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Helping Families Cope with Perinatal Loss

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INTRODUCTION

Perinatal loss is the outcome in approximately 1.2% of pregnancies beyond 20 weeks up until one month postpartum.[1] While 15–20% of all recognized pregnancies end in miscarriage, there may be an equally high number of subclinical early pregnancy losses that are typically experienced as a "late period" rather than as a miscarriage.[2] Ectopic pregnancies, the frequency of which increased more than threefold between 1970 and 1986, now occur in almost 2% of all pregnancies.[3] Approximately 25% of bereaved parents demonstrate significant psychological difficulties during the first two years after these losses.[4, 5] This chapter explores why pregnancy and newborn demise is such a difficult loss to endure, identifies the multiple ways it affects family members, and offers approaches to caregivers that might help deter lasting harm. While the focus of this chapter is on perinatal loss, other reproductive losses including miscarriage, ectopic pregnancy, infertility, and pregnancy termination for fetal anomaly are briefly considered and contrasted.

HISTORICAL REVIEW

Identifying Perinatal Grief

Prior to the 1970s, the medical and psychological literature showed little awareness that perinatal loss caused substantial distress. In a logical outgrowth of their pioneering work on the development of parental attachment to the newborn, consolidated in "bonding," Kennell and Klaus[6] were among the first to recognize the pattern of grieving after the death of a baby. The growing recognition of the usually intense grief after perinatal loss culminated in the first major study of this death by Peppers and Knapp[7] in 1980, followed by more than a dozen handbooks over the next decades directed at bereaved parents.

Illumination of the typical pattern of profound grief after this type of death coincided, ironically, with richly textured descriptions of the individualized reactions to perinatal loss. Several researchers highlighted how the incomplete separation of the baby from the physical and psychological selves of the parents, particularly the mother, can lead to profound confusion, disappointment, and lowered self-esteem.[8, 9] Lewis poignantly documented how seemingly psychotic behavior by a newly bereaved mother, who tried to walk her dead baby and frantically kissed his navel, mouth, and penis, enabled her to optimally mourn her child by:

> ' ... attempting to come to terms with the baby's lost future. In her mind she maintained the continuity of the cycle of life. By kissing the umbilicus she was remembering her creative link with the baby *in utero;* kissing the mouth may be linked to the kiss of life, to resuscitation. The mother longed for her son to grow teeth and learn to walk. Kissing his penis could be considered a wish to restore her dead son's potential capacity to create life. Creating memories about her baby in this way facilitated mourning.'[10]

Widespread Study and Changing Hospital Practice

Throughout the 1980s, quantitative investigations demonstrated that perinatal loss in the Western industrialized world was considered a major loss of a family member. (See reviews by Leon[11, 12] and Zeanah[4] for more extended discussion.) Studies in the United States, Canada, Great Britain, Sweden, and Australia revealed a similar pattern of intense grieving after this loss. However, methodological weaknesses such as failing to use measures specific to perinatal loss or to track the trajectory of this grief made it difficult to clearly understand what is unique about death at the inception of life and also made it difficult to detect early high-risk factors leading to later psychological difficulty.

Hospital practice, however, dramatically improved. This decade marked the increasingly routine use of protocols embedded in perinatal bereavement programs helping parents to grieve the death of their child. Kellner[13] pioneered perhaps the earliest multidisciplinary, hospital-based

Perinatal Mortality Counseling Program integrating effective counseling with data collection and research. RTS Bereavement Services (formerly Resolve Through Sharing)[14] offered specialized training to hundreds of hospitals, especially nurses confronting perinatal loss, throughout the USA. Finally, nonmedical caregivers played a crucial role in spawning self-help groups and materials emphasizing the importance of developing social support and recognition for this previously ignored loss. Under the direction of Sister Jane Marie, for more than a decade, SHARE (founded in 1977) provided a model for more than 400 community-based self-help groups oriented to pregnancy loss throughout the United States and other countries.[15] Sherokee Ilse's "Empty Arms"[16] and Deborah Davis' "Empty Cradle, Broken Heart"[17] are most frequently given to parents soon after a perinatal loss, helping them to normalize their powerful reactions and encouraging the construction of memories to facilitate grieving.

