overnight shomer²⁰ for a thirty-day old baby that died. I was deeply touched by the experience of being his shomer and spent the night chanting and reading psalms to bring comfort to his soul. After his death I continued to feel his soul's presence as I worked in the NICU providing comfort to babies and their families. I can still feel his presence on occasion when serving in the NICU and dealing with a baby struggling for life. It as if his soul helps me to feel I can touch and comfort the baby's soul.

Another person I knew had a stillbirth at 25 weeks. When the family sought to have customary tahara and shomrim, the chevra kadisha refused because it did not consider the baby a human life – they said all they would do is simply dispose and bury the remains. The family rejected that advice and filled the ritual void by doing a personal tahara and burial with the help of friends and a Rabbi. They created their own tahara ritual and did their own burial.

I realized there was a great gap in understanding of the journey of the families, addressing community support, and in designing rituals and prayers – in simply bringing attention to the problems of perinatal loss faced by Jewish communities. So, my community support organization “The National Bikur Cholim Conference”²¹ and “I Was Supposed to have a Baby,”²² sponsored a three-part program on Jewish approaches to perinatal loss in 2023 -- The First Jewish Perinatal Loss Summit.²³ This was the first comprehensive program on the subject and it addressed: (1) the personal journeys of the families, (2) approaches for community support, and (3) efforts at prayer and ritual. There were over 200 attendees. The program identified several gaps in the ways Jewish communities support perinatal loss and the deep gap in removing the stigma and silence around these losses.

The program documented the tremendous lack of guidance and education regarding the provision of spiritual care for perinatal loss in Jewish families. I do not think the gap is totally inadvertent – these are profoundly traumatic losses both for families and for the care providers. And perinatal loss generally is cloaked in silence and it is difficult for communities to provide support.

²⁰ Jewish religious practices require that a person sit and watch a dead body until the time of burial. This person is known as a “shomer” which means guard

²¹ The “National Bikur Cholim Conference” was part of the National Center for Jewish Healing that no longer exists. I took over the conference in 2020 and have run it as an annual virtual conference. It is now known as the National Jewish Healing Conference.

²² See <https://iwassupposedtohaveababy.org/>

²³ The Conference and supporting materials can be found at <https://jewish-healing-center.org/perinatal-loss/>.

From my work as a Chaplain, I know about the general lack of guidance for Chaplains in providing spiritual care for perinatal loss. I was fortunate enough to have a training session with the social worker in my hospital who handled these losses, but I know that opportunity was unusual. And I know from my own experience in searching for resources that there is not much support. And the issues arising from these losses may be extremely difficult for Chaplains to struggle with. **So, the first purpose of this paper is to identify the lack of guidance and fill that gap – provide a document that can give voice to the stories of the families and guide Chaplains in delivering compassionate spiritual care.**

The second purpose is to bring greater visibility and understanding to the issue of perinatal loss in Jewish communities. The issue is clouded by the inability of communities to grapple with traumatic events which are shrouded in silence and plagued by stigma. There is a simple lack of community support within traditional Jewish institutions. It is exacerbated in Jewish communities because some spiritual caregivers often turn to legal issues -- the Halachic state of the loss – rather than the spiritual and emotional trauma the family is enduring. The gap in religious guidance and the paucity of rituals, which has not been addressed in a significant fashion by traditional institutions only increases the trauma and renders grief even more disenfranchised and ambiguous. To the extent there are new rituals or forms of support they come from nontraditional entities often formed by individuals. **A second objective of this paper is to enhance awareness and understanding of the impact of perinatal loss and stimulate a much-needed spotlight on the problem to spur greater dialogue and attention in the Jewish community.**

V. The experiences of the families suffering perinatal loss

General themes -- Disenfranchised Grief and Ambiguous Loss

Perinatal loss can be characterized as disenfranchised grief or ambiguous loss. Disenfranchised grief is the experience of loss in which “the survivor is not accorded a “right to grieve So, although the person experiences grief, that grief is not openly acknowledged, socially validated, or publicly observed.” (Doka 1999 p. 37) Although the individual is experiencing grief there is no social recognition, social sympathy or support. “Perinatal loss is an example of a loss rarely recognized by society. Without societal recognition, bereaved parents are not extended societal permission to grieve their loss.” (Berry 2023). The families are denied access to traditional sources of support and the rituals that give meaning and credence to a socially acknowledged loss. Perinatal loss is a private event making the grieving

process even more difficult. The private nature leads to a lack of social support and empathy.

Perinatal loss also is ambiguous loss. Ambiguous loss is defined by Boss (2006) as a loss in which a significant component is missing, thereby interfering with the ability to mourn and cope. When there is a perinatal loss, the death is “invisible,” and there is little physical material in the form of sights, sounds and smells that create memories of the deceased. (Cacciatore, DeFrain, & Jones, 2008; Leon, 2008). The mourning is not in the past, it is in the future as parents grieve the loss of a potential life, relinquishing their wishes and hopes for a child who never truly lived (Robinson et al., 1999). These factors create a realm of ambiguity. Society discounts it as less than a loss because there was not a live birth. (Cacciatore et al., 2008). Mothers’ and partners’ status as parents becomes complicated because there are no tangible signs of parenthood to affirm their roles or to mark the infant’s membership in the family, at times citing an existential crisis (Cacciatore et al., 2008). Ambiguity also exists because they may never know the cause of the loss.

Perinatal loss is shrouded by silence, shame and a paucity of understanding. For stillbirth, invalidation may arise from ignorance, discomfort or even good or misguided intentions. Stillbirth is not like other child deaths. As Cacciatore observes “while most child deaths are recognized as tragic, the emotional backlash of stillbirth is generally minimized or treated as a non-event.” (Cacciatore 2010). For the mothers who carried the baby for months it certainly is not a non-event. Nor is it for their partners. The common reaction that “you are young and can have another” which may be meant to be consoling strikes many parents as dismissive and insensitive.

This study highlights the degree that perinatal loss is disenfranchised grief and ambiguous loss. The lack of public discussion and attention to perinatal loss places it in solitary confinement. The lack of support and education materials for Chaplains and the lack of prayers for these losses are indicia of how these losses are hidden in the shadows. The parent suffers behind the veil of silence, isolation and shame. “Without societal recognition, bereaved parents are not extended societal permission to outwardly grieve their loss. In the absence of societal recognition of the emotional impact of perinatal loss, parents often experience emotional distress which compounds the grief of their loss. In essence, perinatal loss results in a disenfranchised loss, often leading to traumatic grief.” (Berry 2023).

As Nuzum observes “a theological and social conspiracy of silence where the unspeakable finds no voice and parents and families travel a silent but aching journey

of emptiness and barrenness unaccompanied by the support, voice, overt care or recognition of a faith community. The disenfranchisement of such a personal grief is further reinforced by the absence of lived and validated narrative.” (Nuzum 2019).

As described infra for Jewish families the sense of disenfranchised grief and ambiguous loss may be even more profound. Jewish law instructs that the family does not observe mourning practices unless the child lives for 30 days. And there are different views depending upon denomination about the legal status of the child. There are extremely limited institutional resources to deal with perinatal loss. For example, only two Jewish family service organizations in the U.S. and one synagogue have perinatal loss support groups.²⁴ There is basically one book (from 1998) to provide rituals for families dealing with these losses. There is little formal liturgy. Moreover, because of the ambiguity of whether the child is a human life (under Jewish law) and the lack of rituals for caring for the body and grieving, the sense that this loss is ambiguous or disenfranchised is even more intense.

The family story²⁵

Words are very inadequate tools to describe the journey of a family that suffers perinatal loss. Most literature starts with the point where the family learns of the death or likely death of their baby. But there is so much that precedes that. Both mother and partner have a vision that they have of one day becoming parents and making a family. This may be the subject of dreams, or bright discussions, or carefully expressed hopes.

And one day they find out that they are about to become parents. They discover they are to be the recipient of perhaps the greatest miracle of life. That their longing, their yearning is about to be answered. Pregnancy brings expectant parents into a place of hope, longing, expectation and promise. They consider names, anticipate gender and begin telling the story of the anticipated blessing.

²⁴ There are over 170 Jewish family service organizations in the U.S. and Canada.

²⁵ While every pregnancy is different, and every experience of pregnancy is different what follows is intended as an example of some of the many strong emotions and potentially profound experiences a couple may have in the months leading up to their expected delivery. This is only a single version of a story of loss of a clearly desired pregnancy and a stillbirth. It reflects the stories I was told by many, but not all of the families interviewed. Every family's story is different and Chaplains should always be conscious of learning and honoring each family's story. For example, this could be one of a series of losses, or the family could have grappled with infertility and undergone time-consuming and expensive treatment. Or the family made a decision to terminate the pregnancy. Or on the other hand there could be ambivalent feelings about having a child especially if the pregnancy was unplanned.

For the mother her life changes completely as, she is no longer caring solely for herself but also another life. Everything she does -- her eating, exercise, sleep, work -- she evaluates for the impact on the life she holds inside her. Her body changes dramatically. She is no longer living for one, she is living for two.

And her partner's life changes. He or she becomes guardian, planner, protector. The first job is to bring support to the life that is coming to join them.

Attachment. There is attachment from the first moment. Parents attach to their dreams of a new life, a new home, they attach to all the plans they make for the child's room, dreams of disposition and desires. They compare notes from their own infancies and wonder how the little one will enter the world.

And they attach physically. The first movement is a marker of existence. The mother experiences the baby constantly, his movement, his kicking, his motions. She feels how he becomes part of her. She can describe in detail the patterns, preferences and behavior of her in utero baby. The parents speak to her and imagine her responses. The baby is becoming a person and they envision and create a personality. The partner can feel the baby's lively presence as he caresses his wife's belly. They know her. The bonds are growing. Precious memories are being created and they cherish the time together.

There are tremendous anticipation and excitement for the baby. Each doctor's visit, each test, each sonogram, the attachment grows. The sound of each sonogram, hearing the precious heartbeat makes their hearts soar. And as time progresses, they begin to let go of the anxiety, they tell themselves the stories of their dreams, of the birth, of walking out of the hospital holding their precious blessing, of bringing the baby home and beginning to know their wonderful loved one.

It is a time of yearning. A yearning they have never known. A yearning to embrace their baby, to have their hearts lifted, to feel their lives complete.

They know they are on a sacred journey. Perhaps they have a religious faith that amplifies that sacred nature. But even without formal religion they know this is sacred -- they are bringing a new life into the world. Something that defines one's reason for being. Simply they will be part of a miracle, a miracle of new life.

They hold each other close and feel the presence of three. Their world is more than normal; they enter into a liminal space because they are about to bring life to the world.

And then their world is shattered. Something is not right. They go in for a test and are told the words that shatter their spirit – the baby is dead. Or the baby dies during delivery. Or there is a life-limiting condition where they will learn that their baby will likely not survive and termination is presented as an option. And they have to make a decision that seems unfathomable. The vibrant life, the life force deep inside the mother is gone, extinguished. Something wholly unanticipated; they were never told this could happen.

The partners go from being in a place of miracles, wonder and imagination to an ocean of trauma, a place of overwhelming suffering. A world of unfathomable shock and disbelief. Of saying good bye without ever having a chance to say hello. The mother goes from being a source of life to knowing she is carrying a dead baby. Her body has become her child's first grave.

New and longed for life ends with no apparent sense of purpose or meaning. The mother is overwhelmed in raw emptiness and bodily pain. The partner suffers trying to figure out how to be of support and what to do about his or her own sorrow. The mother must birth the child which almost inevitably involves induction and a labor that may take several days with the result of delivering a dead child. Going through delivery is emotionally wrenching; it is simply a nightmare. Unlike a live birth the baby cannot do the work to be birthed. No matter whether alive or dead to the parents the newborn is "perfect." There are no cries of joy upon delivery. There is deafening silence, just the sounds of the machines. The handling a small precious dead body.

Upon delivery, the mother's body goes through dramatic hormonal changes prepared to bond with a live baby, such as beginning to produce milk. Every instinct cries out to nurture. But none of this is possible; this makes the trauma even more excruciating.

