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“The Box” and the Dark Night of the Soul: An Auto-ethnography from the Force of Circumstances from Losing a Child in the Delivery Room

According to the March of Dimes, about forty percent of all pregnancies end as miscarriages. In Texas, the infant mortality rate is higher than the national average with Tarrant County leading with seven deaths out of every one thousand births. The infant mortality rate is often used to measure a nation’s well-being. The CIA has reported that the United States falls at one hundred and sixty-nine out of two hundred and twenty-four with an infant mortality rate of 6.17 per 1,000 births. Monaco was two hundred and twenty-four with only 1.81 deaths per 1,000 births. Afghanistan has a 117.23 infant mortality rate making it the highest rated nation in 2014. These rates and losses are not only numbers but are representative of babies who have died. Implicitly, they also represent parents who have experienced this loss, often in a hospital’s labor and delivery. Hospitals have ethical responsibilities to parents who have lost children in delivery rooms, and those responsibilities are best expressed in gestures of compassion.

To understand the impact of the death of a child, one simply has to recall the names of Tullia, Adeodatus, and Nathanael. In his *Tusculan Disputations*, Cicero (1927) made the case that the true Stoic is one who is able to control his emotions and admits that grief is of no benefit. Nonetheless, Cicero became distraught over his daughter Tullia’s death and admitted that he was inconsolable, to the point that his writing was “interrupted by fits of weeping, against which I struggle as best as I can. But so far it is an unequal fight” (Cicero, 1993: 9 March) Similarly, Augustine thought highly of his “Gift from God,” the literal meaning of Adeodatus, his son’s name. When recounting the major events in his life such as his baptism and the death of his mother Monica, Augustine reflected that it was Adeodatus who had been by his side. At the age of seventeen, Adeodatus suddenly died, and Augustine tried to console himself with the thoughts of Adeodatus’s conversion, but he was moved to many tears (Augustine, 1961). On November 1, 1829, Schleiermacher delivered a sermon at the grave of his son Nathanael. Schleiermacher acknowledged the difficulty of making sense of God’s love in light of the traumatic events that human beings face (Blackwell, 1977) In spite of being aware of God’s presence, Schleiermacher recalled, “Many a heavy cloud has passed over my life, yet what has come from without, faith has surmounted, and what from within, love has recompensed. But now, this one blow, the first of its kind, has shaken my life to its roots” (Blackwell, 1977: 73) In all three examples, we see men, regardless of their philosophical and religious views, overcome with grief at the loss of a child. Even so, the grief of these losses and countless others remains conspicuously absent from most academic work.

That scholars have given little attention to this element of these thinkers’ personal lives reflects two presuppositions about knowing that I seek to challenge: first, academia has promoted the image of the dispassionate and rational scholar whose unbiased use of reason leads him or her to the truth of a particular subject. But Hans-Georg Gadamer and others have offered powerful critiques of this position: for example, Gadamer argues “A person who has no horizon does not see far enough and hence overvalues what is nearest to him” (Gadamer, 2006). He and others would argue that such a diminished or restricted horizon, when coupled with absolute faith in the power of reason, can become a barrier to more fully understanding the role that experience and emotions play in our investigations of the myriad things of the world. My intention, then, is to expand the *horizon* of healthcare professionals who care for the parents who have lost a child. This article thus challenges the discourse of scholar as inquiring subject that has been imposed on us from now antiquated and deeply flawed views of academic work.