Improving Research and Individualizing Care

During the late 1980s and throughout the 1990s, more sophisticated questionnaire measures of perinatal loss were developed, helping to longitudinally track long-term outcome as well as understand the different dimensions of this loss. Using their Perinatal Bereavement Scale, Theut and colleagues[18, 19] reported that recovery from pregnancy loss was often facilitated by a successful subsequent pregnancy. Lasker and Toedter's Perinatal Grief Scale,[5, 20] a 33-item questionnaire that has become the standard in the field, distinguished three separate components of grief reactions (*i.e.* active grieving, difficulty coping, and despair) that were differentially associated with long-term outcome. This scale has been used among 2485 subjects in 22 studies from 4 countries with strikingly consistent findings.[21, 22] While "active grieving," the normatively most benign and time-limited response to pregnancy loss, is strongly associated with a longer gestation and mothers (*versus* fathers), the subscales "difficulty coping" and "despair" often presage more long-term and difficult grief reactions significantly associated with poorer internal and interpersonal resources (*i.e.* prepregnancy emotional problems and less social support, both between partners and among family and friends). The emotional expression embodied in "active grieving" has been shown to limit more extended and despairing grief, and dreaming has been reported to facilitate coping with grief.[23]

A significant gap in our understanding of perinatal loss is the absence of much empirical literature on responses by American minority groups. One study of middle-class, mostly college-educated, African-American women indicated the importance of sharing grief with family and support networks, nurturing memories and keeping memorabilia of the baby, and considering a subsequent pregnancy with trepidation–all common findings in the usual middle to upper-middle class population of almost all perinatal loss studies.[24] However, this African-American sample demonstrated a greater reliance on and efficacy of prayer and spiritual connection, sometimes "going inside myself" for inner healing, as well as a seemingly larger proportion of women (*i.e.* 30%) who had never discussed the loss with anyone than is typically reported in the larger

perinatal loss literature.[24] A study of low-income African-American parents revealed additional psychosocial stressors including economic hardship and other recent death or serious illness.[25] These parents frequently misread signs of pregnancy complications and often perceived their medical treatment as substandard.[25] Clearly more research is necessary to better appreciate the impact of cultural and class differences on the experience and outcome of perinatal loss.

THE IMPACT OF PERINATAL LOSS

Reactions to perinatal loss can be understood only if we appreciate the occurrence of this death during pregnancy. In discussing the psychological tasks confronting the parents after perinatal loss, the corresponding meanings of pregnancy will be reviewed.

Mourning the Death of a Baby

Attachment to the Baby-to-Be

By the last trimester of pregnancy, both expectant parents, but especially the mother, develop an intense attachment to their unborn child as a unique, separate person,[26, 27, 28, 29] indicating the importance of applying attachment theory in understanding perinatal loss.[30] Parental images of the unborn child are so powerfully established by this time that there is a statistically significant degree of continuity in parental perception of the baby's temperament (*e.g.* activity, rhythmicity, adaptability, and mood) *in utero* and postpartum.[31] Anecdotal reports vividly illustrate how the highly individualized prenatal perceptions of the unborn child influence parental view of the child at one month:

> Mother A—prenatal: I feel this is a very, very emotional and intense child—very active. Very verbal and very intense. I'll know when it's upset and when it's happy. I cried when something beautiful happened at work. I was sure the baby cried, too. The baby kicked and kicked. It felt what I was feeling.
>
> Mother A—postnatal: Definitely not quiet. He's got a mind of his own. He's very alert. If he had his way, he wouldn't sleep all day. He likes to stay up and observe things. Likes human contact, likes a lot of love.[31]

Grieving Perinatal Loss

The typical pattern of grieving has been recognized for over 50 years.[32] After the initial shock and numbness on learning of the death (especially if it was unexpected), a period of intense confusion usually follows with lapses in memory, anxiety, restlessness, irritability, and somatic distress. As the reality of the death is gradually absorbed, the bereaved yearns for the return of the deceased. Inconsolable sadness and preoccupation with memories of the deceased, with intensely

painful periods of loneliness, guilt, anger, and hopelessness over ever feeling better periodically wash over the bereaved in waves of emotion. Over the next year or two, the bereaved gradually becomes reconciled to this permanent loss. There is a resumption of everyday activities, a renewed interest in other relationships and the world in general, and a restored capacity to feel pleasure.

Usually there is not, however, a complete recovery, meaning a total return to one's "old self". Major losses will often result in important changes in one's outlook on life, valuing of relationships, and sense of future. Furthermore, despite certain common threads in this pattern of grieving among most people, grieving is highly individualized, certainly not to be viewed as a "one size fits all" process or series of stages.[33, 34, 35]

Although this pattern of grieving provides a useful lens for viewing perinatal loss, it is important to recognize that the nature of this unique loss usually makes grieving more complicated, and often more difficult. Perinatal loss is frequently traumatic, occurring quite suddenly and without any anticipation in this age of high technology, where there is the increasing belief that deaths like this no longer occur. Children are not supposed to die before their parents do. It leaves bereaved parents feeling more helpless and dazed, doubting the reality of what has happened. By preventing a more gradual, manageable, and total assimilation of the reality of the loss and the pain of active grieving, traumatic deaths often lead to a less completely resolved loss than deaths after a terminal illness.[33, 36, 37]

