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An Introduction to the Special Section on Psychotherapy for Pregnancy Loss: Review of Issues, Clinical Applications, and Future Research Direction

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This introduction article to the special section on psychotherapy for pregnancy loss reviews important societal and psychological issues, key clinical processes and recommendations, and future research directions. Differences and similarities among the articles in the special section are discussed along with each article's contribution to the higher order goal of viewing pregnancy loss through a psychological rather than solely medical lens. Each article in this section reviews different therapeutic modalities, interventions, and key clinical process issues when working with patients who have suffered the loss of a pregnancy. The important role that psychotherapy can play in helping parents to mourn the loss of a pregnancy is explored in this introductory article and throughout the special section.

Keywords: reproductive loss, disenfranchised grief, miscarriage, perinatal grief, psychotherapy for pregnancy loss

Grief must be witnessed to be healed.

—Elisabeth Kübler-Ross

Elisabeth Kübler-Ross, Beyonce′ Knowles, Barbara Bush, Audrey Hepburn, Oprah Winfrey, Marilyn Monroe, Jacqueline Kennedy Onassis, Barbara Walters, and Mary Tyler Moore are among the approximately 1 in 10 women said to have suffered a miscarriage. Despite the odds, no parent ever enters into a pregnancy prepared for a loss. Expecting the birth of a healthy child, when instead a pregnancy is lost, life is eclipsed by death in a way parents never before thought conceivable. *Pregnancy loss* is an umbrella term for the death of a conceptus, fetus, or neonate before the 21st day of life and affects a substantial amount of women and their partners. It has been estimated that 20 to 50% of all pregnancies end in miscarriage, or the loss of a pregnancy before 20 weeks gestation. Moreover, about 1–2 out of every 100 births in industrialized countries are stillbirths, or the death of a fetus after the 20th week of gestation and before birth (see Diamond & Diamond [2016] for a review of various estimates). Lastly, it is estimated that >3% of all pregnancies in the developed world have significant abnormalities, of which 58% to 93% are terminated due to a fetal anomaly (Coleman, 2015). Although pregnancy loss is a relatively common event, it is too often only seen under the celebrity spotlight, whereas the experiences of most grieving parents are left largely in the dark.

Perinatal grief, or a parent's emotional reaction following a pregnancy loss, has been likened to Doka's (1989) concept of *disenfranchised grief*, which is used to describe an experience of loss not openly acknowledged, publically mourned, or socially supported. In Western society, pregnancy loss is not typically viewed as a legitimate type of loss and expressing feelings of perinatal grief is considered taboo (Layne, 2003; Markin, in press). The absence of culturally defined and accepted mourning rituals for the loss of a pregnancy leaves parents feeling as if they have been cheated out of their right to mourn (Lang et al., 2011; Layne, 2003). Parents are then forced to mourn within a culture of denial and intellectualization that discourages them from grieving (Frost & Condon, 1996). Well-meaning family and friends attempt to console grieving parents with such clichés as, *It wasn't meant to be*, *just think positive*, or *you just need to relax*. Such comments, however, minimize or deny parents their experience of grief. The ability to mourn and psychologically adjust following a pregnancy loss is thus complicated by the fact that others do not recognize this loss as legitimate, and, rather, tend to dismiss or minimize feelings of grief (Markin, in press). In contrast, psychotherapy can play a critical role in helping the many parents who experience a pregnancy loss to mourn and move-on, through acknowledging the loss as real and validating feelings of grief and loss (Markin, in press). Although each paper in this section addresses a different aspect of psychotherapy for pregnancy loss, they all work toward the higher order goal of illuminating the all-too-often ignored mental experience of grieving parents.