The second and related presupposition that I wish to challenge is internal: that is, the reluctance of academics to write from a personal perspective, even though many recognize the influence that one's identity, experience, and ethical framework exert upon scholarship. Expanding on his earlier "hermeneutics of suspicion," Paul Ricoeur elaborates on the scholar's role in the production of knowledge and writing: "it is the experimenter who defines the conditions of the test and who validates the reality status of the fact to be attested to" (Ricoeur, 2004). In this and many other ways, scholars are clearly involved in the construction of knowledge; even so, these presuppositions and a discourse of the dispassionate scholar reflect a form of coercive power that can be wielded to exclude other discourses; particularly, in this case, one that creates a valid space in which the interplay I have outlined just above is a legitimate form of knowledge production (Foucault, 1980). Recognizing the power relations at play in the production of research and knowledge, some scholars advocate the explicit inclusion of the self in all research: "*Als Methode verbindet die Autoethnografie Merkmale der Autobiografie und Ethnografie*" (As a method, auto-ethnography brings together characteristics of autobiography and ethnography) (Ellis, 2010: 346). By combining autobiography and ethnography, Ellis and other scholars bring together the analysis of cultural and personal experiences in research resulting in "*sowohl eine Methode/einen Prozess als auch ein Produkt*" (As a method, ethnography is both a process and a product) (Ellis, 2010: 345).

In addition to being such an auto-ethnography, this article also highlights a "*sachzwang*," or "force of circumstances," that is the death of a child. As a "dark night of the soul," this death, phenomenologically, is what Heidegger refers to as "*geworfenheit*" in its fullest sense, because of its "thrownness" into the possibility of death (Heidegger, 1962). In the possibility of death, *Angst* arises, not out of an identifiable fear, but because it "is completely indefinite" (1962: 186). But, being indefinite does not exclude its "factuality." "*Angst* 'does not know' what it is about which it is anxious." Yet, the angst is real because it is, in Heidegger's terms, "real Angst," that is to say it is not derived from fear. Instead, it is real, and it is indefinite. Angst "is so near that it is oppressive and stifles one's breath-and yet it is nowhere." The elusiveness of this existential fact demands the language of the "dark night of the soul." This piece, then, is an *autoethnografie aus sachzwang* (auto-ethnography that comes from the force of circumstances) and is a philosophical and ethical reflection on the existential dilemma of losing a child. Hospitals have ethical responsibilities to parents who have lost children in delivery rooms, and those responsibilities are best expressed in gestures of compassion.

The shape of this article is primarily hermeneutical because it is interpretive of a parent's traumatic experience of losing a child. The hermeneutic I have in mind owes its basis to Foucault's texts, *Madness and Civilization* and *Mental Illness and Psychology*: it is a form of investigation that considers the extremes of human experience (Foucault, 1973). Here, it is a hermeneutic of self-reflection as one experiences the tragic. These individuals of whom we will speak are the mad in comparison to the sane, who are the norm (Foucault, 1987). The mad do not measure up to the sane; they are truly "other" because they are not bound by social constraints or social truth. Instead, they have tragic truth in which there is no "Truth." To the mad, this is the "dark night of truth," of "no truth to Truth" (Caputo, 1993: 233, 238).

Foucault's "dark night of truth," is similar to the mystical idea of the "dark night of the soul," found within St. John of the Cross's *The Dark Night of the Soul* (Thompson, 2003). St. John's dark night is a moment of purgation of one's sins and an illumination of the kindness and graciousness of God. In spite of his focus on the grace of God that sinners experience, St. John understood the profundity of the experience of being abandoned and being without hope. The

depth of this abandonment is complete darkness. There is no avoiding the abyss or the dark night of the soul. Many travelers seek to rush through to grace and peace and want to forget and not discuss the dark night. We prefer to remain in the light of day because of our unfamiliarity with darkness. In darkness we are uncertain of what we may encounter. Walking in darkness requires blind faith. We are cautious with each step. Omnipresent, darkness pervades our realities, whether the darkness we experience when the lights go out or the metaphorical darkness that can cover our being/souls. But it is ludicrous to attempt to avoid darkness; it is everywhere. The early mystics chose to embrace the dark night rather than avoid the pain.