The raw material feeding the grieving process is scarce or absent after perinatal loss. Grieving demands recollecting the sights, sounds, smells, and touch of the beloved—the favorite chair in which he would sit, the sound of his laughter, and the image of his smile. When the unborn child dies, there is so little to grieve—very limited sensory memories or interactions and, in times past, not even a body to see. So much of perinatal loss involves grieving the loss of the future: relinquishing the wishes, hopes, and fantasies about one who could have been but never was (but briefly). For this reason, virtually all researchers and clinicians working with perinatal loss strongly recommend giving the bereaved parents many opportunities to see and hold their baby, creating mementos of their baby's existence and making memories to facilitate the process of grieving.[4, 7, 8, 10, 11, 13, 14, 15, 16, 38, 39, 40, 41] The tactile interaction of bereaved mothers with their dead babies is quite like that of mothers getting to know physically their live births, first touching with the fingertips and then moving to full-hand contact with the head and trunk.[42] Making the reality of this child—and his death—as clear as possible promotes the tasks of grieving, which require accepting the reality of the loss as well as painfully reviewing the concrete memories of that relationship. Contact with one's child may also facilitate the parents' construction of a clearer identity for that child by noting family resemblance,[39, 43] just as collecting precious mementos and having a funeral serve as additional social means of

endowing personhood.[44, 45] Thus, seeing one's dead child may further the important transformation from experiencing the loss of one's ambiguously defined baby to the named, identified death of a son or daughter, who becomes a permanent member of one's family.

Because the identity of the baby in perinatal loss is initially so vague, ephemeral and lacking social validation, finding ways to, respectively, distinguish, remember and memorialize this loss is particularly crucial. Rituals may become a vital means to purposefully create meaning, especially when personalized by the parents rather than following the caregivers' agenda or preferences.[46] Rituals may also provide a bridge between a couple's unique grief and the shared customs and traditions of one's religion and community, enabling the socially unknown child to become a real presence in the family's genealogy.[47, 48] Finally, developing symbolic associations, promoting the child's visible presence, maintaining the child's place in the family, and sustaining lifelong impressions are all additional vehicles ensuring that the deceased baby will be forever remembered by having a unique position in the family.[49]

Based on the developing perception of the fetus as a baby and the deepening attachment to that child over the course of pregnancy (especially after quickening and through the second trimester), one of the most robust reported findings is the significantly increased grief after a longer gestation.[18, 20, 21, 50, 51, 52, 53] Yet, as challenging as it might be to grieve perinatal loss, different complications may ensue in grieving earlier pregnancy losses, accounting for the sometimes prolonged distress in coping with miscarriage and ectopic pregnancy.[5, 54, 55] When this loss is experienced as the death of a baby (especially in second-trimester intrauterine death) there still may be no baby to see and grieve, no social conventions to confer personhood, and, crucially, no recognition by family, friends, and medical caregivers that a major loss has occurred. Not surprisingly, this may leave the bereaved couple feeling confused, angry, and bitter, accounting for the significantly higher levels of bereaved parent dissatisfaction with medical caregivers after early pregnancy *versus* perinatal loss.[40, 52, 56, 57, 58] Even under these difficult circumstances, it may be possible to devise means of embodying and personifying this loss through writing, modeling, and other artistic creations,[47, 59, 60] as well as burial rituals originating from ancient times.[61]

Perinatal loss often involves grieving not only the death of a specific child one has grown to love, but the identities of other figures psychologically linked with that child. For the expectant mother, pregnancy typically revives, in an often less than completely conscious fashion, experiences of being mothered.[62, 63] Many clinical reports demonstrate that depression after perinatal loss often stems from an earlier unresolved grief that became associated with that unborn child, especially the loss of a mother or a parental figure in childhood.[11, 64, 65] In such cases, both the loss of that particular baby and the legacy of earlier losses and identities conferred on that child must be grieved.

Studies indicate that as many as 25–40% of couples experiencing perinatal loss report little increased anxiety or depressive symptoms soon after the loss or in the subsequent two years.[35, 66] This challenges the usual assumption that perinatal loss inevitably leads to overt grief (or pathologic consequences if repressed or delayed). Because it has been frequently reported that better preloss emotional functioning is strongly related to less intense grieving after perinatal loss,[21, 67] empirical evidence indicates that at least one adaptive form of adjusting to loss in general,[68, 69, 70] and perinatal loss in particular[71] may involve a nonemotionally reactive resilience. This does not mean that the expression of intense grief is pathologic, but, instead, challenges the orthodoxy among many grief counselors that the absence of significant grief after a major loss necessarily signifies maladaptive avoidance or denial.