The world is turned upside down. There are multiple losses: the loss of identity as a pregnant woman, the loss of potential for becoming a parent, the loss of a future child; the loss of dreams of a family. Instead of looking for cribs the family is shopping for tombstones. Instead of cradling a sacred new beginning they are focusing on the disposal of a precious body. Instead of learning to breastfeed, the woman is learning how to suppress her milk.

The parents have entered an emotionally painful wilderness. Guilt, shame, and blame overwhelm them creating endless waves of sorrow.

The death of one's child is one of the most difficult forms of loss to endure. When a child is stillborn, the bitterness of death is even more cruel than usual. The natural rhythm of life has been turned upside down: birth brought forth the end of life, and parents have to say their goodbyes to a child who should have been welcomed into the world. Parents have usually formed a concrete attachment, and made physical and emotional room for the new child in the family. They expect to leave the hospital with a child in their arms. Now there is no live child.

Forms of suffering

A. Overwhelming trauma and shock

"There are moments that the words don't reach / There is suffering too terrible to name." Lin Manuel Miranda, Hamilton

Perinatal loss, especially stillbirth is a trauma with devastating, long lasting effects that may include severe depression, posttraumatic stress disorder, suicidal ideation, marital dissolution and "disconnectedness from friends and families and struggles with one's faith." (Petro 2015) Parents are physically, psychologically, spiritually, and existentially overwhelmed by the experience. (Malm et al 2011) "The death of a baby through stillbirth is recognized as one of life's most challenging bereavements with long-lasting consequences." (Nuzum 2017).

Parents suffering perinatal loss are simply overwhelmed. Most of the mothers interviewed described waking up after delivery crying hysterically. Many mothers described a sense of a deep hole inside and an unimaginable pain. A sinking heavy sadness, a sense of suffocating in pain. One mother observed "I just could not understand how the sun rose; how life could go on." Parents described their foundations being decimated, an inability to breath or even comprehend what is going on. Parents no longer feel able to trust the world. (Berry 2023).

One mother reported "walking around carrying a deceased baby was very haunting. My body which just a day before was the source of nourishment, comfort and nurturing had now become a tomb. Everyone around me was describing a necessary clinical procedure in technical terms and I just wanted to touch her and feel her. I was in a portal a portal with veils of life and death. The veil between these portals is very thin. I was carrying life; I now am carrying a dead body."

B. Sadness and grief

The grief these families face is profound. Often, we have a chance to anticipate grief, prepare ourselves, begin to expose ourselves to the sorrow that dwells inside. These families they are plummeted directly into grief from a point in which their lives are uplifted in anticipation of joy and miracles. There is no time to prepare for grief, nor is there a set of experiences with a living child.²⁶ The families experience shock, disbelief, devastation, sadness and anger. It is not only the intensity of the grief; it is the extreme devastation from a point of anticipating the greatest joy.

As one mother stated “my moment of loss was unacknowledged. I never had a chance to say good bye. You can’t imagine how much the words that are never said hurt deep inside. It’s so awful to know we will never hear her voice.”

When a baby dies it is not only the loss of a life. Parents find themselves grieving not only for the baby but also for their sense of themselves as parents and their dreams of a future of providing their baby with a long and happy life.

The grief is intense. Almost all families reported suffering from a grief far more intensely than the grief from other losses. “The grief went to my core, my reason for being,” said one mother. Intense grief occurs when there are symptoms including severe anxiety, major depression, posttraumatic stress disorder and suicidal ideation. (Hutti et al 2018). Intense grief is so overwhelming that the body is traumatized. Several mothers stated they could still feel the grief inside although the loss was years ago.

Parents tend to grieve differently. Mothers feel the grief more intensely in part because of the loss of the intimate attachment. Women tend to grieve more privately. As described *infra*, some fathers tend to suppress their grief and not express it. Some fathers see their role primarily as a problem solver, caregiver or protector. These men, trained as problem solvers, are forced to deal with a problem without a solution.²⁷

Grief is a risky subject to share publicly. Communities have difficulty talking about perinatal loss and embracing the grief of parents. It is a subject that creates significant discomfort since it seems so contrary to the natural order. Too often

²⁶ This may be different to a degree if they have other children.

²⁷ This study did not address if female partners faced similar challenges as male partners. Nor is there much literature addressing how female partners address perinatal loss.

others may seem to avoid contact, look awkwardly or make dismissive comments such as “you can always have another.”

Yet communal responses can be vital to handling grief. Social support from the community can reduce the level of grief. Research has shown that when parents are able to grieve publicly, through some type of ceremony, it helps to reduce the levels of grief.

Jewish communities struggle a great deal at communal recognition of stillbirth or miscarriage. There are traditional memorial prayers known as Yizkor said four times a year. This is a time for the community to mourn as a whole and recognize their collective losses. Yet there is no traditional Yizkor prayer for a perinatal loss. Nor are parents obligated to say the Kaddish (memorial) prayer for a perinatal loss, potentially robbing them of an opportunity to acknowledge their loss or have their loss acknowledged by the community.

C. Alienation from the self

For many, the parental identity has been organically tied to the expectation of birth and the creation of a new family. This identity is torn asunder by the loss and the self is overwhelmed by feelings of powerlessness and guilt. The parents interviewed spoke of searching intensely for a cause and perceived themselves to be the culprit – perhaps they neglected the pregnancy, exercised too strenuously, ate the wrong foods and caused the pregnancy to end. (Of course, these feelings rarely reflect reality). These feelings of guilt and failure are only intensified when a medical explanation is lacking. For the mother the loss may attack her sense of being a woman and the ability of her body to fulfill her feminine self. As one therapist reported the mother faces the most painful existential questions: “will I ever be able to have a baby? Is there something wrong with me?”

The alienation itself may also attack the foundation of the marriage and undermine the couple’s ability to support one another. The experiences of grief are different between partner and wife and that may make one partner feel unsupported. Four of the twelve families interviewed reported very different approaches to grief between partners.²⁸

²⁸ For example, they may differ on taking pictures, how to mourn the baby, whether to say kaddish, recognize the date of death and how to memorialize the child.

Several mothers reported that perinatal loss undermined the very foundation of their sense of self and meaning. One mother reported “I wondered why I was here, what is my purpose?” “Stillbirth experience shook parents core beliefs about the self, the world, or a Superior Being, leading the parents to experience an inability to find meaning and purpose in life after the loss. [The grief experience poses] a risk of spiritual crisis through profound questioning of, or lack of meaning and purpose in life.” (de Andrade Alvarenga, Willyane 2019)

D. Guilt

Families endure a great deal of guilt for the loss. Upon hearing the news, they quickly evaluate whether there is anything they might have done or not done to prevent the loss. There is a search for causes and responsibility as they try to bring some sense of order and understanding to what has occurred. Friends and family may increase that sense of guilt by questioning what caused the loss or posing questions that may suggest the parents did something wrong.

Studies have shown that mothers assess whether they did anything wrong and followed appropriate rules for care. Most mothers interviewed discussed that searching self-analysis. They tried to establish, as one mother noted “that the cause of the stillbirth was not my fault and I was indeed a “moral” mother.” Parents may be concerned over the risk they will be stereotyped as inadequate parents.

One issue explored in the interviews was whether the parents asked their lost child for forgiveness. Several mothers reported feeling guilty that their “body” had failed to adequately care for the baby. Some mothers tried to respond by asking the baby to forgive them for failing to adequately protect the baby.

E. Doubt and lack of meaning

For bereaved parents “a child’s death is perceived as ‘senseless’ and parental roles in its wake are forcibly transformed in a distinctly unwelcome direction. Meanwhile the search for meaning becomes a nigh-unbearable task.” (Cacciatore 2013, p.78) “The experience of perinatal loss is nearly synonymous with random, incomprehensible, chaos.” (Petro 2015). Parents are engaged in an intense search for understanding and meaning to help them comprehend a reason for the unfathomable tragedy. (Practically speaking over 40% of parents will not learn the reason for the stillbirth). (Star Legacy Foundation, “About Stillbirth,” <https://starlegacyfoundation.org/about-stillbirth/>)

Many parents reported the loss as having a profound effect on their sense of meaning. As one Chaplain observed this loss can be “an existential threat to meaning, like a rupture in the moral fabric in the universe.” “This shook me to the bones and made me question my own being,” said one mother.

Parents demonstrate a strong desire to seek to understand the reasons for death or life limiting disability. Many families asked “why did this happen to our baby and us? What did we do wrong?” Parental search for meaning is very valuable. “Parents who reported the discovery of meaning in their child’s death... reported less mental distress, greater marital satisfaction, ongoing bonds with the child who died and better physical outcomes.” (Petro 2015).

All parents reported seeking some understanding for the loss and suffering. The absence of reasons only intensifies the sense of suffering. Ultimately, this may begin a task for the parents of making meaning from the loss – for example by donating organs from the baby, or beginning causes to promote education on the reasons for the death, creating organizations to support families in grappling with perinatal loss.²⁹

Other families they question what happened to their baby after death such as the well-being and whereabouts of the baby. (Nuzum 2017, Tseng et al 2014). Having a concrete sense of what happens to the baby’s body and soul is important for a sense of meaning and a type of resolution. Parents interviewed expressed a wide variety of views – some believed that the baby’s soul was in heaven, often with beloved relatives. Others reported a sense that the baby’s soul was united with the cosmos.

The Jewish practice of burying babies in unmarked collective graves could only strengthen the distress and sense of disenfranchised grief. There never will be a specific marker or place to mourn. Similar problems may exist for Muslim, Buddhist and Taiwanese cultures. (de Andrade Alvarenga, Willyane 2019). For the families interviewed, even where the remains were not buried parents often established a place of mourning in their home.

G. Loss of faith

²⁹ Almost all of the Jewish support group organizations that deal with perinatal loss were started by families who suffered perinatal loss.

Spirituality is a critical element for many. It is a dynamic and intrinsic aspect of humanity that helps guide us to seek ultimate meaning, purpose and transcendence. Spirituality helps us to orient ourselves in the world and understand our relationship with ourselves, others, society, and for some, a higher power.

Parents are overwhelmed with spiritual aches, mostly about the status of the baby. One mother reported asking “is my baby somewhere good? Does she know I love her and wanted her? Does she know how much I wanted her? What does this mean about me as a parent? Does Gd want me to be a parent?”

For many parents there is a crisis in spirituality. “For those of faith, stillbirth can rock one's belief structure to its core especially where there is negative religious coping and expressed religious distress.” (Nuzum 2017) For many the question of theodicy looms large – how can a higher power permit such suffering looms large. Why would Gd do this? Why did I deserve this?

Theodicy is defined as “the tension between three incompatible axioms: divine goodness, divine omnipotence/sovereignty and the existence of suffering.” (Cooper-White 2012). In perinatal loss these three axioms are at war – how can a Gd of goodness condemn a child who has done nothing wrong to die. As Nuzum observes “perinatal death opens up the often-theological barren area of needless pain and unjustified anguish.” (Nuzum 2015).

For many the experience of stillbirth weakens their spiritual foundation. Some parents express anger that Gd permitted the death of their child. As Rabbi Perolman reports after her loss of her daughter

“Through my tears, I cursed God for causing me so much pain, for not ensuring my medical team caught my complications, and for the insensitivity of those who misgendered our daughter for her name or, even worse, referred to her as a “fetal demise.” I hated that after I was released from the hospital, I would have to bury my daughter and utter cruel words of praise to our Creator (the Kaddish).” (Perolman 2024).

Some parents may feel the stillbirth is punishment for their sins. (King, Michael 2019). In Exodus Gd instructs that if the people follow his commandments there will be no miscarriage. (Exodus 23:26). Implicitly if there is child loss it must be because someone transgressed. David and Bathsheba lost their son because of David's sins (2 Samuel 12:15). The Torah instructs that Gd will visit “the iniquity of the fathers on the children to the third and the fourth generation of those who hate

me.” (Exodus 20:5). There is an implicit relationship between sin and child loss. None of the families interviewed reported they believed the stillbirth was punishment for their sins.