The Mental Experience of Grieving Parents: How the Head Got Detached From the Body

My 6-year-old daughter recently drew a picture of what looked like a head with an odd-looking brain. When I asked her to tell me about her picture, she explained that the head belonged to a pregnant mother and what looked like a malformed brain was actually the mother's baby growing inside her. As an older sister, she is of course aware of where babies physically mature in the mother's body. Yet, to my 6-year-old, this is where babies come to life—inside the mother's mind—where imagination and fantasy

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give birth to a real person (see Slade, Patterson, & Miller, 2007). Quite strikingly, this lies in contrast to how the modern industrialized world views the experience of pregnancy and by extension the experience of pregnancy loss—not as a psychological, mental, and emotional process but as a medical event.

Take for example the work of Dr. William Hunter, one of the most famous obstetricians in all of Europe in the 18th century—the period of time during which pregnancy and pregnancy loss moved out of the everyday public life and into hospitals and medical practices. Dr. Hunter's famous illustrations of the "human gravid uterus" depict a pregnant woman as nothing more than an extended belly and torso; her neck and head are literally severed from her body (National Institute of Health, 2016). Historically, as pregnancy and pregnancy loss became medicalized, society started to view these phenomena as medical and scientific events, divorced from the parent's mental and psychological experience (Côté-Arsenault & Brody, 2009). In particular, we forgot about the mind of the expecting mother and focused solely on her body (Raphael-Leff, 1982). One implication of viewing pregnancy as a purely biological rather than psychological experience is that, when a pregnancy is lost, others cannot possibly comprehend the meaning of the loss to the parent. For instance, despite research suggesting that pregnant women often develop rich mental representations of the unborn baby and attach relatively early on in the pregnancy, miscarriage is typically treated as a nonevent (Frost & Condon, 1996; Hutti, 1992). This cultural phenomenon may partially explain the lack of psychotherapy research and clinical guidelines on pregnancy loss, as it is viewed as largely belonging in the medical rather than the psychological arena.

Although the outside world typically pays little attention to the psychological experience of pregnancy loss, grieving parents are internally often contending with a myriad of intense emotions, thoughts, and experiences. Numerous studies have documented the devastating effects of pregnancy loss on parents, particularly on the mother, including chronic and severe grief that may extend for years, beyond the birth of a healthy baby, and does not follow the typical linear decline found with other types of grief, as well as symptoms of depression, anxiety, and trauma. Furthermore, after a pregnancy loss, women tend to report feelings of guilt, self-blame, a yearning for the lost baby, low self-esteem, and an increase in suicidal thoughts and obsessive–compulsive symptoms. Women have lost faith in their bodies, in the world as a fair and predictable place, and in others as a source of support and comfort. Additionally, some studies have documented the negative effects that a pregnancy loss may have on certain subsequent pregnancies, including heightened pregnancy-related anxiety, or the constant fear of another loss, prenatal depression, and prenatal attachment difficulties, all of which may extend to the post-partum period and impact the new mother's adjustment in this critical period and the mother–infant attachment relationship (see Diamond & Diamond [2016] for a review on the effects of pregnancy loss). In sum, despite the fact that studies have documented the distressing effects of pregnancy loss on parents and the relatively high rate of occurrence, research and specific clinical guidelines on psychotherapy for this population are surprisingly lacking,[1] perhaps partly because as a society we tend to see pregnancy and pregnancy loss from the neck down.