Just as Foucault's mad incorporates individuals that society has cast away, so too the traveler along the dark night of the soul is reflective of who we are as individuals and as a society. The sane must learn to listen to the mad who speak in the extremes. Similarly, contemporary audiences, and for the purposes of this article, hospital administrators and health care workers, must learn to listen to the rumblings of those who have traveled through the dark night of the soul. The "dark night of truth" is a reflection on the fact that there is "no truth to truth," so also the traveler who has gone through the dark night is unable to speak in absolutes. Instead, the communication is a reflection, a rumination, in the Nietzschean sense. On one hand, it would be easier to write in a simplistic and rational style by focusing on theories reflecting on ethical practices such as compassion. On the other hand, I could have written a case study that focused on the events of losing a child in the delivery room. Like a purely theoretical approach, a case study is too anesthetized to reflect the human condition. Instead, I have tried to walk a fine line between theory and praxis by engaging in what Aristotle refers to as *phronesis* – practical reasoning/thought. I have chosen to focus on the messiness of the traumatic experience of losing a child. Some will view this article as a reflective consideration of a human experience because they would rather have a dispassionate approach to an ethical dilemma. Instead, I have resisted the schizophrenic approach of academia by focusing on the total personality, which involves the ability of thinking through an experience and reaching an in-depth understanding without having another point out what should be obvious. In *On the Genealogy of Morals*, Nietzsche complains that modern human beings have lost the art of reading due to their unwillingness to take the time to ponder and re-ponder the readings and consider the meanings of the symbols that are present (Nietzsche, 1967). Modern men and women prefer clarity over ambiguity, avoiding that which requires deep, nuanced thought. We want simplicity in the form of clear-cut binaries: self and other, sane and mad, and so on. Yet, the dark night offers everything besides simplicity.

The following article reflects on my own journey, as a father and an academic, into the dark night of the soul. I do not claim to be sane, but rather mad because I write of the tragic night. Some will question the need for such an essay as mine because it would be easier to simply push this experience into the deep recesses of my memory. But I write as a fellow companion to those fathers and academics who have lost a child in the delivery room and have thus have begun to travel into the dark night. My tragic experience, and thus my dark night, came on November 10, 2009 when both Alexander and Amelia were born, only to die less than an hour later. I held them tight until they quit moving.

When a pregnancy has been confirmed, most parents will make plans to enjoy the pregnancy, birth, and care of the child. These plans include choosing the right hospital with the most suitable labor and delivery rooms, facilities, staff, administrators, and support facilities, especially rooms that will provide the perfect ambiance for a newborn child. Both father and mother will envision how the room will be decorated with "Congratulations!" and either "It's a

Boy!,” or “It’s a Girl!” balloons. Music will often be part of the planning. Some couples will choose classical music, others instrumental, while still others will opt for more popular music, such as Adele, Beyoncé, Prince, Michael Jackson, and so on. Recognizing the benefits of music, hospital staff and administrators are more than willing to accommodate the couple’s musical choice by providing the electronic devices and speakers that will allow for the mood to take shape.

Aware that parents are shopping for the perfect facility in which to bring forth their child, hospital staff and administrators set out to market their facilities, personnel, resources, and accomplishments in order to attract these expectant parents. For instance, Loyola University Medical Center in Chicago tells all new parents that it has been recognized for the smallest premature surviving baby: Rumaisa Rahman was born in September 2004, after only 25 weeks of gestation. The previous record was Madeline Mann who was born at twenty-six weeks, also at Loyola University Medical Center. In their concerted efforts to lure expectant couples, hospitals will often provide tours of the facilities including the labor and delivery rooms so that the consumers can make informed decisions about where they will welcome the new child into their home.

The courtship between hospital administrators, staff and parents often continues up to the day when the mother goes into labor. The trust that couples have in the particular facility and personnel is formalized by the signing of the financial responsibility forms. These forms contain the promise that couples make to pay for the services rendered. In return, hospital administrators and staff accept the couple’s trust, both explicitly and implicitly, by assuring that the needed medical care will be provided. Under normal circumstances, the above scenario would be unproblematic. However, we must recall that the 7.0 infant mortality rate of Tarrant County is not just a statistic; rather, it represents real babies who were born prematurely, were still-born, or were miscarried.