Absorbing Injuries to the Self

Reproduction fulfills many cherished wishes and ambitions that have little to do with parenting a baby and everything to do with consolidating a new parental identity and enhancing self-esteem. By understanding how pregnancy is oriented to enriching the self, we can better appreciate the multiple depressive consequences resulting from perinatal loss. Quantitative studies have been able to isolate low self-esteem as an significant, independent contributor to depression,[72, 73] with one investigation reporting that grief may account for as little as 20% of the extent of postloss depression.[74] Diminished self-worth, especially for women who typically feel their bodies have failed them after these losses, is probably a more serious long-term hazard to resolving pregnancy loss than grieving the loss of the baby.[5, 8, 11, 12, 21, 22]

Perhaps more than any other human act, reproduction allows the expectant mother to taste omnipotence. Procreation touches the divine. Stories of birth and creation are usually core beliefs in religion and mythology. The reproducing couple, by obeying the first and most basic command, become co-creators with God: “So God created man in his own image … male and female he created them. God blessed them and said to them, ‘Be fruitful and increase …'."[75]

By creating life, the reproducing couple triumphs over death. Latent wishes for immortality may be realized through the projection of one’s own biologic heritage into subsequent generations.

On a psychological rather than spiritual level, pregnancy enables women to feel more fully feminine. Early childhood wishes to make babies become one means of defining oneself and enjoying being female.[76, 77] When those wishes are later frustrated because of infertility, the woman often has the humiliating experience of not feeling fully feminine. This has been documented in clinical[78] and sociological[79] reports. Finally, the sense of omnipotence and completeness in becoming a mother, associated with the very real power mothers exert in meeting the needs of a dependent baby,[77] may become another self-enhancing pleasure in attaining pregnancy.

In the early stages of pregnancy (and to a lesser degree throughout the pregnancy), the fetus is experienced by the mother as a part of herself.[8, 9, 11, 12, 76, 77, 80] This, too, usually becomes a source of pride and increased self-worth. If not too hemmed in by our cultural preoccupation with slimness, the expectant mother will enjoy "showing off" her fuller figure. Alternatively, her self-esteem will abound as she vicariously relishes the imagined perfection of her unborn child. All the attributes and goals she was unable to attain will now be granted to her as the unborn baby "… appears as an ideal child, usually representing the dreamer herself endowed with her own best qualities and all those she would like to have."[76]

Perinatal loss typically produces profound and multiple blows to self-worth. The growing intimation of omnipotence is shattered by this loss. The mother is unable to experience even the usual sense of control over her body. She faces the harsh finality of death when she least expects it, in the very act of creating life. Her own mortality is awakened, as she sometimes fears she will die as well.[9, 81] The pride in her femininity is transformed into a sense of shame and humiliation. Many of the usual reactions to pregnancy loss, such as persisting worthlessness, intense guilt, rage at the unfairness of it all, feelings of emptiness and fragmentation, and psychosomatic symptoms,[5, 7, 8, 11, 12] may be better understood as a pattern resulting from overwhelming injuries to self-esteem rather than the usual pattern of grieving the death of one's baby. Were this constellation of reactions enduring (usually it is not), the bereaved would appear to be suffering from the depleted self-esteem epitomizing narcissistic personality disorder.[82] Such profound feelings of failure and loss of self-esteem help explain the very frequently reported significant improvement in well-being when a woman achieves a successful pregnancy after her loss.[19, 21, 83, 84, 85] This allows her the opportunity not only to parent but to repair a damaged self.

Injuries to the self may constitute a particularly important source of emotional distress after miscarriage.[54] Difficulty in finding meaning in one's grief and reconciling one's loss with a prior view of the world as a just, predictable, and benevolent place may instigate traumatic, unresolved grief.[68, 86, 87, 88] Making sense of a loss that feels so real but remains so ambiguous—"Did my baby die? Was/am I a parent?"—contrasting one's profound longing with the relative indifference or minimization by medical caregivers, friends and family; and feeling so responsible for an event so out of one's control—"Why did my body fail?"—may be the cognitive correlates of the intense distress frequently experienced after miscarriage. Just as the absence of a baby may also make it harder to grieve the loss of that unborn child in later miscarriages, not having the complementary opportunity to express maternal love and devotion in the caresses of interaction with one's baby may interfere with forming a positive maternal identity out of the experience of this loss. The frequently reported heightened anxiety after miscarriage[55, 89, 90, 91, 92] may be a product of this form of psychic trauma challenging the woman and her partner to make sense of this loss, independent of the degree of attachment and grief experienced over the loss. Depressive responses to miscarriage appear to include time-limited grief reactions—typically more intense

with longer gestations—that heal over the course of the following year as well as more chronic depression based on diminished self-worth as a result of injuries to the self.[52, 53, 72, 92, 93, 94, 95, 96] Each kind of depressive reaction may exist together or apart,[72] frequently accompanied by increased anxiety caused by psychic trauma.[89, 90, 91, 92, 95] For either perinatal loss[97] or miscarriage,[98, 99] being given a medical causal explanation appears to mitigate self-blame and resulting depressive responses.