The Need for This Special Section: Putting the Head Back on the Body

Following this, the idea for this special section was born from the pressing need for more clinical and empirical literature on psychotherapy for patients grieving the loss of a pregnancy. Because pregnancy loss impacts so many women and their partners and has the potential for severe psychological consequences, and because society generally does not support grieving parents through the process of mourning, we clearly need more research on psychotherapy for this population. The few psychotherapy studies that do exist for pregnancy loss tend to involve only one or a few sessions, are crisis-oriented, address symptoms of depression and anxiety rather than feelings of grief and loss, and suffer from severe methodological flaws, such as small sample sizes, lack of standardized measures, and the absence of control groups (Wright, 2011; Zeanah, Danis, Hirshberg, & Dietz, 1995). Relatedly, there are to date no known studies on therapy for pregnant women with a history of pregnancy loss, for whom studies show are at increased risk for pregnancy-specific anxiety, depression, and prenatal attachment difficulties (Cote-Arsenault & Donato, 2011; Lin & Lasker, 1996; Zeanah, 1989). Lastly, studies yield conflicting findings regarding whether a history of pregnancy loss predicts mother–infant attachment problems with a subsequent child, from the prenatal to the postpartum period (see Al-Maharma, Abujaradeh, Mahmoud, & Jarrad [2016]; Diamond & Diamond [2016] for a review). We lack research identifying which parents with a history of loss are at increased risk for attachment difficulties with a subsequent baby, and thus could potentially benefit the most from psychotherapy, and on corresponding attachment-based psychotherapy interventions to help these parents facilitate the grieving process on one hand and the attachment process on the other (O'Leary, 2004). Big picture, increasing clinical and empirical attention to psychotherapy for pregnancy loss issues represents a fundamental paradigm shift, wherein we focus more on the mother's mind or psychological experience and less on her body or physical experience of loss.

The lack of empirical research and clinical guidelines on psychotherapy for pregnancy loss is problematic for several reasons. First, studies suggest that 15% to 25% of women who experience a pregnancy loss have enduring adjustment problems and may seek professional help to support them during this challenging period (Hughes, Turton, Hopper, & Evans, 2002; Klier, Geller, & Neugebauer, 2000). Similarly, some studies suggest that up to 30% of pregnancy losses are followed by significant emotional reactions (Zeanah et al., 1995). Estimates suggest that about 10% of the time these significant emotional reactions are diagnosable disorders, including acute stress disorder, PTSD, other anxiety disorders, depressive disorders, or substance abuse (Janssen, Cuisinier, Hoogduin, & de Graauw, 1996). Second, pregnancy loss is likely to become an even more pressing clinical problem in the future because of the increasing use of fertility treatments and medical technology that allow for early diagnosis of a lethal fetal anomaly (Bennett, Litz, Lee, & Maguen, 2005). As reproductive technology continues to

[1] In relatively recent years the field of nursing has amassed a body of research and clinical guidelines for pregnancy loss. Within the field of psychotherapy, clinical guidelines have begun to emerge for psychotherapy and pregnancy loss (Covington, 2015).

advance, women feel more in control of their bodies and the loss of a pregnancy is thus increasingly surprising and devastating, perhaps leading to more intense grief reactions and need for psychotherapy (Covington, 2006). Lastly, parents who experience the loss of one or more pregnancies must contend with an array of insensitive and ignorant comments that add insult to injury from family, friends, and health care providers (Lang et al., 2011). When they do muster the courage to seek professional help, it can feel devastating to experience a professional therapist as similarly (though not intentionally) unempathic and ignorant of their circumstances. From this, therapists need training, clinical guidelines, and research on how to work with pregnancy loss. Although the papers in this section focus on clinical processes, hopefully, they offer both useful guidelines for practicing psychotherapists *and* inspire future research in this area.

Goals and Aims

The ultimate goal of this special section is to raise consciousness among psychotherapists regarding the unique psychotherapy needs of patients who have suffered a pregnancy loss and to provide practical suggestions for clinical practice with this population. Although of course not all psychotherapists will work with patients coming to therapy specifically for pregnancy loss issues, statistics suggest that all therapists will eventually work with patients who have suffered a pregnancy loss. Clinical experience suggests that unless the therapist has received specific training in this area, the loss will most likely be discussed in a vague and passing manner and a significant opportunity for healing and growth will be missed (Markin, 2016). A secondary, although no less important, goal of this section is to stimulate future research that is theoretically guided and applicable to practice. Specifically, this special section aims to highlight current forms of psychotherapy for pregnancy loss and special considerations when working with these patients. Each author was instructed to discuss the psychology of pregnancy loss from his or her theoretical perspective and to detail the clinical application of one's chosen theory to practice. In each manuscript, the author(s) attended to the following question: *What are some key issues or areas of focus, discussion, or intervention that the author(s) would engage in with these patients*? Authors were instructed to provide several types of interventions, the theoretical and empirical basis for these interventions, and therapist–patient dialogue to illustrate the use of the proposed interventions.