Spirituality is a critical element in coping with loss. Spirituality may provide a safety net for those falling, overwhelmed with anger, doubts, and uncertainty. But the safety net of spirituality is ripped apart by a perinatal loss since it seems so inconsistent with the natural order. Spiritual loss is an additional loss. “Bereaved individuals suffer profoundly not only in relation to the death of their loved one but also in their relationship with Gd and their faith community a condition known as complicated spiritual grief.” (de Andrade Alvarenga, Willyane 2019).

Perinatal loss may shatter the structure of spiritual support. Parents may question their belief and values and the role of a Higher power. How can a world ruled by a benevolent deity permit such suffering? This often leads to a crisis of faith, due to a sense of punishment, injustice, abandonment, betrayal, or unfairness. The sense of trust and belief in a caring Higher power may be shattered resulting in religious disorientation.

“Stillbirth experience shook parents’ core beliefs about the self, the world, or a Superior Being, leading the parents to experience and inability to find meaning and purpose in life after the loss. [A literature review] supported these findings in identifying the grief experience as posing a risk of spiritual crisis through profound questioning of, or lack of meaning in life.” (de Andrade Alvarenga, Willyane 2019).

Inability to make sense of death emerged as the most salient predictor of grief severity. Complicated spiritual grief is a form of maladaptive bereavement related to a crisis of faith over the loss. Perinatal loss led to spiritual distress reported as “a state of suffering related to the impaired ability to experience meaning in life through connectedness with self, others, world, or a Superior Being.” (Cadiera et al 2013)

These problems may be exacerbated by the response of religious communities. This appears to be a significant problem in Jewish communities. Perinatal loss may be perceived as a taboo subject with few if any prayers to deal with the loss and no public funerals or other ceremonies. Even though perinatal loss is not that uncommon, this study found only one synagogue support group to deal with these losses, and relatively little attention to these losses in Rabbinical training or sermons.

H. Stigma and Shame

Like many challenges that reside in the dark shadows of our lives stillbirth has a strong element of stigma and shame. Bereaved parents are socially isolated and feel silenced because stillbirth is perceived as a taboo subject. Providers typically do not make prospective parents aware of the possibility of stillbirth. “You never consider it as a possibility until it happens to you,” said one mother. (None of the families interviewed had been told of the potential for stillbirth).

The stigma of stillbirth is set forward in the Torah. When Aaron and Miriam gossip about Moses they are punished with a scaly affliction -- tzaraat. This may have been upsetting to view for Aaron says to Moses “Let her [Miriam] not be like a stillbirth that emerges from its mother’s womb with its half its flesh eaten away?” (Numbers 12:12). The stillborn is not embraced – it is humiliated. As Rabbi Karen Perolman notes about the loss of her daughter “[i]t felt cruel that tradition used my daughter’s permanent and eternal state as a physical insult, a condition brought upon as punishment.” (Perolman 2024).

Gd says “Were her father to spit in her face would she not be humiliated for seven days.” (Numbers 12:14). The image of stillbirth is of something tamei – impure, humiliating, and perhaps polluting. Something stillborn is foul and distressing.

Parents may also have that sense of tamei --- impurity. For generations stillborn babies were simply taken away and buried without ceremony or marker, as if to try to remove the pollution from among the people. They were buried in a separate distant part of the cemetery, creating a sense of impurity. Generations of treating the stillborn as impure may reside in the collective memory of communities and the mourning parents.³⁰

Blame can also be a source of trauma. Parents naturally search intensely for a reason for the stillbirth and scrutinize whether they were at fault. They have carefully cared for every moment of the infant’s life in utero; it is natural to search for fault and for the parents to assume blame.

One mother observed “I tried to find someone to blame. How could I carry a dead baby and not know it?”

³⁰ For Orthodox Jewish families the father cannot touch the mother after childbirth because she is tamei – impure. He cannot touch her until bleeding stops for 7 days and she goes to the Mikvah – ritual bath.

Parents may also blame themselves to gain a sense of meaning or control. If they were at fault, they understand why the stillbirth occurred. If they were at fault then perhaps, they have control so future pregnancies are successful. A 2011 study found that 29% of mothers believed they were at fault for the stillbirth. (Froen et. al. 2011).

Stigma is the “spoiling of a person’s identity,” typically defects of body, character, or tribal stigma. A 2019 study found that 38% of bereaved parents felt they experienced stigma and shame. (Pollock 2020).

Silence is a social tool that reinforces stigma. When a person lives with stigma, the imprisonment grows stronger through silence. Encounters the parents have with the health care staff, friends or their social network where people avoid talking about the baby or the loss only reinforces the imprisonment of stigma and shame. The sense of stigma and shame is especially strong for mothers who grapple with the sense that their body failed.

Bereaved parents may not feel like a parent because of the absence of a live child. Bereaved parents will struggle with the question of “how many children do you have?” Bereaved parents feel stereotyped after the loss as “the parents who lost their baby.” Sometimes social groups may exclude the bereaved parents from social settings with children in order to avoid making them uncomfortable.

Feelings of shame are very common for bereaved parents. In studies parents report the sense of being at fault, that having a child is so intimate and organic it must suggest a deep unseen flaw in the person. One mother reported “I didn’t know my daughter had died. I felt an immense sense of shame.” Another mother reported “I felt betrayed by my body, how could it fail to care for this precious child?” Silence only exacerbates that sense of shame, like it is a mistake no one can talk about.

We should recall that we are only a generation or two removed from the situation my mother faced where her daughter was simply taken away without her having a chance to say good-bye. For decades perinatal caregivers were instructed not to allow the parents to hold or touch the baby after death and to remove the baby immediately to avoid trauma.³¹ The rules against physical touch just intensified the trauma, suffering and sense of stigma.

³¹ Studies encouraging hospitals to have parents hold the baby are just over a decade old and not all clinicians advise this is the best approach.

For Jewish families the lack of prayers and rituals and the ambiguity of whether the baby is a human life just intensifies the sense of stigma and shame. As one mother reported “I wanted the loss of my baby to be recognized like any other loss. The fact it was hidden and shrouded in silence made me feel like I was not really a mother; I was a mistake.”

I. Separation and Isolation

The feelings of shame and stigma may lead to separation from the community and isolation, which simply reinforce the sense of stigma and shame. Parents may self-isolate to avoid painful encounters, lacking energy or being worried about creating discomfort in others. Parents are well aware there is no language to speak about perinatal loss and there are stigmas and misconceptions. As a study of the trauma of perinatal loss noted “[l]ong-standing stigmas and misconceptions regarding perinatal loss contributes to the shrouds of silence which often obscures the parents’ grief from others.” (Berry 2022). Parents may isolate themselves if they feel devalued or disrespected or anticipate they will feel that way. Perhaps unconsciously there is a sense that such parents are contaminated or may contaminate the community.

As an extensive survey of parents found: “[t]he silence and loneliness that these parents describe, long after the death of their baby, are palpable. Much of the isolation is caused by the awkwardness and discomfort felt by others when parents of a stillborn try to discuss their experience, or when they try to normalize it by mentioning their stillborn child alongside their live children as part of their family.” (Kelley 2012).

Isolation and withdrawal from society may actually exacerbate the sense of disenfranchisement. The isolation may create a sense of being separated and silenced. This may lead to further disenfranchisement in the form of self-disenfranchisement. Self-disenfranchisement is a person silencing their own needs and emotions. (Weiss et al. 2023) Again this demonstrates the multiple losses from perinatal loss.

Social support is critical when facing traumatic events. Unfortunately, because of the stigma and silence and the lack of education surrounding perinatal loss social support is often absent. Almost all parents surveyed cited a lack of social support and a strong sense of isolation. Almost all of the parents expressed a sense of sorrow of not being supported by their community.

All of the parents surveyed reported feeling isolated and alone and that interactions with friends and families were often hurtful and insensitive. (Berry 2023) For Jewish communities there is often a significant gap in embracing the journeys of families dealing with perinatal loss. There are substantial prayers and rituals to honor the delivery of a child or the loss of a life, but there are no prayers or rituals for perinatal loss. Synagogues have annual ceremonies to honor all of the children in a congregation and will clearly celebrate new births. These may be times when the families suffering perinatal loss may feel particularly isolated. Moreover, there are limited social service or synagogue resources to deal with these losses.

VI. The approaches of Chaplains

A Chaplain will likely have a relatively short encounter, perhaps a one-time visit with the family soon after the loss. Birth and death are two of the most intense events in life and they merge in stillbirth. Labor and delivery of a dead child can create a traumatic and haunting memory for the parents. The care that bereaved parents receive in this initial period after birth may be crucial to their beginning a path to grappling with their grief. Studies have shown that “the care that bereaved parents receive during this time can shape their whole grieving process and recovery.” (Nuzum 2017). Every parent interviewed could recount in great detail their feelings of anguish and trauma. I know from my own experience in the annual memorial ceremonies that families remember these encounters in detail many years later.

The environment of the perinatal loss room is unique. It is quiet, solemn, with grief ever present. The world around is probably filled with the excitement and joy of new birth, but this is a place of unfathomable pain and tragedy. It is a place where celebration was to occur, and now just a search for a way to say good bye. There is the silence, not cries and the silence inflicts sharp pain. The medical caregivers are there trying to find ways of being supportive, helping parents find a place of attachment and honoring in a place of overwhelming pain.

A. Being self-reflective.

Dealing with perinatal loss poses many unique challenges because new life and death are combined, the loss is often unexpected and traumatic and the family is in a state of shock. This is a scene of profound suffering of utter emptiness, decimated dreams, and pain. Many Chaplains recognized the need to ground themselves before entering into this unique traumatic space.

As one Chaplain noted: “As in many encounters I spend a few moments to ground myself before leaving the office. I ask Gd to help guide me to be open, slow and compassionate. I know I am entering into a space of great trauma so I touch some aspects of trauma within myself to remember its excruciating pain but also recognize it is part of me. I hope that enables me to be more empathetic and fully present with the family.”

Chaplains recognized the importance of knowing their own sense of loss. They are entering into a place of great suffering. One Chaplain observed “I try to remind myself of my own loss and suffering; not that this visit is about me. But I carry with me those losses as I try to be a companion to their loss. This is not an environment where there are easy to access tools – we are really empty handed.”

Another Chaplain observed “when we touch the depths of our grief, it stirs our own loss and trauma, tending to our stew pot of loss keeps us in touch with Gd and emotions and keeps us real.”

Chaplains should be prepared for the questions for which there are no easy answers. A family suffering perinatal loss is in a place of profound suffering, anguish and doubt. Studies have found that Chaplains absorb that suffering and grief.

Chaplains also spoke of the need to ground themselves after the visit, to recognize how they were touched by the encounter and say a prayer for the family. Most turned to their normal support in prayer, but almost all took a break to recenter. Some reported taking the time to honor the loss in prayer and ask for Gd’s loving presence and support for the family. Another Chaplain always self-inquired what he learned from the encounter and how he could deliver care more effectively. Sometimes these encounters can reside for a while in the Chaplain. One Chaplain mentioned that when she goes to Israel, she attends Rachel’s Tomb and prays for the lost babies she has served.

B. Being present and holding space

Being present, focusing on the patient, family and the room is a sine qua non of Chaplaincy practice. But it is even more essential in the face of perinatal loss. Chaplains need to assess the status of the family. For some families this may be a crushing loss and they are overwhelmed with trauma. Other families may have distanced themselves from the situation. Every family is different.

Initial Assessment

A Chaplain should strive to understand the meaning and significance of the loss to the family by determining how real the pregnancy was and how attached they were to the baby. Attachment is not simply a matter of the duration of gestation; some parents may be very attached to a baby lost early in the pregnancy. Other parents, perhaps those who have suffered many losses may not have developed a strong attachment.

One approach is to check in with the nurse to learn:

- What the family understands about the loss;
- Has the mother delivered and how was the delivery;
- The birth history of the mother. Have there been other losses, are there children in the family; and
- What language is the family using to refer to their loss—baby, fetus, pregnancy, etc.

In the room, listen closely for the language the family uses. Follow their lead. If it is unclear just ask, “What language would you like me to use when I refer to the child?”