Surmounting Developmental Crisis

Pregnancy ushers in a new stage of development—parenthood —which dramatically changes one's life, how one views oneself, the meaning and purpose in life, and the value of family and relationships.[100, 101, 102] As with any major developmental advance, there is heightened turmoil in one's inner life. The usual sense of order in one's world is disrupted, leading to confusion. The uncertainty of the future challenges prior feelings of security, often producing anxiety. With crisis comes the opportunity for change. This process of inner disorganization facilitates a reintegration and further development of the personality, optimally increasing adaptation.[102, 103]

Perinatal loss occurring during pregnancy is a crisis within a crisis. Especially when it is the first pregnancy or when there are multiple pregnancy losses, there may be developmental interference rather than progression. Internal stagnation is common. Women and their partners experiencing pregnancy loss often talk of not getting on with their life goals, plans, and dreams. They feel stuck, off track, as if they are running in place as life is passing them by. Erikson's landmark delineation of the eight stages of human development emphasizes the crucial role of generativity, serving as mentor to the next generation, which is typically, though not inevitably, realized in parenthoood.[104] A qualitative study of the elderly suggested that lingering grief for their pregnancies of decades ago, and perinatal losses, may be related to their not having any grandchildren, failing to take one's place in the generational hierarchy.[105] Finally, the opportunity in parenthood to rework childhood disappointments and problems with one's own parents through developing a different kind of relationship with one's child, is denied.[102]

There is interpersonal isolation for women and their partners, as well. As family and friends move on to have families of their own, there can be profound estrangement and loneliness. This occurs both in their internal life, as they see themselves being left behind, and in actual interactions, when they are left out of the new activities and roles that come with parenthood. Many of the usual responses to perinatal loss, such as visualizing or hearing a baby, wishing to have another baby as soon as possible, and feeling intense pain and envy when exposed to other babies, may sometimes be based less on grieving the death of their particular child than on confronting the painful frustration of not being able to parent.

One of the most frequently reported predictors of more intense depressive reactions after miscarriage is the absence of living children in the home,[53, 89, 94, 96] suggesting that the interference that pregnancy loss causes in the desired milestone of becoming a parent is a

significant, additional emotional burden for the couple. While this association has been empirically supported in some studies examining perinatal loss as well,[21] it is worth speculating that frustrating as perinatal loss becomes in preventing the assumption of active parenting, the increasing opportunity to grieve these late-term losses as real children making the couple real (albeit bereaved) parents may afford some important measure of parental fulfillment. This is not possible with earlier pregnancy loss and infertility when there is no baby to grieve, name, and identify as one's child.

Reviving Psychological Conflicts

Pregnancy usually revisits earlier stages of psychological development along with the individual's salient problems at those times. Although this provides an opportunity to resolve some of those problems that occurred in childhood more effectively, very frequently the difficulty is repeated, being passed down to the next generation.[11, 62, 63, 76, 77, 102, 103, 106, 107] For example, an expectant mother having difficulty tolerating her own needy wishes may need to deny the dependency of her unborn child and later infant, depriving him of important emotional sustenance and repeating the cycle of maternal distance and unresolved neediness.[62]

Perinatal loss may lead the bereaved mother to construct distorted understandings of her loss based on these earlier issues. For example, a perinatal loss may be unconsciously experienced as a punishment for sexual or aggressive feelings that remain conflicted. Clinical accounts[11, 64, 65] as well as quantitative studies[5, 20, 21, 22, 67, 73] indicate that earlier psychological problems can interfere with the successful resolution of perinatal loss, requiring psychological treatment.

FAMILY AND SOCIETAL REACTIONS

Mothers and Fathers: Grieving Apart and Together

Because mothers experiencing perinatal loss have been studied more extensively than fathers, much of what has already been discussed is most applicable to women. By appreciating how men respond differently to these losses, we may better understand the stresses upon a marriage that perinatal loss can create.

Fathers grieve for their unborn, stillborn, and newborn children who die. Their grief, however, typically tends to be less intense, significantly shorter, and not as filled with guilt than that of their mates.[18, 21, 38, 51, 66, 108, 109, 110, 111, 112, 113, 114] Peppers and Knapp[7] attributed the pattern of "incongruent grieving" to the significantly earlier and more intense attachment to the unborn child by the expectant mother compared with the prospective father. While attempting to be supportive, husbands sometimes betray impatience and irritation over their wives' prolonged grieving. Fathers wonder when and if their wives will ever "get over it" and often wanting to resume earlier pleasurable activities before their wives are ready.