Parents begin to enjoy the baby as it forms in the womb and dream about its arrival and experience him or her as a presence in their lives. The baby’s untimely death at the hospital shatters these dreams. These dreams are often demolished in the place where they were to be born. Parents who lose a baby in this way seemingly leave the hospital just like all other parents. But they do not. They will, like the others, make arrangements to have a car pull up to the front of the facility. They will make phone calls that they will soon be returning home. Like most parents leaving the hospital, these couples will take the long walk from the delivery room to the front of the hospital. Unlike all others, however, they will get into their vehicles with an empty car seat in the back seat. Unlike the others, these couples will have no nurse who will come to them to make certain they know how to properly adjust and strap a car seat around the newborn babies. Instead, the nurse will give them a Box to take home.

Along with the empty car seat, this Box will be a continual slap in the face of the dreams that will never be. Most couples who have lost a child in the delivery room are fully aware of the contents of “The Box.” Those who do not know the contents are more than blessed because they have been spared a plethora of emotions that run the gamut of the emotional scale. “The Box” contains the memory of memories that will never be. It is the constant reminder of unplanned birthday parties, unscheduled PTA meetings, and unchanged diapers. While most couples will have a series of hand prints and foot prints stamped on their walls, couples who have left their babies at the hospital will not enjoy comparing various hand prints that increase in size as the children grow. They do not have foot prints that reflect the skipping of little feet down the hall or in the kitchen. Instead, they have a Box with hand prints that will never increase in size. The

foot prints in the Box will never reflect little feet that run across the house or whose toes curl up with the cool sensation of a freshly cut lawn. Similarly, other couples will make various markings in their homes that reflect the growth spurts of their children. Couples who receive “The Box” will have a tape that took the final and only measurements of their dead baby. “The Box” will be the constant reminder of the child who was and who ceased to be. Only parents who have been to the hospital and left a child behind with no hopes of ever taking her home will receive this box. “The Box” may clink and clatter in the empty car seat as parents make the long road trip to a quiet home.

An amazing aspect of this all-too-common scenario is the apparently unreflective and unemotional nature of hospital administrators and nurses as they hand over “The Box” of shattered memories. Many hospitals have coordinated follow-up meetings with parents of newly born babies, either at their homes or at a clinic. Yet they have failed to provide any type of significant follow up with parents who have lost their babies. Once these couples leave the hospital, there often is no follow up. Nurses will not call to ask parents if they have questions. They will not inquire into the emotional stability of the mother, nor will they consider the psychological well-being of the father. We are simply not taught to deal with loss, with failure, with death. It is as though administrators have washed their hands clean of any responsibility. However, my argument is that hospitals have an ethical obligation to couples who have lost a child. I want to suggest three gestures of compassion that health-care workers could exercise.

GESTURES OF COMPASSION

Encompassing Care

Hospital administrators have an ethical responsibility because they have chosen to be agents within institutions of life. It would be absurd to think that expectant parents choose hospital delivery rooms as places where they want their children to die. Institutions are usually chosen because people seek healing. They want to feel better. They want someone to care for them by removing what ails them or at least make it easier to live with the ailment. Individuals turn to hospitals because they are filled with people who have knowledge and compassion – indeed, the desire to remove the suffering of others informs the call of compassion, whether understood as a religious or humanistic calling. That is, healthcare professionals are healers and, as such, have the responsibility of providing optimal services that ensure the well-being of the patient. Oftentimes, while administrators effectively market their services to attract more consumers, they de-emphasize or even ignore compassionate action.