A humble curiosity is an important first tool. One Chaplain guided that they ask “it would be helpful for me to know what is most important to you as we spend time together as a family?” It is important to give them a sense that they have some degree of control in this world in which they may feel powerless and lost. Or as another Chaplain observed “I am there to help them find and use their own wisdom.”

Caution with language – “baby” or “fetus”

One must get a sense of where the family is at, how attached they are to the baby, whether the birth is wanted or not, whether they see the pregnancy as a “baby” or a “fetus.” One should try to get a sense of their “conception history,” whether this is a first child, there are other children, or there have been other losses. One must be very attuned to their language and not assume a level of attachment that may not be there. Similarly, one should proceed cautiously in inquiring on matters of spirituality.

Consider the issue of whether you refer to the loss as a “baby” or “fetus.” People have different approaches to the question of when life begins. Whether you

use “baby” or “fetus” may be a question of simple nomenclature, the family’s intimate feelings, or medical speech. In any case, a Chaplain should proceed carefully guided by the family’s language and beliefs.

Space, presence, words and tone

The space for loss is sacred. It brings a unique liminal space combining birth and death. One Chaplain reported “there is a deep fog of anguish, pain and suffering. A thick slow stillness.” And it is sacred because of the child. As one Chaplain observed “It is a rare gift to enter into this space. Older people are known by many but I will be one of very few people to know this precious baby.” Another observed “it is a precious blessing to be present for the hardest moment of a family’s life.”

Physical space is important. There are five guideposts for creating a mutual space of support:

- sitting instead of standing;
- eye contact if culturally appropriate;
- touch if appropriate;
- having ample time; and
- active and engaged listening.

These tools create a sense of patient centeredness and support. Studies show that parents value providers who “look them in the eye and are present with them in their sadness.” (Kelley et al. 2012). A Chaplain should also enter with an open mind and spirit. Judgment and evaluation will just create obstacles to creating connection.

A Chaplain’s words and tone are also important to creating a sense of patient centeredness and support. Technical language like “fetus” may inhibit connection and create a sense of separation. It may also be traumatizing. Asking the parent the child’s name and referring to the baby by name will create a sense of support. Tone can be vital. As one Chaplain advised “I try to access the place in my heart and speak in a warm embracing fashion to give them a sense that they are cared for.”

Chaplains often return to their own sources of spiritual support. One Chaplain reported “I bring my sense of the divine spirit into the room and recognize Gd’s presence in this place of suffering. I try to create a sense of a bubble of safety protecting the family.”

Creating connection

Giving the family a sense of connection is important. They may be suffering tremendous trauma. They may feel completely isolated, alone. They may be overwhelmed by shame and suffering probably unlike any feeling they have faced before. One Chaplain explained “I try to follow what the family needs, to find connection, to find avenues for connection so that they know I am there to support them as they face suffering. I want them to know I am there for as long as they need. They are often suffering trauma brain and can hear only a small part of what I say.”

By being fully present and sensitive to the unique environment where both life and death are present, Chaplains have the opportunity to offer the family the opportunity to create sacred moments, to say good bye, to tell the story of their child’s life. As Berry suggests “[b]eing present through the birthing experience becomes the cornerstone to foster healing. Being present is remaining flexible and adapting to parents’ needs as they arise. It means listening not only to parents’ stories but also their silence. It is being an advocate and stable presence amidst a turbulent force of grief.” (Berry 2023)

Deep listening and embracing their voice

Deep listening is crucial in this process. The bereaved parents often feel dismissed and silenced. They may feel they were unheard by the healthcare staff, or may feel so overwhelmed that words cannot arise. It is vital to give the parents some sense of autonomy and control. “Giving a voice to the individual living in the wake of trauma validates and affirms their experience. Along with regaining a sense of safety and control the individual whose experiences have been genuinely validated are able to feel empowered to heal from their trauma(s) and to face life [in the future].” (Berry 2023)

Time and deep suffering

The “time” for bereaved parents is not like any other time because they are overwhelmed by shock and trauma. Time moves much more slowly. Families interviewed reported how every moment with their baby was precious. (Thornton 2015)(“being given unrestricted, uninterrupted time with their baby was seen as a gesture of kindness by the staff”). Parents may simply want to suspend time because they want the moment with their child to last forever. Chaplains need to gauge the pace of the room and move slowly. At best, creating a sense of compassionate support by being silent, trying to feel the spirit of the room and being guided by the

parents. As one Chaplain noted “I try to be a gentle guide, to use a light touch and witness; offer safety and protection in a sacred holding place, a place of devastation.”

The parents are incredibly confused with what is happening. “I felt overwhelmed, like in a tsunami of pain,” said one mother. Others reported being overwhelmed by shock, being completely numb and paralyzed. Other providers may be coming in with pointed questions and suggestion and create a sense of an agenda. The role of the Chaplain is to enable the parents to feel they are in control, even though they feel so much chaos. As once Chaplain suggested “to allow the parents to be in control – to find their way to their own sense of order.”

The families are in a place of deep suffering. As one Chaplain observed “I cautiously move and create my presence. I realize how difficult it is for them to hear and absorb in this moment of extreme trauma. They probably hear only about half of what I say and they are dealing with the unfathomable. I just try to be present and create an environment of support.”

Chaplains may feel anxiety if there are in a situation where they are apparently doing very little. Yet parents reported that the quiet presence of the Chaplain gave them comfort. As one parent said: “just his sitting there quietly, with this solemn but compassionate look, gave us comfort. It was as if his presence was saying I have faith you will make it.”

The critical tool -- empathy

Being present involves the ability “to empathetically care for bereaved parents and to enter what is a painful place by coming alongside them and accompanying them on their grief journey.” (Nuzum 2015). This involves very deep listening, a quiet affirming presence so the silence becomes less fearful. The Chaplain is affirmatively entering into a world of deep woundedness.

Empathy is crucial. As one mother reported: “trauma isn’t what happens to us. It’s what happens to us in the absence of an empathetic witness.”

One Chaplain affirmed: “I am totally dedicated to their pain and trauma. I want to be fully present to give them a sense that what they are enduring is not alien, but a natural but crushingly sad part of life.” Another Chaplain observed “I try to convey a sense of safety. My presence tries to say ‘I have been in this place before and we will make it through this.’”

To be completely engaged in the suffering is crucial. As one Chaplain noted “I want to be fully open to the unfathomable pain, to absorb it.” Another Chaplain explained “One’s prior work is vital. You must tolerate and welcome being broken yourself. You need to learn to recognize your brokenness and operate from that place of brokenness. Recognize your own heartbreak for them.”

It may be difficult to understand, but empathy begins by recognizing one’s own woundedness. As Pope Benedict XVI guided “To accept the ‘other’ who suffers means I take up his suffering in such a way that it becomes mine also. Because it has become a shared suffering, in which another person is present, this suffering is penetrated by the light of love.” (Jorgenson 2024, p. 36). Indeed, suffering is transformational for the caregiver whose heart is touched by the loss.

To be fully present a Chaplain must wrestle with their own sense of pain and doubt in the face of such a profound loss. Many Chaplains reported that they needed to touch their own sense of suffering, their own anguish. “It is the theological wrestling with suffering and doubt ... that enables Chaplains to convey presence. ... Presence ... is possible when the Chaplain has critically wrestled with and is able to come close to the experiences of pain and grief.” (Nuzum 2015). Thus, Chaplains must be ready and able to identify their own wild edge of sorrow to be fully present for these families.

Cautious boundaries

Similarly, Chaplains need to recognize when their own assumptions or spiritual assumptions or beliefs are popping up. It can be the case that the Chaplain’s theological beliefs differ from the parents, particularly in situations involving terminations for medical reasons. Theological beliefs on perinatal loss may conflict. As Jorgenson advises when assumptions arise “I visualize clothing myself in humility and ... I ask Gd for help in leaving judgment to Gd.” (Jorgenson 2024, p. 24).

Being present also guides us on territories in which not to venture. Chaplains all reported that they avoid being in a fix it mode or giving advice. Chaplains are present not to fix but to provide presence to comfort the anguish. As one Chaplain observed “[i]t’s not your job to make things better; it’s your job to be a companion for those in suffering.”

Courage

Courage is an important element of being present. One Chaplain reported a patient asking “will you be brave enough to keep showing up for me?” This Chaplain observed that a perinatal loss requires a different kind of courage because the loss is so contrary to our understanding of life. “I realize the mothers need awesome courage. For they will walk out of the hospital with nothing in their arms, when their dream was to carry forth their child. I try to recognize the courage they need and hopefully call on my own courage to give them strength.”

C. Being patient centered – Being a companion

Some Chaplains reported an approach – a mindset of trying to companion the family. This may reflect an approach developed by Dr. Alan Wolfelt is to providing presence by “companioning the bereaved.” Companioning's approach to grief support emphasizes “being present” to a mourner's pain rather than “fixing” or treating it as an illness. It focuses on walking alongside the bereaved, honoring their unique journey, and fostering a safe space for them to navigate their own loss. (Wolfelt 2002, 2006); (Heustis et al 2005). (See also Berry 2023 “in companioning the [provider] adopts an attitude of *being with* of acknowledging perinatal loss as a life altering event and becoming a partner with the parents through the experience.”)

Core principles of the companioning model include providing supportive presence and not trying to fix. The goal is to support, not to treat, cure, or manage symptoms. In companioning, the caregiver assumes the role of a learner, allowing the bereaved to lead the way and act as the expert on their own grief. It encourages diving into the “wilderness of the soul” with the person rather than rushing them to “get over it.” In companioning, a Chaplain is guided by listening with the heart, bearing witness, respecting disorder and confusion, and appreciating silence. Grief is not a disease, but a normal, necessary, and sacred experience that changes a person's life forever.

As one Chaplain explained: “as a companion I believe people internally know best what they need. My job is to provide a safe container for them to explore. I see myself walking aside them, not leading. I try to discern what they need and provide them support along that path. The essential tools are empathy, curiosity, patience and compassion.”

Some of the key principles of companioning are:

- Companioning is about honoring the spirit. It's not about the intellect.

- Companioning is about curiosity, not expertise.
- Companioning is about learning from others, not teaching.
- Companioning is about walking alongside, not leading or being led.
- Companioning is about being still in silence.
- Companioning is not filling every painful moment with talk.
- Companioning is listening with the heart. It's not analyzing with the head.
- Companioning is about being present to another's pain. It's not about taking away or relieving the pain.
- Companioning is about respecting disorder and confusion. It's not about imposing order or logic.
- Companioning is about going into the wilderness of the soul with another human being. It's not about thinking you are responsible for finding the way out, the importance of seeing things from the family's point of view.

Dr. Wolfeldt advises to lead with “humble curiosity, of learning from each person how to best support them even if we come with years of experience. Companioning means being with.” As one Chaplain observed “[o]ne’s presence is simply to sit in that place of anguish and suffering and give the parents’ permission to feel what they need to feel.” Or as another observed “your presence is like a calm reassurance. You try to assure that they are not at fault.”

Chaplains generally recognized the need to be guided by the families. Families that have suffered perinatal loss are in a very fragile emotional state. As one mother suggested: “Chaplains need to listen, more than offer. Let the family guide you.” Chaplains should be guided by a quiet curiosity and humility.

This is an area where subtlety and sensitivity are necessary. As one Chaplain observed “often families are in such overwhelming shock that they are unable to state preferences, ask questions, they simply cannot guide. So, one must navigate carefully and try to guide with humility – suggest based on your experience what types of things might be helpful.”

D. Embracing parenthood and personhood for the baby

Embracing personhood, acknowledging the human life and feeling it is acknowledged is challenging for the family. Too often, especially in the past, families would be told “don’t worry you can always have another.” Or there is a social expectation that they should get over the loss. Or a sense because the child

was not born alive their loss should be less significant. These feelings may freeze the family in their trauma.

For the family it is crucial to affirm the presence of a human life and the relationship that has existed since conception. As one Chaplain observed “a perinatal loss can be worse than the death of a loved one who has lived. For a perinatal loss the parents developed a story that never came to be. It’s the loss of a future. You never met the child you dreamed of. You never lived the story.”