The texture of grief often differs between mothers and fathers. Because the child-to-be is more a part of the woman's physical and psychological self, felt to be under her control and responsibility, maternal guilt and damaged self-worth tend to be more important ingredients of grief among women than among men.[11] Some men are more comfortable expressing their disappointment and frustration in anger. Because the bereaved mother is more inclined to identify the child-to-be with herself, her husband's readiness to "move on" and not be as hurt as she is may be experienced as a personal rejection of her, as if her baby (and ultimately herself) did not matter that much to him.

Cultural gender roles that discourage masculine expression of intense feelings in general and grief in particular[115] sometimes magnify the increasingly different experiences of perinatal loss for fathers and mothers. Men are often inhibited from expressing their grief, believing they should be "strong" (*i.e.* show little feeling). Social norms reinforce those role expectations as husbands are commonly asked how their wives are doing, with often little expression of concern about how they are faring.[116, 117, 118, 119, 120, 121] This can be a double-edged sword. In one study, protecting their partners was an important source of meaning and relief for expectant fathers,[122] perhaps mitigating the traumatizing helplessness they suffered. Fathers become marginalized, isolated from accepted social channels of maternal mourning. Despite the deeper grief mothers commonly report, fathers may experience as much or even more intense distress than their wives due to the lack of social support and greater difficulty expressing and coping with their feelings.[56, 67, 119, 121, 123] Due to not having the visceral affirmation of a woman's motherhood *via* her pregnancy and the social validation of her central reproductive role, fathers may struggle more than their partners with constructing their paternal identity after perinatal loss, especially needing to see the child, possess mementoes and be recognized as the father.[117, 120, 121, 122] Sometimes they feel threatened by how sad they can feel, fearing losing complete control of their emotions.

A father began to sob uncontrollably as he recalled how painful it was for him to see his dying daughter on life-support. Instantly gaining his composure, he voiced his concern about his wife "going off the deep end," while observing he was not aware until now how deeply he felt.

For this young father, his wife's more open and comfortable expression of grief may represent an unwelcome reminder of the extent of his prior unspoken sadness. When a man objects to the possibility of sharing his grief with his wife, claiming he has to be the "strong" one to keep things from "falling apart," it can be a powerful and liberating intervention to turn to her, asking if that is so. Invariably, she will disavow that notion, stating how much better it would be for her if he shared his sadness sometimes, allowing her to feel not so alone and closer to him, as well as bolstering her self-worth by providing rather than solely receiving comfort from him. Other fathers may comfortably express their grief vicariously through their wives, using them as

emotional outlets. Very commonly a man will respond abstractly and unemotionally when asked directly by a therapist how he is doing, only to be quietly crying along with his wife as she more openly shares her grief later in the same session.

Other culturally rooted gender role differences that assign men the responsibility of taking care of their wives and managing concrete affairs such as funeral arrangements may reinforce men's preference for acting rather than feeling. With the bereaved mother often recuperating in the hospital, more concrete tasks often become the father's responsibility, sometimes giving him little time to feel his loss. Men are usually expected to return to work soon after the loss, while their wives grieve alone at home. Men may work overtime as a way to continue to avoid their own sad feelings and to avoid being with their grieving wives. Sometimes they may unconsciously seek to replace their lost baby or repair damaged self-worth by work accomplishments. When this maneuver sidesteps more direct ways of coping with their feelings, work problems may ensue.

Not long after the stillborn death of his son, an engineer became consumed with his job, which was building a satellite. Unable to express the extent of his loss, he was very worried that his coworkers were not taking seriously enough their responsibility of making sure "his baby" (i.e. the satellite) would have a safe launch. Conflicts with colleagues led to a poor performance evaluation.

Finally, men will usually resort to a different vocabulary to express their grief, their usual semantics grounded in actions proving independence rather than feelings that make connections. This often exacerbates the problems in communication between spouses, who are talking at rather than to each other.[124] Frost's "Home Burial" poignantly illustrates the misunderstandings between a couple as the bereaved mother mockingly repeats his seemingly insensitive words to her after he had returned from burying their baby.

> "I can repeat the very words you were saying. / 'Three foggy mornings and one rainy day / Will rot the best birch fence a man can build.' / Think of it, talk like that at such a time! / What had how long it takes a birch to rot / To do with what was in the darkened parlor. / You couldn't care! ..."[125]

This bereaved father's despair and helplessness in the face of his child's death, expressed in the futility of nature tearing down what man makes, was not understood by his wife.