Differences and Similarities

Although each paper in this special section differs in terms of the specific theoretical orientation from which it is written, they all share the use of some theory that provides a meaningful framework for understanding the complex mental experience of pregnancy loss, while also offering a basis for theoretically guided interventions. For instance, Wenzel (2017) describes how cognitive–behavioral theory (CBT) can be used to understand the experience of pregnancy loss and how to apply this theoretical framework to associated interventions. In particular, she discusses how three common CBT techniques—behavioral activation, cognitive restructuring, and mindfulness and acceptance—can be artfully used to help patients cope with feelings of self-criticism, depression, and anxiety following a loss, and to mitigate problematic behaviors of avoidance and social isolation. Importantly, she stresses the significance of focusing on affect, allowing for feelings of grief to emerge in the therapy hour, and the therapy relationship when delivering these techniques to grieving parents. Consistent with CBT, Wenzel (2017) argues that it is not only the event of the pregnancy loss itself that is distressing to a woman but also the profound meaning the loss often carriers, which disrupts the woman's core belief system and leads to severe emotional consequences (guilt, depression, and anxiety) that cannot be managed using her typical coping skills. In other words, it is essential for therapists to understand the highly personal meaning that the loss holds for the patient.

Jaffee (2017) uses a reproductive story framework to conceptualize and treat patients experiencing infertility and pregnancy loss. Patients with reproductive challenges are often forced to grieve not only the loss of one or more pregnancies but also the loss of the dream of how one would have a baby and become a parent (Jaffee, 2017). In essence, Jaffee (2017) argues, these patients have lost their *reproductive story* (Jaffee & Diamond, 2011)—the conscious and unconscious narrative of how one will become a parent, what one's children will be like, and what one will be like as a parent. From this, Jaffee (2017) offers suggestions on interventions to: help patients grieve the loss of one or more pregnancies as well as the loss of their reproductive story as it was "supposed" to unfold, feel less responsible for how their stories went awry, and to write a new and more positive ending to their reproductive story. Furthermore, Jaffee (2017) offers suggestions for how to help couples work through disagreements that often arise during the course of infertility and pregnancy loss, as couples struggle to make major revisions to their reproductive story. Such recommendations for couples are essential, as several studies suggest that pregnancy loss and infertility can lead to marital dissatisfaction and conflict (see Diamond & Diamond [2016] for a review). In sum, it is important for therapists to understand that parents grieving the loss of one or more pregnancies after infertility are grieving the loss of a highly personal story of how one's life and journey to parenthood was supposed to go—a story written over a life time and imprinted into one's core sense of self.

From a continued bond/attachment theory perspective, O'Leary (2004) explores therapeutic interventions for parents pregnant after loss within a group setting. Therapeutic educational interventions are discussed to support the parent's continued bond to the deceased baby while also risking attachment to the new baby. Through clinical vignettes, the author illustrates how the group format can be used to promote a sense of universality, decreasing feelings of alienation and shame, and to help patients advocate for themselves within the health care system. The primary focus of the interventions discussed here are on facilitating and validating parents' attachment to the deceased baby as separate from the growing attachment to the current unborn child, viewing these babies as siblings not replacements. Attachment interventions such as these are badly needed, as research suggests that pregnancies after loss are at risk for prenatal attachment disturbances, as the mother may forestall attachment as a self-protective mechanism against the threat of another loss (Côté-Arsenault & Donato, 2011).