Creating the family story

A survey of perinatal loss studies found the vital role for the families to create a sense of personhood. “[P]arents from all included studies spoke of the importance of personhood. They considered the fetus to be a person whom they named and for whom they created an identity. Parents wished for their fetus and pregnancy to be acknowledged rather than ignored, for others to ask questions about their fetus, and for others to understand the important place their fetus had in their families.” (Berry et al 2020). (The study found this was true even in situations where families bonded with their baby even after learning of a life-limiting condition).

Perinatal loss can be crushing to the parents and lead them to question whether they are parents. “Their status as parents becomes complicated because there are no tangible signs of parenthood to affirm their roles.” (Cacciatore et al 2013). A mother may question her motherhood since after caring and nurturing in a wholly organic way she now has no child to hold or nurture.

One of the difficulties for parents who suffer perinatal loss is that there are few persons who have seen the child or had any encounters with it. The moments with the parents and the child soon after delivery are sacred moments. Fully recognizing the child as a human being can help parents achieve “confrontation” being able to accept their child as real, so that they can begin to grieve the loss and integrate it into their life. (Wretmark 1993 p.175); (Singh et al. 2004).

Chaplains do this by being curious story listeners. They ask the parents to recount the story of the pregnancy with careful and compassionate inquiry. This is the beginning of a vital process – of creating the story of their parenthood.

The path of parenthood

A Chaplain may ask the baby's name and the reason for the name. She may ask the parents about their dreams and what they had hoped for in the child's life. She also recognizes and strengthens the parents' sense of their baby's presence. The parents will be encouraged to hold the baby, have the baby lay on their skin, kiss her, talk to her, read to her, sing to her, tell stories, choose her clothing, bathe and dress her. (This is a delicate process in which the providers try to discern and honor the wishes of the parents). The hospital may support taking pictures and making a mold of the baby's feet. Many of these activities can provide intimate and deep connection. We seek to engage in the parent into their new role as parent. "Caregiving [is] especially important, allowing [parents] to create positive memories with their baby while simultaneously helping them to step into their role as parent." (Thornton, et al 2021).

One Chaplain spoke of providing a prayer affirming and blessing their parenthood. Providing care as a parent is vital and strongly affirms their role as a parent. Studies have shown that these steps of parenthood – engaging with the child, providing care and making memories, affirmed their role as parents and "allow[ed] them to honour the individual identity of the baby and step into the role as parents." (Thornton, et al 2021).

Embracing personhood and solidifying bonds

Concomitantly, the team treats the baby as like any other baby. Nurses observe the baby like any other baby and notice the physical aspects of the baby – how beautiful she appears, her lovely countenance or beautiful hair. Chaplains should join in these affirmations so that the parents have an emboldened sense of the baby's personhood.

One Chaplain observed "I will treat the baby as any other child. I will talk to the baby, recognize how beautiful she is, note her special characteristics. I want the parents to know that in my eyes she is a beloved child. I think that is the way God sees her too."

Embracing personhood includes the physical and physical contact provides a rich connection. This is a vital opportunity for the parents to bond with the baby. It takes courage to embrace a dead body; a Chaplain can help strengthen that courage.

Beginning the process of bonding and creating continuing bonds is vital. In many hospitals the nursing staff will help create a memory box which will include

clothing, a lock of hair, pictures, footprints, etc. A Chaplain can participate in and strongly affirm the creation of these memorabilia.

The afterlife

Some parents may inquire about the afterlife. Although the child is not alive many parents have a strong sense of the baby's soul. Parents wrestle with the question of the baby's soul and where is that soul?

Most Chaplains reported responding to these questions with supportive curiosity. One Chaplain reported: "I try to get a sense of their beliefs of the afterlife and what would give them comfort. For some families they have a clear and strong desire to see the soul of their baby embraced in heaven and dwelling with and being welcomed by other members of the family. Others attach to the sense the baby has become an angel and is embraced by other angels."

Another Chaplain explained; "I try to enhance the relationship with the baby and her soul. If the parents sang to the baby in utero I will suggest they continue to do that. Some parents may feel a sense of guilt for not being able to deliver a healthy child and I will ask them if they would like to ask forgiveness."

Chaplains perceived that this was only the first step in a vital process of keeping the connection with the baby. Almost all the parents interviewed described extensive efforts to keep the memory of their child in their lives.

Jewish Chaplains and Rabbis seemed to struggle with when a soul exists and is present. All the Chaplains and Rabbis interviewed were asked "when is a soul present (e.g., at conception, at a certain point of gestation, at birth, at a point after birth)?" Many non-Jewish Chaplains answered the question confidently, most answering at conception. Jewish Chaplains struggled with the question and several simply declined to answer. This could be from a concern over protecting the right to choose. However, it suggests an intriguing theological gap which may create an obstacle to connection. Patients may pick up on that discomfort and in turn that may increase their sense of disenfranchisement (that their loss is not recognized as a loss).

Rituals

A Chaplain can design rituals for the visit and may work on creating memorabilia such as a naming certificate. Naming certificates are very important to

the parents who will want some recognition that there was a life. The only certificate a family will otherwise receive is a death certificate.

A ritual at the end of the visit is very important. The Chaplains interviewed typically used some type of spontaneous prayer or ritual to try to incorporate the deep feelings and the parents' wishes for support. It creates connection for a Chaplain to thank the family for welcoming her in and giving her the opportunity to meet the baby at the end of the visit.

Ultimately the goal is to solidify the relationship so that the parents can have the experience of being a parent and embracing their role and begin to feel the bonds that exist. In the interviews we found that those families that were able to create a sense of personhood at the time of loss were also able to more fully memorialize their child.

E. The search for meaning and attachment.

A core concern for parents is finding meaning for their loss. At this moment of tremendous pain, they desperately seek to make sense – of the reasons for the loss and the meaning of the child's life. As one mother said: "I was desperate to know my daughter's life was not for nothing."

For the most essential questions of why did this happen, or how Gd could permit this to happen a Chaplain typically must just be present and validate those questions. As one Chaplain noted: "I will really try to feel their anguish and let them know their words touch me, not verbally but by my physical presence. And then I will tell them I can see how painful this is, but there are some things in which we really don't have answers."

Another Chaplain noted: "I try to fully absorb their questions and validate them. If I am pressed for an answer, I may acknowledge that I believe that Gd suffers along with us; if we are crying Gd is crying too." A Christian Chaplain said he might speak of Gd suffering as Jesus was suffering. A thoughtful teaching by Rabbi Kalonymus Kalman Shapira, the Rabbi of the Warsaw Ghetto captures this notion of the person in suffering crying with Gd:

"It is the Holy One Who is crying within the inner chambers. And whoever presses himself closer to Gd through Torah is able to weep there together with Gd and also to learn Torah with God....The pain and grief someone suffers over their own situation, alone, in isolation, can break a person. They may

even fall so far that they become immobilized by it. But the crying that a person does together with Gd makes them strong. They cry and are strengthened.” (Strausberg 2024).

One mother reported it is vital to fully recognize that this is a sacred event. “It’s vital to acknowledge the moment of loss. To honor the mother and the baby. The act of creation is our highest act, the most courageous thing we do. We should honor this immense undertaking. When you become pregnant you give your body up – and it’s a tremendous undertaking. That is beautiful and to have it fail is a tremendous sacrifice. And you are suspended between life and death.”

Non-Jewish parents sometimes have a sense of the child being “chosen” – selected for this brief existence for a reason.³² This is not a concept embraced by most Jewish parents. However, one Orthodox Jewish parent spoke of a sense of the baby being chosen: “We know that everything happens for a purpose; those neshamos (souls) have fulfilled their tafkid (purpose) and are now returning to Shamayim (Heaven)—the very best place possible – in the very state of purity and innocence they’ve descended to Earth. Although we cannot always find meaning in the misery, there is a comfort in knowing that there’s a purpose to the pain.” Her belief was that the baby’s soul would be entrusted with the parents’ prayers, hopes and dreams and she could intercede for the parents in heaven.³³

Attachment with the baby is critically important. The parents are about to enter a world which will have extreme difficulty acknowledging their connection and loss. It is a world that lacks words for the loss in which people may be dismissive (e.g., “you can always have another”). Many Chaplains reported how it is vital to witness, honor and validate the patients’ role as parents. However, Chaplains should not assume the couple wants to embrace the role of parents; so, they should inquire how the family evisions and speaks of the relationships. For example, a family many not want to be called parents if there was ambiguity about having the birth.

³² Being “chosen” could also mean being chosen by Gd to bear the child or the child selected you to be its mother. Being chosen can create a sense of being honored or privileged.

³³ A study of Ultra-Orthodox Jewish mothers in Israel found that they believed Gd was beneficent and with them in the birthing process and the death of the child was for their benefit. “[I]t seems that the meaning ascribed to stillbirth by the participants in the study led them to feel they were “the chosen” – reflecting Gd’s love toward them. Adopting such a view justified the tests of their faith and released them from tortious questions and guilt feelings.” Hamama-Raz et al 2014; see also Levitan et al 2022 (similar study of Ultra-Orthodox women in Israel).

Finding meaning may also often involves helping the family to tell the story of their caring for the baby and the baby's life in utero.³⁴ Many Chaplains discussed talking to the family about what the pregnancy was like, which the baby enjoyed, how it acted and responded, what it's in utero personality was like. Chaplains may inquire about singing to the baby, telling her stories or how she responded to certain foods. As one Chaplain noted: "I don't walk in with an agenda but one thing I hope for is to talk to them about how they have been a parent – how they cared for their child with loving compassion, and how they will always be the child's parent. I will make a point of trying to call them 'mom' and 'dad'."³⁵

Listening and validating their past and present role as loving parents is an important first step to help the families reconcile the loss and begin to envision going forward. One Chaplain mentioned "I always affirm that I can see how much they love their baby and how fortunate the baby is to have such loving parents." The attachment and love they felt for their baby is not extinguished. Besides telling the past story they are beginning to tell the ongoing story of the child in their lives. Those stories will be part and parcel of how they keep the child in their lives.

The search for meaning and connectedness is vital. The baby may have touched people in ways that are not obvious. Some parents interviewed suggested that they benefited from identifying "circles of meaning," or ways in which their baby touched other lives – other relatives, healthcare staff, friends. (Raingruber et al 2007). It means a lot to parents when health care providers recite that they were touched by or felt close to their infant. This sense of connection allowed parents to reconstruct a semblance of meaning in the midst of their loss. Chaplains' observations about how they are touched makes that sense of connection concrete. Chaplains can also help uncover how the baby has touched other lives.

There may be an even more integral form of attachment for the mothers. Carrying a baby in one's womb changes the mother's body, changes her in a permanent way. The baby is always part of the mother even though not a living child.

During pregnancy, fetal cells cross the placenta and enter the mother's body, where they can remain for decades – sometimes forever. This process is known as

³⁴ The cases of termination for medical reasons posed very interesting situations. Two families reported that they move actively bonded with their baby after receiving the diagnosis of life-limiting condition, being extra aware of the movements and "personality" of the baby. One parent described the sense of being distanced from the baby in a state of emotional limbo.

³⁵ Of course, Chaplains should be sensitive to whether the parents want to be identified in that fashion.

Microchimerism. These cells can settle in various places – including the brain, and aptly – the heart. Microchimerism offers a quietly powerful reminder that the connection between mother parent and child can live on at the cellular level long after the child is birthed. Lost babies “leave a biological imprint – not simply a memory – but a presence, which can be lifelong.” (Miscarriage Association, Woven in Heart and Cell: Microchimerism and the Enduring Connection After Miscarriage 2025).

The spiritual mirror to this notion was captured beautifully by a Rabbi who counseled a bereaved mother after stillbirth. She explained that the shards of the broken Tablets of the first set of the Ten Commandments were not discarded but were placed in the Ark with the Second complete set. The broken tablets were preserved. Similarly, the mother will always carry the brokenness and heartache of her previous child in her body. It will never disappear. The spirit of that first pregnancy is preserved in the mother’s body. It is every bit as precious as any subsequent children.