While the primary patient is the baby in the labor and delivery rooms, it is the parents who speak and make decisions for the child. As such, they too should be considered as being under the care of the hospital staff. Thus, in neonatal care centers, both the baby and the parents must be considered when taking on the ethical problems arising from a baby’s death (Carter, 2015). Healthcare facilities have often delegated responsibility for compassionate action to those they assume are better trained to serve the needs of the grieving. Yet hospital chaplains are ill-prepared to accomplish this task because they have been primarily trained to respond to the needs and requests of patients. Many Clinical Pastoral Education (CPE) programs are based on self-reflection; students are asked to reflect on why they are moved to assist individuals who are experiencing some form of tragedy. They are not trained to be proactive, but rather wait quietly and comfortably for families to ask for prayers and religious insight. In short, they are trained to consider who they are as spiritual caregivers and to be present to others. According to the Health Care Chaplaincy Network, the training that chaplains receive “is a form of chaplain practica or internships whereby students are taught to observe, listen, communicate and more effectively

respond and attend to patient spiritual needs” (Education) Of course, this is a wonderful service that is provided in the hospital, but the problem arises when parents do not make a request for a chaplain to be present at the hospital or after they arrive home because chaplains will not initiate a call. Doctors or nurses could make a simple phone call to both parents to reflect the care and compassion that hospitals often advertise.

Embracing Life in its Fullest

Health care officials should be ethically responsible to parents who lose children because death is part of the nature of a health-care facility. The existentialists such as Heidegger are correct when they argue that one is unable to live life until the contemplation of one’s own death (Heidegger, 1962). By admitting that one has a limited time on this earth, one is forced to think in depth about the choices that one makes in life. Often, this kind of contemplation leads to anxiety and dread. Unfortunately, this component of death is often avoided, particularly in obstetrical hospital settings. It is unfortunate because as human beings we must come to terms with our own mortality. We are part of this world, but we will one day cease to be; yet the world will continue. In spite of the uncertainty of our ceasing to be, we must exercise courage because we are still here, at least for now. This uncertainty produces both anxiety/dread and courage. Yet we seek to avoid our own mortality by seeking a tranquil notion of death, which hospital personnel are more than willing to support.

While it is well hidden to incoming patients, health-care facilities are familiar with death and dying patients. We learn from a quick perusal of available data that over 400,000 patients will die within a year due to a hospital error (Hospital Safety Score). What happens to these people when they die? Where are they taken? How are they transported? Hospitals have a wonderful system that makes certain that other patients are distanced from the death that others are experiencing under the hospital’s care. It is possible that the corpse is removed while nurses are busy in the rooms with their patients to prevent exposing and frightening patients on the same floor. Many use the freight elevators to avoid the general public. The fact that patients and visitors in hospitals rarely see death raises the question whether hospital administrators believe that the general public is unwilling and unable to confront death.

Parents who are in labor and delivery are often slapped into existential turmoil with the death of their child. The angst begins with the resounding silence after the delivery. Rather than nurses and doctors calling out for suction, blankets, and scissors, during a miscarriage, the silence rings loudly. There is no screaming of the child. Doctors do not ask for suction. Nurses remain silent. Even in cases where a baby is born too early, the silence is overwhelming. Although I held Alexander in my hands until he stopped moving, or, rather, until he died, no one offered me a blanket or towel to keep him warm. When Amelia followed, there was no celebration that twins had been born. Instead, everyone waited for the moment when death came and life ceased. Whereas most babies are placed in incubators for warmth and comfort, my babies, Alexander and Amelia, were placed on a cold metallic cart that rattled as the nurse brought it into the room and placed their tiny bodies on top. In moments like these, both parents and health-care personnel would be better served to talk about the undeniable event that has taken place. It serves no good to pretend that death did not take place, or even to make it a more tranquil death by staying silent.