Although many people assume that parenthood after loss is an idyllic time period for parents, as they have "achieved" an often long sought-after goal, research and clinical practice suggest that

this is often not the case (see Diamond & Diamond [2016] for a review). Diamond and Diamond (2017) review relevant theory and research pertinent to parenting after pregnancy loss and pay special attention to the potential impact of reproductive trauma on the attachment relationship with the subsequent child. In particular, as consistent with the theory of self-psychology and more broadly a relational psychodynamic approach, these authors focus on the narcissistic wounds that reproductive losses often inflict on parents, which trigger feelings of shame and inadequacy of one's very personhood. As Diamond and Diamond (2017) discuss, if not addressed, these wounds, and the shame they engender, can impact a parent's way of being with his or her future children and jeopardize the growing attachment relationship. They delineate three interventions, aimed both at healing the parents themselves and at protecting attachment relationships with subsequent children: (a) initially staying present-focused and engaging with the painful details of the loss experience; (b) eliciting the reproductive story to identify and integrate past losses, and in its revision, to allow for hope and repair; and (c) attending to both acknowledged and denied grief. In essence, Diamond and Diamond (2017) depict the impact that pregnancy loss can have on a patient's very sense of self, the lasting wounds that this loss leaves behind, and the feelings of shame and inadequacy that may persist long after the loss has occurred.

Lastly, Leon (2017) examines key therapeutic tasks and interventions for psychotherapy with parents who have terminated a wanted pregnancy because of a fetal anomaly (or are in the process of deciding whether to terminate the pregnancy). These therapy processes and interventions are explored not from any one meta-theoretical orientation, but from the perspective that the therapeutic relationship is facilitative of therapeutic growth across theoretical orientations. Specifically, he focuses on empathy, or the therapist's empathic engagement, as the concept spans the theories of attachment, client-centered, and self-psychology, as both a primary instrument of healing and a facilitator of other therapeutic tasks and interventions. In his paper, the therapeutic tasks argued to be essential with these patients include absorbing the impact of learning about the anomaly, defining what or who has been lost, deciding whether to continue or terminate the pregnancy, and deciding who to tell what. Leon (2017) suggests that when these tasks are performed within the context of an empathic therapeutic relationship then other therapeutic goals are believed to be met, including empowerment, normalization, validation, and the processing of grief and trauma. This focus on therapist empathy is consistent with what we know about the importance of the therapy relationship to the effectiveness of treatment in general (Norcross, 2011). An empathic therapeutic relationship is arguably essential to effective psychotherapy with all patients who have experienced a pregnancy loss, as they typically come to therapy feeling misunderstood, alone, unsupported, criticized, and often stigmatized.

Future Research Directions

Future research on psychotherapy for pregnancy loss should address—

- The effectiveness of different types of treatment in terms of theoretical orientation and treatment modality (individual, couples, and group), particularly to ameliorate unresolved grief and not just the associated symptoms of depression and anxiety. These studies should examine not only the reduction of something that feels "bad" (i.e., grief, anxiety, and depression) but also the increase in something that feels "good" (i.e., constructing a sense of personal meaning and purpose from the tragedy of loss, forming a more coherent narrative of the loss experience, and increasing attachment to subsequent children after loss).
- Inclusion of standardized measures and control groups.
- Multiple process variables (e.g., emotional expression and coregulation, understanding and editing the reproductive story, and restructuring maladaptive thoughts and cognitions) that predict multiple outcomes (e.g., resolution or transformation of grief, change in depression or anxiety, reduction of trauma symptoms, and quality of marital relationship).
- The role the therapeutic relationship (empathy, transference/countertransference, and alliance) in the process and outcome of therapy.
- The process and outcome of psychotherapy with expecting and new parents with a history of pregnancy loss, particularly for parents at risk for attachment disturbances with children following loss.
- Variables that help to identify (a) those parents in need of supportive psychotherapy to help facilitate the grief process and postloss adjustment, and (b) those parents in need of more intensive psychotherapy following a reproductive loss.