F. The spiritual wilderness

Perinatal loss results in spiritual distress and parents find their connection to the eternal shattered, torn from miracle maker to mourner, and search for understanding in the face of unanswerable questions (several parents did not have a reason for the stillbirth). They enter into a spiritual wilderness of lament and signs of traditional guidance and support may have been extinguished. Many studies have found that a large portion of bereaved parents (about 25-30%) suffer from complicated spiritual grief (CSG). (Hawthorne et al 2015). CSG is a profound, lingering grief that disrupts a person's spiritual understanding of life. It is distinct from ordinary grief as it directly challenges long-held spiritual beliefs. It can result in intense sorrow, questioning or doubting faith, feeling abandoned by God, anger toward God, and feeling alienated from a religious community. Their relationship with Gd or their sources of spiritual support is shattered.

Parents may ask: why did this happen to me? Why did Gd hate my baby? Why were my prayers not answered? What did I do wrong? Why am I being punished?

Psalm 44 captures this distress: “[Y]ou have crushed us ...and covered us with the shadow of death. Why do you hide your face and forget our grief and oppression?”

As meaning making humans Chaplains want to be able to answer the question “why?” when faced with suffering and this is a world in which answers are absent. As Nuzum explains:

“In framing the theme around the question ‘why?’ it brings theodicy and suffering together as two sides of the same coin. In a world of causality and meaning-searching, perinatal death opens up the often theologically barren area of needless pain and unjustified anguish. In perinatal healthcare ministry the enormity of theodicy comes into sharp and painful focus where the joy and happiness of new life and parenthood exist alongside heart-rending grief and pain for others in the same building.” (Nuzum 2017).

All the parents interviewed spoke of emotions such as fear, anxiety, sadness and doubt that suggested spiritual distress. Many parents expressed anger amplified by the loss of such essential hopes of being a parent and the long and intense period of expectation. (See the earlier quote from Rabbi Karen Perolman). Many parents felt guilty about expressing anger and the anger only increased their sense of shame. One Orthodox mother said: “I simply felt betrayed by Gd. It was hard to see him as a source of love and mercy. I could not get beyond my anger.”

Chaplains reported facing the spiritual struggles with a quiet and supportive curiosity. Chaplains report that they are patient and wait for the parents to raise the subject. If they do not, they may inquire about how the parents see the spiritual in their lives and ask about their sources of spiritual support. They will then slowly explore how the loss has affected their spiritual foundation.

Some families may not identify with any faith tradition. For those families one can guide. One Chaplain suggested guiding “it can be meaningful to say a special prayer for you and your baby while you are here at the hospital. It is a way that we can acknowledge your baby's uniqueness and presence among us and also pray for you as a family and all that you are navigating. It is a pretty short blessing; we will acknowledge their name and bless how you have come to know him while you were pregnant. How does that sound?”

Many Chaplains spoke about embracing the parents’ anger at Gd. One Chaplain explained: “I listen openly and try to convey my support; I try to give them the sense I join them in their anger. It is totally normal. I tell them it’s ok to be angry with Gd. He understands its right to be angry and even if you leave his door is always open and he is understanding.”

As noted before there is often a search for blame. The family will not want to blame themselves and may blame Gd to protect themselves.

With some spiritual crises one can only be present. The level of trauma may be overwhelming and all one can do be create a supportive presence.

G. Providing guidance on rituals

Both families and Chaplains reported on the vital role of rituals. Rituals can be a vital tool to assist families to say good bye, to create a sense of meaning from the loss, to deal with the questions that can never be answered. Rituals help create concrete memories that can be a source of solace in the future, or a tool to connect with the ineffable. Rituals help one have a sense of control and an effort to compose the story of a life lost so soon. And these may be the only rituals the families receive.

Rituals are vital when we deal with liminal moments such as birth and death. In the space of perinatal loss where these liminalities are brought together there is even greater need for rituals. When the larger family is present one Chaplain creates a ritual where the family members gather in a circle. Each individual holds a candle and expresses a blessing, his or her hopes for the baby or the family and then passes on the candle. In that way they create a circle of support. Other Chaplains spoke of the need to incorporate praying to ancestors in rituals. Praying to ancestors is very common in many faiths.

Every Jewish bereaved family interviewed sought guidance on rituals and end of life tasks – how to dispose of the remains, how to become a mourner, whether to name the baby and how to name them, whether to perform the rituals of tahara and shmira, how to hold the funeral, whether to sit shiva and whether to say Kaddish, and how to memorialize the baby. There were a tremendous diversity of responses and the Rabbis consulted often had difficulty giving straightforward answers. This increased the sense of anguish for the families which wanted a clear path with a strong foundation to guide them in honoring their baby's life.

Rituals play a critical role in providing a sense of a child's being and acknowledgement of their life and the parent's feelings. Rituals create a sense of acknowledgement of bringing in the sacred. Studies have shown that parental "grief was negatively impacted when they were not 'allowed' or offered the opportunity to engage in cultural rituals surrounding their loss." (Berry 2022).

The lack of rituals for Jewish families was quite striking considering the rich and detailed rituals for most losses. The gap of resources is highlighted in a treatise on perinatal loss rituals Erin Denney-Koelsch, Perinatal Bereavement Rituals and Practices Among U. S. Cultural Groups (2023). The treatise contains chapters on

various cultures and faiths on how to memorialize these losses. The Chapter on Jewish practices relates almost entirely on the law and sets forward few rituals for memorialization. Other cultures and faiths had more robust approaches to memorialization.

Many of the families interviewed developed their own rituals for remembering their child, including ceremonies, memorial places, objects of memorialization, and rituals for remembering the baby. They each noted there were very few resources they could rely on for this task.³⁶ Various rituals may exist but they are not available in an organized fashion.

H. Caring for both partners³⁷

Because the mother is the child-bearer it is natural to focus on her and her physical and emotional needs. But studies increasingly show that fathers suffer emotional and spiritual pain. Our study interviewed four fathers each of whom reported a sense that their status was ignored or dismissed. As one father reported “I was suffering from tremendous anguish and to be placed into a zone of silence only intensified that pain. I felt I had no voice.” One study found that society overlooks the experiences of fathers who suffer perinatal loss. (Lang et al, 2011). Studies have found that fathers suffering perinatal loss distance themselves from their emotional reactions and set their personal needs aside, focusing on supporting their partner. (Hutti 2004). Other studies have found that fathers receive hurtful or insensitive comments from others and have difficulty in being strong when they needed to be supported. (Berry 2022).

In essence fathers suffer a double disenfranchised grief. First, like the mothers they experience a loss that society tends to dismiss (e.g., it’s not really a loss, it was not a live birth, you can always have another). Second, it’s not the father’s loss, the loss belongs to the mother. And in many cases the entire focus of support is on the mother.

³⁶ One resource is on Ritualwell, “For Stillbirth and Infant Loss; Baby Naming and Good Bye Rituals,” <https://ritualwell.org/ritual/for-stillbirth-and-infant-loss-baby-naming-and-goodbye-ritual/>. For an example of a created ritual see “There was no Jewish way to Mourn Stillbirth – So we created our own,” Kveller (May 16, 2022) at <https://www.kveller.com/there-was-no-jewish-way-to-mourn-stillbirth-so-we-created-our-own/>.

³⁷ This discussion will refer to the non-birthing partner as a “father.” We recognize many non-birthing partners are women and in three of the family’s interviewed the non-birthing partner was a woman.

Although fathers have the best intentions, they tend to give instrumental support rather than emotional support.³⁸ This may result with the mother feeling unsupported and the father feeling guilty. Fathers feared that they would make their wife feel worse if they expressed their feelings. “Men may ... suppress their feelings of anger, hurt, and loss and {try] to appear stoic.” (Hutti 2004). This may lead the mother to feel “he didn’t love the baby.”

As a result, men are often at risk of not receiving the emotional and spiritual support they may need. Furthermore, differing grief responses and expressions between men and women may marginalize individual needs, straining their marriage and their ability to grieve. (Capitulo, 2005). A 2019 UK study found significant evidence of fathers suffering symptoms of PTSD. (Berry 2022).

Fathers typically see their role as protector or supporter. They are there to help their wife during her tremendous physical and emotional pain. They tend to set their own feelings aside and typically are reluctant to talk about their feelings. As one father reported “I was laser focused on being the caregiver.” They tend to camouflage their feelings, their sorrow because of their need to be the protector.

As one Chaplain observed “I know my job is harder for the fathers. I try to help them break free from their role of observer and protector and bring them back to being a parent. I let them know they don’t have to be strong or hide their feelings. I need to let them know it is not selfish to have feelings or to express them. That they are actually helping their wife, perhaps validating her grief, by expressing their own.”

Perinatal loss can often lead to marital strain. Parents in four of the families interviewed highlighted strongly different feelings about how they approached the loss. Having both members of the couple share their immediate grief can help them grapple with their different feelings and provides a start for their journey into grief.

VII. Obstacles to providing spiritual care for Jewish families

Providing spiritual care for families suffering perinatal loss is challenging for all Chaplains, but those challenges seem even more significant for Jewish Chaplains and Rabbis. Only one of the Jewish families interviewed reported receiving

³⁸ Terry Martin and Kenneth Doka in *Men Don’t Cry, Women Do, Transcending Gender Stereotypes of Grief* (2000) describe a continuum of grief with two different patterns on either end. The Intuitive pattern, often stereotyped as female, is an emotional and affective expression of grief. The Instrumental pattern, often stereotyped as male, is where grief is expressed in a physical or cognitive manner.

compassionate spiritual care from a Rabbi or Chaplain. Often parents were disappointed with the care they received. One mother reported “all I wanted was a compassionate presence, for there to be someone who could listen without judgment and embrace my words, my sorrow.”

Jewish faith beliefs can create obstacles to providing spiritual care. For Jewish families the spiritual problems concerning perinatal loss can be substantial. Jewish law and customs vary depending upon the denomination.³⁹ A recent survey of the subject detailed the differences in approaches to religious law over several pages, demonstrating the complexity and ambiguity. (Schlagman 2023). The traditional view is that a child is not a “life” unless he or she is born and takes a breath. The Orthodox view is that parents are not obligated to mourn a child unless he or she lived for 30 days.⁴⁰ The rituals concerning death (shmira -- watching the body, tahara – washing the body, burial service, shiva – supporting the family for 7 days after burial), saying kaddish, were not appropriate.⁴¹ There are also ambiguities about whether to name the baby or have a bris. Babies who lived less than 30 days were typically buried in unmarked graves without a burial ritual, and the family may not have chosen a name.⁴² Some families have been extremely frustrated because of the inability to do tahara and shmira.

This world of anguish, of ambiguous loss, was captured in a Midrash by Nehama Weingarten-Mintz, “He Supports the Fallen”:

“What is the grief that knows no end? It is the grief of the woman who miscarries before her time. For the grief of pregnancy, and the grief of birth, and the grief of the land have a beginning and an end and a great joy comes after. And the grief of a woman and her babe who was snug and enfolded end to end and never saw the light -- that has no time, no end, no healing. And our Rabbis said at the death of a stillborn, a fallen babe (nefel), a father's heart does not grieve, and you don't rend garments for him, or mourn for him, nor

³⁹ For a fairly comprehensive discussion see Schlagman (2024).

⁴⁰ The Conservative movement in 1998 adopted a very thoughtful, nuanced and careful responsa to deal with perinatal loss. See Rabbi Stephanie Dickstein, “Jewish Ritual Practice following the Death of an Infant Who Lives Less Than Thirty-One Days.” https://www.rabbinicalassembly.org/sites/default/files/public/halakhah/teshuvot/19912000/dickstein_infant.pdfview. The responsa details practices for burial and funeral, naming the baby, circumcision and shiva.

⁴¹ Until recently Chevra Kadishas in Israel regularly denied parents the right to attend the funeral or even know where the infant was buried. “Parents Kept from Funerals of Stillborn,” Jerusalem Post, March 6, 2012 available at <http://www.jpost.com/Jewish-World/Jewish-News/Parents-keptfrom-funerals-of-stillborns>.