The worst silence was when my wife was taken away for a D&C surgery (the procedure to scrape and collect tissue from inside the uterus) shortly after delivering our twins, Alexander and Amelia. I was informed that the surgery would take about an hour. While I was waiting for my wife to return, I found myself sitting in front of the cart with the babies still present. I must

have lived a thousand lives, experiencing the span of emotions ranging from anger to dread. Having gone into surgery, my wife was the target of my strongest emotions that included anger and frustration. I blamed her for the corpses that lay before me. I wanted them to cry. I stared at them so long that I even imagined that they had miraculously moved before my eyes. But they did not, and I could not do anything except blame my wife. Of course, I never said anything to her. I kept the anger and disappointment deep inside because as a man I had rarely been encouraged to reflect on or make sense of my emotions. An hour and a half after she left the room, a nurse and assistant brought my wife back to the room. She was still groggy when she asked, "Where are they?" She fell asleep when I responded, "They are still in the room." It was clear to me that my relationship to my wife would change. When she awoke, she wanted to see the babies. I wrapped them in a small blanket that I found on the bed. Her arms stretched out for her babies and tightly held them close to her heart. For the next ninety minutes we held the babies, gave them kisses, cried, and held each other's hand until the nurse came back into the room and asked if she could take the babies. As she walked away, I realized that I would never see them again. I could not walk down the hallway and peek through the window into the nursery to wave at my babies. Instead, the nurse returned and handed us The Box.

Health care workers should consider how they can overcome the tranquil death that serves no one. A simple acknowledgement that death has come can often serve as a fount of compassion. Also, simple gestures such as wrapping the dying child in a warm blanket will make it easier to cope with the pain of losing a family. Similarly, it is especially important to get rid of that damn cold metallic cart that does nothing but take dignity away from the child who has died. While the child may have not reached viability because of early birth, miscarriage, or stillbirth, he or she was still the child of a couple who had dreams of walking out of the hospital with a newborn. Hospital administrators would do well to revisit their policies that determine their actions when a child has died in labor and delivery.

Maintaining Community

Finally, during the process of registering at the hospital, couples believe that the family unit will be entering the facility and will be leaving with a new member. The family is celebrated. Administrators, staff, nurses, and doctors congratulate the couple for being pregnant and being about to give birth. Often, this attention is turned to the father who is acknowledged as someone who is very lucky to have a family. The problem is that couples who have experienced the death of a child will often end up getting divorced. According to Gold, Sen, and Hayward, couples who have a miscarriage are 22 percent more likely to break up, and the rate rises to 40 percent in cases of a stillbirth (Gold, 2010). It is difficult enough to stay married for a prolonged period under normal circumstance, but it becomes much more so when faced with the death of one's child. In light of the potential ending of a marriage following the death of a child, health-care facilities can contribute unintentionally to these break ups by erecting a façade of the family unit that includes a couple who leaves labor and delivery with a child. For couples who walk out of the hospital with that dreaded "Box," they are confronted with the misguided notion of what it means to be a childless family after going into the hospital with a baby. Without their baby in their arms, many feel like they have failed in achieving the dream of being a family. As such, the stress is too much for many. And, health-care professionals may contribute to the façade that frequently ends in divorce.

A health-care facility should celebrate the birth of a child. There should be celebrations of joy. Smiling faces and congratulations should be numerous. But health-care personnel should be aware that some couples that walk in pregnant will walk out with just a Box filled with death.

Likewise, they should realize that this event will pull at the bonds that bind a couple. Often, these knots break. Administrators, nurses, physicians, and staff must continually remind themselves that while they are a business, it is one that has promised to care for its clients. Couples who have lost their children are most in need of healing.

As stated at the beginning, this essay is an autho-ethnography in that it has combined both autobiographical and ethnographical methodologies to inquire into the trauma that a father experiences when he loses a child, as well as the ethical responsibilities that health-care workers have to these parents. I have used the framework of the dark night of the soul to frame the traumatic experience of a father who has lost a child who was born too early. This essay counters the common practice of the dispassionate academic by using academic rigor to reflect on a very personal and traumatic experience. The goal of this essay is to highlight the ethical responsibilities that hospitals and health-care workers have to parents who have lost children in delivery rooms. I have outlined these responsibilities in terms of gestures of compassion that counter the insensitive and often thoughtless gesture of handing parents a box that contains the painful memories of dreams that will never be realized.

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