Clinical Suggestions

Based on the articles in this section and the author's clinical experience, the following clinical suggestions are proposed:

- Emotional experiencing and expression of feelings related to grief and loss are key to a successful treatment if coregulated within the therapy dyad. Clinicians should be aware that these feelings most likely come in waves over time and do not typically show a linear decline and that these patients are mourning multiple losses, including the loss of a baby, their reproductive story, and often, close relationships with friends and family.
- Clinicians should pay careful attention to feelings of shame, inadequacy, and guilt that impede the parent's ability to mourn and damage a vulnerable sense of self.
- A strong therapeutic alliance is crucial for reproductive loss patients who are prone to feelings of shame and guilt, are in a narcissistically vulnerable state, and are accustomed to feeling dismissed or criticized by close family and friends.
- Clinicians should explore the unique meaning that the pregnancy loss carries for the individual patient and how this impacts the patient's thoughts, feelings, and behaviors.
- Clinicians should pay careful attention to trauma symptoms that may arise from reproductive loss, including psychological avoidance, intrusion, and hyperarousal. Creating an atmosphere of security and safety for the "traumatized" parent is necessary to facilitate other therapeutic tasks, such as helping the parent to weave a

coherent story of his or her reproductive losses and putting feelings to words, rather than internalizing these feelings or unknowingly externalizing or projecting them.
- Validation, psychoeducation, normalization, and empowerment are often critical interventions that facilitate the repair of self-wounds and the process of mourning.
- Because these patients typically feel unsupported during a time of great distress, past attachment experiences wherein the patient did not feel supported by significant others during times of distress, trauma, and/or loss are likely to emerge and need to be grieved.

Conclusion: Challenges and Rewards of Working With Pregnancy Loss

Psychotherapy for pregnancy loss remains a largely neglected and niche area, despite the fact that, given the relatively high rate of occurrence, most therapists will work with patients who have suffered a pregnancy loss, and despite studies revealing the devastating psychological impact on grieving parents. We can perhaps understand this reluctance, found to some degree within our field and in the larger society, to get too close to the experience of pregnancy loss as an understandable reaction to the trauma of loss. Research on mentalization, attachment, and trauma suggests that when we do not feel safe to approach the overwhelming and frightening affective experience of some trauma, then the mind goes into survival mode and effectively shuts down, focusing on concrete behaviors and observable phenomenon instead of mental experience (Fonagy, Gergely, Jurist, & Target, 2002). Given this, patients who have suffered a pregnancy loss or some reproductive trauma need to experience a safe and trusting relationship with their therapist to approach the traumatic affect associated with the loss. At the same time, psychotherapy researchers and clinicians may also need to receive adequate supervision and training to feel safe enough to empathically connect with emotions of grief and loss that can feel too frightening and overwhelming to carry. In essence, it is perhaps the fear of experiences and emotions perceived to be threatening or painful that, at times, keeps us all at a safe distance from pregnancy loss issues.

In some respects, this fear has a persuasive argument, for in doing this kind of clinical work one hears a great deal of stories of trauma and loss, rich with the kind of details that many people never have to hear. Stories of mothers walking around with a dead baby inside of them, feeling like a human coffin. Stories of parents faced with the impossible decision of whether to terminate a wanted pregnancy because of a diagnosis of a fetal anomaly, and, of that mother, having decided to end the pregnancy, watching as she is injected with a chemical compound that will stop the heartbeat of a baby she would do anything to protect. Stories of mothers going through hours of labor only to give birth to a stillborn baby, as she shows you pictures of her beloved newborn and unknowingly rocks a box of tissues back and forth in her arms. Stories of women suffering repeated miscarriages and all the blood, invasive medical procedures, and terror and fear associated with their losses. These are of course terrible stories of grief, trauma, and loss, and the therapist must have the capacity to help hold the intensity of these emotions without looking away in terror or disgust. Yet, if one listens closer, these are not just stories of loss, these are also stories of love. For the depth of a parent's grief is also the heights of his or her capacity to love a child he or she never knew or will get the chance to meet. In essence, although it is true that as therapists we face a great deal of grief and trauma when working with pregnancy loss, we also get the privilege of witnessing a parent's primal and enduring attachment bonds in the most clear and raw form imaginable. To help heal the wounds of loss, we bear witness not only to the patient's grief but also to a parent's love.

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