⁴² Torah Viewpoints on Pregnancy Loss, Mikvah.org, <https://mikvah.org/article/torahs-viewpoint-on-pregnancy-loss#:~:text=By%20Jewish%20law%2C%20no%20formal,of%20kin%20is%20not%20kept>.

weep. And what's more the babe was to them like a fish or insect or locust or crawling thing, or even a sandal.”⁴³

For Rabbis and Jewish Chaplains, it may be challenging to provide spiritual care because of the lack of training on providing spiritual care for perinatal loss and the ambiguous approaches to whether and how to mourn. For Orthodox Jews a life is not acknowledged unless the baby lives for 30 days. One common rationale for the 30-day rule was that centuries ago miscarriage and stillbirth were so common that if there were mourning obligations families would be in a constant mode of observing the mourning obligations. Of course, now stillbirth and miscarriage are far less common.

But that may not be the best interpretation for the rule. As Rabbi Jason Weiner observes:

“The Jewish laws of mourning are not a reflection of the sadness caused to the mourner, but of the loss to the world.... [A perinatal loss] never became a “viable” person. From a technical perspective, the world never merited to have this child dwell within it, and the child was thus not “lost” to the world.... [F]rom a spiritual perspective, the pure soul of a fetus or newborn never completely entered the human realm, and thus never severed its total attachment to God. The soul of the baby thus remained pure and holy; it merits going directly to the World to Come, and to eventually return to life with the resurrection of the dead.” (Weiner 2023).

Weiner observes that Rabbis may have taken this approach to try to encourage families to move on and minimize grief. Although Rabbi Weiner’s approach may be analytically satisfying and comforting to some people, to others it may be distressing since it may seem like a suggestion there is no place for grief.

Rabbi Yamin Levy, whose family suffered perinatal loss notes the tremendous costs of the traditional Halachic approach:

“As a result of the halakhic position on infant deaths, Jewish couples who suffer such a loss experience do not have a formal structure as an outlet for their grief. The painful silence of Judaism on this tragedy adds to the anguish and creates a climate of isolation. Even the bereaved parent’s basic needs for comfort and support, *niḥum avelim*, are overlooked by many pastoral care

⁴³ Dirshuni: Contemporary Women’s Midrash (2022).

givers. Their unstated assumption: if Jewish law does not offer a religious framework for such grief or a religious structure for comforting those who experienced such a loss, this means either: (1) the bereaved really do not need to grieve and to be comforted, or (2) it's best that they not grieve and be comforted. Of course, neither of the two assumptions is correct.” (Levy 1998, p. 51–2).⁴⁴

One parent interviewed (a Rabbi) spoke about his tremendous anguish that the baby was not acknowledged as a human life because he was not 30 days old. He spoke about how this “shook his faith.”

Families may be told that technically they are not “mourners” under Jewish law because the baby did not live for 30 days. That is shocking and distressing to families because they are experiencing such profound grief. To suggest that grief is not recognized seems like the sine qua non of disenfranchised grief.⁴⁵

As noted earlier, Jewish Chaplains and Rabbis interviewed struggled a great deal in being able to say when life begins or at what point there is a soul present.⁴⁶ The perspectives varied from conception to birth to 30 days after birth and some simply declined to answer the question. (As noted *infra* the inability to be able to affirm the existence of a soul may cause spiritual distress for the family).

Some families picked up on that uncertainty and it made them uncertain about whether the Rabbi or Chaplain recognized the depth of their loss, or how they should consider the life that was lost, whether it was a life and whether they could share their loss with their community. They felt that their anguish was compounded and they were silenced from expressing their grief.

The ability to affirm when life begins or when a soul is present may be an important factor in being able to deliver spiritual care. A 2004 multifaith study of chaplains and religious caregivers found that those who could affirm that life began

⁴⁴ That does not mean Halacha cannot be a source of comfort for some families. Zack Truboff in Torah Goes Forth From Zion observes that halacha can provide a framework for grappling with grief “[a]s I sat beside my wife in stunned silence, I remember feeling as if a chasm had opened up beneath our feet, and the two of us were perched precariously on its edge. We were able to regain our footing but only by turning away from the language of science and toward the language of Halacha. It provided us a ‘home’ at the very moment when we felt adrift in the world.” (Truboff 2022a, p. 227).

⁴⁵ There are some approaches of Orthodox Rabbis to provide community involvement and comfort for the bereaved. See Joel B. Wolowelsky, A Note on Comforting Parents Who Suffer a Perinatal Loss.

⁴⁶ In some respects, the conflict may be understandable. A Rabbi may want to say that a soul is present at conception to protect the emotional needs of a family that is suffering perinatal loss. On the other hand, a Rabbi may want to say a soul is not present until after birth to protect the emotional needs of a parent choosing to have an abortion.

at conception “did not struggle with the tension between maintaining ritual traditions and practical pastoral concerns.” (Singh et al. 2004). For these caregivers a pregnancy loss is simply the loss of a person.

The Reform and Conservative movements have a very modest liturgy to assist in these situations and some of it may not be sensitive to the needs of the parents. To provide an example, the Rabbis Manual for the Conservative movement, *Moreh Derekh*, has a prayer for the termination of a pregnancy that refers to the lost life as a “fetus.”⁴⁷ Most families may strongly object to the life that it considered a baby being referred to as a fetus. A 2024 UK study found that referring to a termination as a “fetus” caused trauma and emotional distress. (Tommy’s, *The Impact of Language on Perinatal Loss* (2024)). Two parents specifically reflected how medical staff calling their child a “fetus” or a “fetal demise” increased their suffering.

As the 2023 First Jewish Perinatal Loss Summit found there is a tremendous gap and uncertainty in Jewish rituals for dealing with perinatal loss. This ritual gap increases the stress and uncertainty for Jewish families suffering these losses and creates an environment of disenfranchised grief. Moreover, ritual guidance is undeveloped and somewhat dated. The responsas and liturgy for the Conservative movement on dealing with miscarriage and stillbirth are over 25 years old, as is the ritual guidance in the Conservative Rabbi’s manual. The guidance for the Reform movement is from 1983. The sole treatise on rituals for perinatal loss – Rabbi Nina Beth Cardin’s Tears of Sorrow, Seeds of Hope is from 1998.⁴⁸ There is a tremendous need for more contemporary and careful consideration of the issues surrounding perinatal loss and creative treatment of Jewish rituals for perinatal loss.

This often puts Jewish families in an uncertain territory where they do not know how to observe and remember the death of their child. Reliance on Halacha may lead to very ambiguous results. Where there are no well-established rituals, Rabbis may simply view this as an ambiguous area and present alternatives and advise “you can do what you want.”⁴⁹ For the families interviewed this advice was unhelpful; being untethered to set rituals only increased the sense of disenfranchisement and ambiguous loss. “Trying to guess at our own rituals made

⁴⁷Part of the ambivalence on the issue when life begins can be due to concerns about diminishing the right to choose for women.

⁴⁸ Cardin, Rabbi Nina Beth, Tears of Sorrow, Seeds of Hope: A Jewish Spiritual Companion for Infertility and Pregnancy Loss (1998). There are also resources on perinatal loss on the website Ritualwell. See <https://ritualwell.org/?s=perinatal+loss>

⁴⁹ A typical conversation reported in the interviews was “you aren’t obligated to do anything, but you can do things if you want.” Since there are clear and well-defined rules for other losses, that only increased parents’ sense that this loss was not recognized and of being disenfranchised.

us feel more lost,” said one mother. Our interviews found that the response of families to this advice was often to do nothing. Another mother observed “we are a religion that has rules and a framework for doing everything. What does it say that there are no rules or that there are such foggy differences of opinion?” Even one Rabbinic educator observed that “if you say your observance is a choice it demeans whether it is a real loss.”

As Rabbi Jack Reimer observes: “It is not enough to tell the families that the mourning rites are not necessary, as if the rites are an onerous burden, which we are trying to spare them. The mourning rites are a therapy, not just a burden and we do sufferers no favor if we excuse them from them.” (Reimer 1995, p. 260).

Additionally, the focus on Halacha may create a barrier for the caregiver to being fully present and identifying and providing for spiritual and emotional issues. Two therapists who deal extensively with Jewish families suffering from perinatal loss observed that these patients perceived that Rabbis and Chaplains “hid” behind Halacha to avoid dealing with the trauma they confront. “Halacha appears to be an obstacle to compassionate care. They are simply unprepared or afraid to deal with the suffering,” said one therapist. Another observed Rabbis may feel safer standing on the foundation of Halacha rather than joining the families in the emotionally turbulent waters. Turning to Halacha puts the Rabbi in a position of power which is antithetical to the role of being a companion; it may create obstacles to being truly present and empathetic. “It removes the Rabbi or Chaplain from the place of suffering,” noted one therapist. It is an obstacle to “taking up their suffering.”

Compounding the problem is that the Halacha is not particularly clear and Rabbis vary their approaches. Rabbis interviewed had various positions about whether a life was present and to parents sounded like they were equivocating. One parent reported “it was so insensitive for the Rabbi to start to give us a lecture about Halacha and when life begins while my precious daughter was in the room. It was as if he was blind to my tears.”

Another parent reported “the clergy focused solely on ritual obligations, not our spiritual or emotional needs. I needed to know my daughter was at peace and not just a clump of cells.” Halacha can serve an important role but in situations of perinatal loss it may act as a barrier to grappling with the profound loss and the need for compassionate care.

One consideration that should be explored is whether Chaplain or Rabbinic training adequately trains spiritual caregivers to enter into the place of suffering with

a vulnerable and empathetic heart. I surveyed training on perinatal loss at the major Rabbinical schools and found that for most it was very brief and focused on halacha. There was no pastoral element. As noted earlier, Chaplains need to identify their own life experience a time of anguish and sorrow to be fully present with the family -- to identify their own wild edge of sorrow. To be able to touch one's own suffering can guide one in being truly empathetic. It is notable that in only one of the Rabbinic schools was there this training on being empathetic in a place of perinatal loss.

VIII. Recommendations

I hope this paper serve as a catalyst for a dialogue about how to provide more effective spiritual care for perinatal loss, especially in Jewish communities. Based on the study, the interviews with families and Chaplains, the analysis of the literature and contacts with stakeholders in perinatal loss I think there are tentative recommendations that can be posed to begin the dialogue on these issues.

A. Chaplaincy training

The study clearly documents a lack of training for Chaplains to deal with perinatal loss. I recommend that each of the Chaplain associations undertake a training program on the subject and assemble background materials to educate their members on this subject. Training on perinatal loss can be part of annual programs or the subject of specific seminars. Many of the articles in Appendix C would be a good source of education. In addition, Chaplain associations should work with associations on perinatal loss such as Star Legacy Foundation or RTZ Hope to focus on how to deliver more effective spiritual care. The dialogue with these family-oriented groups could be invaluable.

ACPE is the leading organization in Chaplaincy education. ACPE should recognize the needs in Chaplain education and consider building a model unit of learning on perinatal loss that then can more easily be distributed and integrated into ACPE units internationally -- including case studies, readings, and theological questions for students to wrestle with.

The Chaplaincy Innovation Lab and other groups such as Transforming Chaplaincy have been a strong force in providing chaplaincy education, especially on cutting edge issues. They should consider programs on the subject.

In addition, most hospitals have clear training programs for nurses and social workers on perinatal loss. They should consider integrating their Chaplains into

those programs. They should also consider creating “best practices” for Chaplaincy education on perinatal loss.

B. Providing spiritual care for Jewish families

Religious Response

The study clearly documents the challenges in providing spiritual care for Jewish families. This is an issue that each of the denominations should engage in. Some of the questions they should consider are:

- Should there be revisions in Halacha or the approach to using Halacha;
- How can more effective spiritual care be provided;
- What resources do Rabbis need – Rabbis should have a set of resources to use in these situations;⁵⁰
- Rabbis manuals should be revised to address perinatal loss;
- How can there be greater development of rituals;
- Creating more substantial prayer resources for these losses;⁵¹ and
- How to overcome the silence and stigma on the subject.

For example, the Committee on Jewish Laws and Standards of the Rabbinic Assembly should review the Halachic treatment of stillbirth and miscarriage. There have been many changes, especially in the understanding of the psychological and emotional impact of perinatal loss since the late 1990s when the Halachic standards were adopted. We have a much greater understanding of the trauma that families suffer and the need for rituals and spiritual care. In addition, the liturgy in *Moreh Derekh* should be revised to take a more sensitive view of the suffering of the families.