In describing these normative differences between mothers and fathers, it should be remembered that these are general patterns that do not determine the individual differences among men and women. Despite the pressure of gender roles and the greater maternal involvement in pregnancy, some men experience a more profound attachment to and loss of their child than do their wives after perinatal loss. Despite the commonly reported significantly greater expression of maternal *versus* paternal grief, the statistical difference in scores between men and women over many studies is relatively small.[21] Just as the significantly deeper

attachment by women *versus* men to their unborn children may obscure the finding that maternal and paternal prenatal attachments are more alike than different,[28, 29] so too differences in maternal *versus* paternal grief over perinatal loss should not exaggerate their overall similarity.

Even though men and women tend to experience perinatal loss in different ways, most couples weather the strain, eventually reporting increased closeness and a deeper marital bond,[7, 38, 109, 115] with no evidence of significantly increased risk of long-term marital disruption.[126, 127] Not surprisingly, one important predictor of adaptive recovery to perinatal loss is spousal support.[5, 20, 21, 22, 52, 67, 74, 122, 128, 129, 130] Recent empirical studies indicate that while fathers are less apt to articulate their grief than their wives and more inclined to find intimacy through sexual intercourse, as long as they remain emotionally available and attentive to their wives' overt suffering, the marital bond is not threatened and is often strengthened.[112, 113] When differences between the couple can be acknowledged and respected with some degree of sharing what has been lost, couples usually find their way back to each other.

Effects on Siblings: The Invisible Loss

Perinatal sibling loss has been called the invisible loss because usually siblings do not see the dead baby, little is heard about the loss, and often there is no acknowledgment of the sibling's many questions, confusions, and feelings about this loss.[131] This has changed considerably over the past 20 years. Now that contact with the dead baby is a routine part of hospital care, siblings are increasingly allowed or encouraged to see the baby as they participate in opportunities for the entire family to grieve. However, there is virtually no quantitative research on the impact of perinatal loss on siblings and the most effective ways of helping them cope with their feelings about this loss. Clinical experience may provide some guidelines here.[11, 131, 132, 133]

Children are capable of understanding the fundamental facts of death (that it is permanent and that there is a total cessation of functioning) much earlier than we usually realize.[11] By the age of two or three, the child can usually begin to grasp these essential details of death if provided with concrete but impersonal examples, such as a dead insect or small animal.[134, 135] Because surviving siblings are often young, perinatal sibling loss can become an occasion for them to advance their developing understanding of death.

A 2 1/2-year-old girl anxiously rushes to her mother after touching her dead sister, screaming "Mommy, my hands are cold!" Recognizing the source of her distress, the mother calms her down, explaining that death is not "catching" and it will not hurt her to touch her dead sister.

A 3-year-old boy is worried about his dead baby brother being buried underground: "He's all alone. Won't he be scared at night? And he won't have anyone to play with." His father explains that being dead means that nothing works anymore inside, that he cannot see, hear, touch, taste or smell anything. He also cannot think or have any feelings so he cannot be scared or have any more pain: being dead means his body does not have any life anymore.

Although a young child can acquire a basic understanding of death, preschoolers will still dramatically distort causality. “Magical thinking” and egocentrism, the ways children confuse their thoughts with actions and view the world from their own perspective, respectively, dominate their interpretation of events. It is quite common for a child’s jealous feelings toward the new baby during the pregnancy to develop into a conviction that he or she caused the baby’s death. At the same time, it is simplistic and inaccurate to believe that sibling rivalry is the inevitable way children greet their new brothers and sisters. Children beyond toddlerhood will often grieve the death of their baby siblings. Powerfully imagining themselves as mothers, girls over the age of four may experience the death not only as the loss of a sibling, but also as the death of their own wished-for baby.

A five year-old girl poignantly grieved the death of her little baby sister, Karen, wanting to take care of her and hoping she would be just like her. She wanted Karen to have her favorite doll as a reminder of how much Karen meant to her.

Obstetric caregivers can play an extremely valuable role in helping parents understand and cope with their children’s reactions to perinatal loss. The range of normal responses by children should be reviewed with parents. Anxiety is common (“Will someone else die too?”). Depressed feelings are associated with many reactions, including guilt (“Was I to blame?”), lowered self-worth (“Nobody pays attention to me any more”), and grieving the loss. Children are not able, of course, to put their feelings into words as effectively as adults, but commonly resort to actions. Grieving may take the form of withdrawn, tired, bored, or even angry behavior (“It’s unfair. Why did this happen to me?”). Both anxiety and depressive feelings may be expressed as somatic complaints, including stomachaches and headaches. Children may become preoccupied with death for a while, staging mock funerals or asking many questions about what happens to the body. Cultural taboos that promote avoidance of death[136, 137] may lead parents to view such normal attempts by children to understand death as being morbid. A child’s reluctance to show any curiosity about the death is more unusual and may be based on the family’s overt or unspoken rules about not discussing that topic. Children may also respond nurturingly toward their parents’ grief (“I’ll make it better, Mommy. What can I do to make the pain go away?”) Perinatal sibling loss may foster a child’s empathy and sensitivity to others’ feelings.