Moreover, our Rabbinic leadership can do much more in bringing the topic of perinatal loss out into the open and creating an environment which normalizes the conversation and reduces the stigma. As Rabbi Dickstein suggests in the Conservative Responsa on infant loss “in our classes on life cycle rituals, and in our conversations with expectant parents, we must discuss the fact that there is a Jewish response to miscarriage, stillbirth and infant death, and we must assure parents that

⁵⁰ For example, the Church of Christ has a set of resources for ministers in dealing with infant and perinatal loss. See <https://worship.calvin.edu/resources/articles/worship-resources-pregnancy-loss-and-infertility>.

⁵¹ For example, Daniel Judson, “A Synagogue Ritual For Miscarriage,” at <https://www.kveller.com/article/a-synagogue-ritual-for-miscarriage/>.

neither we as rabbis, nor the Jewish community, will abandon them if everything does not turn out as they pray that it will.” That is a strong recommendation that needs considerably greater attention by each denomination.

Rabbinic Education

In addition, each of the Rabbinical schools need to implement a careful evaluation of their perinatal loss training. They should evaluate whether the training provides the necessary tools to provide effective spiritual care. Training focused on Halacha is not sufficient; training should include the pastoral care skills necessary to provide care in a place of great anguish and suffering. It should include role playing in providing care and practicing creating rituals for these encounters.

One good model may be the approach taken by Yeshivat Chovevei Torah. Once a year in collaboration with their sister yeshiva, Yeshivat Maharat, they meet for a week-long seminar and this year was on Medical Ethics Issues on Beginning of Life. The program went beyond Halacha and included a lively discussion on ethics issues, some of the practical problems in dealing with beginning of life losses, including termination for medical reasons. What was particularly valuable was hearing participants real world stories of dealing with these issues and opportunities for participants to discuss personal, emotional and spiritual issues. This pastoral component was essential. As one participant observed “it gave me a much more concrete notion of the suffering in these losses and my need to develop my own emotional awareness in these situations.”

Rituals

There is a clear sense from the interviews that rituals for perinatal loss are haphazard and undeveloped. Rabbis and Chaplains occasionally could point to some prayers but there seemed to be little formal resources. Moreover, the resources that existed seemed dated. As one Rabbi observed “rituals should be ‘transformative’ and that [we need] ‘theological depth’ in new rituals for pregnancy loss and not just diluted versions of old rituals.” (Singh et al. 2004). Some families created their own rituals. There are rituals being individually developed but they are not being assembled, cultivated, and shared. And there are no initiatives for the development of rituals. There is a tremendous need and opportunity that needs to be met.

Communal Response

Jewish communal support needs to be strengthened. The Jewish community is blessed with several voluntary organizations that provide services for families suffering perinatal loss – I Was Supposed to have a Baby, NechamaComfort, Jewish Grief Groups, National Council of Jewish Women, Our Love Continues, Knafayim, ATime and Uprooted, among others.⁵² None of the voluntary groups that deal with perinatal loss receive substantial funding from major Jewish associations. That should be reversed and these entities need stronger support.

Moreover, the Jewish health service agencies need to make a renewed effort to creating support for families suffering these losses. Only two Jewish Service Agencies have support groups for families suffering perinatal loss.

Bringing Perinatal Loss out of the Shadows

One of the chronic problems in dealing with perinatal loss is dealing with the lack of information, stigma and shame. It is simply a problem shrouded in silence. Some of the ideas to be considered include:

Greater resources on spiritual care and rituals. As noted earlier the most recent comprehensive resource on perinatal loss is Rabbi Cardin's book from 1998. There is no single source of resources. Moreover, ritual development seems sporadic. There should be a greater effort to develop and compile resources on prayer and rituals. There should be a single curated Internet site to assemble and cultivate these resources. Individual denominations should consider cultivating these types of resources and placing them on their websites and disseminating them in other ways.

Having prayer for perinatal loss can be very valuable. Individual movements should develop their own sets of prayer resources. For example, the Anglican Church has created a set of prayer resources. "Worship Resources for Pregnancy Loss and Infertility."⁵³ Perhaps the most important time for Jewish families to memorialize is the Yizkor prayer done 4 times a year. Until recently there was no Yizkor prayer for stillbirths or miscarriages and the prayers are not part of formal prayer books.⁵⁴ Each movement should focus on the development of additional liturgy to provide an opportunity to mourn these losses.

⁵² See National Jewish Healing Conference, Resources for Perinatal Loss, <https://jewish-healing-center.org/perinatal-loss/>.

⁵³ <https://worship.edu/resources/articles/worship-resources-pregnancy-loss-and-infertility>

⁵⁴ For examples, see National Jewish Healing Conference, Resources for Perinatal Loss, <https://jewish-healing-center.org/perinatal-loss/>.

Religious leaders can help bring light and dialogue on these losses. As one Reform Rabbi observed after her miscarriage:

“On the eve of every Sabbath at my synagogue, we read a list of the names of the members of our communal family who are not well, and then we say a blessing for only those suffering from socially acceptable afflictions are mentioned, by our mutual consent. In the last few years, it has occurred to me that the list is a well-meaning sham... Those with broken covenants, troubled children and empty wombs are not mentioned.”

Clergy can play a critical role in bringing these losses out of the shadows. Some Rabbis, like Rabbi Perolman, have authored articles about their losses and those Rabbis reported that these articles enabled families to feel comfortable enough to open up about their losses. Another example is a blog created by Cantor Hinda Labovitz to remember her son Ronen.⁵⁵ Cantor Labovitz has reported that the blog has encouraged families to open up and speak about their losses.

Having a memorial place for perinatal losses can also normalize and enable people to voice their losses. For example, in the past few years several cemeteries have established places with a monument for perinatal and infant losses. This gives these families an opportunity to mourn and reflect, even if the remains are not buried there. And some synagogues like Ohr Kodesh Congregation in Chevy Chase, Maryland created a specific place of reflection outside the synagogue that has enabled many families to have a place of mourning. It also creates a sign of normalization, that these losses are part of the community.

Sinai Memorial Garden Chevra Kadisha (funeral home and cemetery) in the Bay Area created a memory Garden for remembering perinatal and infant losses. It was created by two women who suffered perinatal losses, Abby Porth and Debbie Findling. It is a single space for families to come together to remember. As the Garden’s Communication Director observed “[having a place like this changes the echoing silence that so many people have carried—across generations—after the loss of a pregnancy, a child, or the family they hoped to raise.](#)”⁵⁶

Synagogues can create the opportunities to mourn these losses, such as a special program or a day of learning to discuss birthing issues. Synagogues could also have a day of remembrance similar to the “Pregnancy and Infant Remembrance

⁵⁵ Ronen’s Torah, see <https://www.ronenstorah.net/>.

⁵⁶ <https://sinaimemorial.org/educational-resources/history-of-the-memory-garden/>

Day” observed annually on October 15. The goal would be to remove perinatal loss from the prison of silence.

Synagogues can also create their own perinatal loss support systems. A good model of this is Congregation Beth Elohim’s Pregnancy Loss Support Group which offers those who have experienced pregnancy loss a chance to find connection and healing in community.⁵⁷ They hold an annual Pregnancy Loss Shabbat to provide community members an opportunity to reflect on and honor their lost children. An interesting aspect of the CBE program is how it draws on a good part of the community for assistance.

Conclusion

I am extraordinarily grateful to my instructors Professors Linda Golding and Stevie Douglas for all of their energetic, positive and thorough support. I am grateful to the dozens of chaplains, academics, social workers, nurses and therapists who gave me wise advice. And I am extraordinarily grateful to the families that opened their hearts and shared with me the story of the worst day of their lives and how they treasure their lost child.

We have always grappled with the heartbreak and trauma of perinatal loss. In the 75 years since my sister Carol Ann died at five days old, we have a much richer, more sensitive understanding of the emotional and psychological costs of these losses and we are beginning to come to grips with how to provide support to these families. Thanks to the scholarship of Cacciatore, Nuzum, Berry and others and their surveys of bereaved families we have begun to understand the depth of the trauma and are beginning to come up with tools to provide healing. There are dozens of voluntary organizations to provide assistance to families as they travel their grief journey and excellent training programs such as AWHONN’s for nurses.

However, perinatal loss is still shrouded in silence and discomfort. As demonstrated in the interviews families suffer isolation, shame, trauma, and spiritual doubt. Although there have been studies of the emotional suffering of these families, relatively little attention has been given to spiritual issues. And as this study demonstrates there is a clear absence of training and guidance for Chaplains for dealing with these losses.

⁵⁷ <https://cbebk.org/life-cycle-guide/pregnancy-loss/>

For Jewish families these problems can be even more severe. The Halachic guidance can lead to dismissal of the family's grief and reinforce disenfranchisement and ambiguous loss. There is a clear lack of resources and support systems for these families. And Jewish institutions need to find ways of embracing these losses.

In doing this project I hope I am guided by the courage and empathy of my parents. When they lost Carol Ann, the "appropriate" action would have been to just bury her, to forget her, to just move on. But they chose to remember her by placing a tombstone, an everlasting reminder of her short life. And they never forgot the anniversary of her loss. They also struggled with being able to talk about their trauma and suffering and I am sad they could not share that and I could not be a source of support. It was a loss covered by silence. I hope their example will guide me to be a source of compassion and empathy for the families I deal with who suffer these losses. And I hope this paper is a catalyst for greater dialogue, more compassionate care, and greater understanding of the pain of perinatal loss.

In memory of my beloved sister, Carol Ann Balto and my beloved mother, Sharon Lee Balto.



David Balto
Statement of Interest
Chaplaincy Research Summer Institute (2026)

Re: Continued Research on Spiritual Care and Perinatal Loss

I am a hospital chaplain with a longstanding interest and involvement in perinatal loss. **A good deal of my work focuses on the NICU and I regularly participate in care for these families. I am also the Chair of the Hospital Committee of**

Neshama: Association of Jewish Chaplains which includes chaplains from over 80 hospitals.

I recently graduated from the Jewish Theological Seminary with a Masters in their inaugural program in spiritual care and counseling. My Masters paper (Capstone project) is on spiritual care and perinatal loss. As part of my study I interviewed over 20 chaplains and families who suffered perinatal loss. (The entire scope of the study including courses taken and interviews is described on pp 6-9 of the study). My goal was to give voice to the families that have suffered these losses and guide chaplains on how to deliver the most compassionate spiritual care.

My assessment based on my interviews of chaplains, literature review and conversations with over a dozen spiritual care experts is that there is very little written on spiritual care and perinatal loss and my work is unique in bringing together the voices of families and chaplains in a single study.

My paper is 61 pages and I have a bibliography of over 10 pages. I recognize that the paper is only a first step. The class on the paper did not address disciplined research methods. The instructors although very skilled chaplains, had modest expertise in research. Most of the guidance I received was from other researchers in the field.

I am deeply committed to this work. (My commitment is described on pp. 12-14). Three years ago through my organization “The National Jewish Healing Conference”⁵⁸ sponsored a three-part program on Jewish approaches to perinatal loss -- The First Jewish Perinatal Loss Summit.⁵⁹ That Conference regularly assembles resources on perinatal loss. In addition I am deeply committed to the task of providing comfort to these families in my hospital (the largest birthing hospital in Maryland).

I have three goals if I am accepting into the program:

- Transform my paper into at least two publishable articles on spiritual care and perinatal loss, one focusing on the Jewish community;**

⁵⁸ The “National Bikur Cholim Conference” was part of the National Center for Jewish Healing that no longer exists. I took over the conference in 2020 and have run it as an annual virtual conference. It is now known as the National Jewish Healing Conference.

⁵⁹ The Conference and supporting materials can be found at <https://jewish-healing-center.org/perinatal-loss/>.

- **Strengthening my research by understanding the tools to use for sophisticated research;**
- **Deepening the scope of my research to fully understand the field of perinatal loss, integrated more psychological and social analysis.**
- **Preparing an education framework for CPE educators.**