Attending the funeral usually helps even young children by making the death concrete and providing social support. The child needs to be prepared for what he will see and hear as well as have a trusted adult nearby to answer any questions that arise. It is crucial that parents be able to explain in clear, simple, concrete terms what happened and how the baby died. Drawing pictures can be useful, and having the child repeat the explanation in his own words will help the parent determine what has been understood. It may be necessary to clarify for a younger child that the death was not caused by anything he felt or did and was because of a baby disease that cannot happen to anyone older in the family. Children may also need to hear that their parents’

sadness over the death of the baby does not mean that they love their living children any less, even though it may be hard for them to be as attentive when they are so sad. It is especially important for parents to make special efforts to show their love for their surviving children and find time for them. Even when children are encouraged to ask questions or express their feelings they may be reluctant to do so, because they know this will distress their parents. Children need to know that it is all right if Mom and Dad become sad and cry when they talk about the baby who died. What is most important for the parents is being able to talk about the death and answer any questions the siblings may have.

In the immediate aftermath of perinatal loss, it is usually difficult to determine what might be a more disturbed sibling reaction. Certainly when reactions become more long-lasting and remain intense, a mental health consultation may be warranted. It is also not unusual for more extreme reactions to be another expression of earlier problems predating the perinatal loss. The most extensive clinical study of perinatal sibling loss revealed that children's disturbed reactions to perinatal sibling loss were strongly associated with:

1. A failure by parents to provide accurate and clear information about the loss and to support the child's feelings.
2. Parental unresolved grief usually leading to some disruption in parenting.
3. Engaging the child in destructive patterns of family interaction, including scapegoating, extreme overprotectiveness, or using a subsequent child as a replacement for the dead baby.[11]

It is particularly tragic when perinatal sibling loss leads to emotional problems in surviving and subsequent children. Instead of effective parenting becoming a means of repairing broken parental self-esteem, a legacy of unresolved perinatal sibling loss is established, damaging the rearing of subsequent generations.

Ultimately, sibling reactions to perinatal loss need to be understood in the context of their family. As John Bowlby, a preeminent investigator of loss, emphasized, "Nothing has impressed me more deeply than the evidence showing the pervasive influence at all ages of the pattern of the human being's family life on the way he responds to loss."[135] Although grieving is a natural primate adaptation to losing important bonds, socialization may determine whether grieving is facilitated or discouraged. Does the family permit the expression of the intense emotions of grief, providing models of grieving as well as the needed stability and security for the hard work of grieving to occur? Or does the family inhibit powerful, especially painful, feelings, teaching that it is better to flee than to approach sadness, and confronting children with chronic tension and stress that allow little remaining energy to accomplish the task of grieving?

Caregiver and Community Responses

Caregiver Reactions

Early work exploring the reactions of medical caregivers to perinatal loss focused on their tendency to resort to psychological defenses to protect themselves against the range of intense feelings resulting from these losses.[7, 138, 139, 140] Essentially, by avoiding as much contact as possible with the bereaved, by not thinking about or remembering these losses, by intellectualizing or rationalizing their reactions, and even, sometimes, by blaming the bereaved, medical caregivers could successfully still their own feelings of sadness, guilt, and inadequacy. This temporary relief of their own distress was bought, however, at the high price of failing to meaningfully engage with their bereaved patients, and effective coping was blocked as a result of their warded-off feelings. Widespread knowledge among obstetricians of parents' profound grief following perinatal loss[141] has enabled them to be somewhat more helpful with their patients. However, medical caregivers will often still struggle with their powerful reactions to these losses.[142]

Obstetricians continue to report substantial stressful repercussions from dealing with stillbirths, with almost 10% considering giving up their obstetric practice for this reason.[143] Self-reported adequate training in dealing with these losses emerged as a significant buffer to stillbirths exacting such a great toll as considering giving up one's practice, blaming oneself, and worrying about litigation when the cause of death is unknown.[143] A meta-study of perinatal loss research indicated that while nurses were viewed as capably providing emotional support, physicians were commonly seen as much less helpful, with complaints including avoidance of the family and failing to provide support due to thoughtless comments and insensitivity.[144] Perhaps not surprisingly, such empathic nursing care embodied in "emotional labor" is typically devalued in the medical model of purely rational knowledge which physicians provide, rather than the understanding of emotional interaction with bereaved parents gained through experiential mentoring by senior nurses.[145]

Medical training that dictates that it is unprofessional to have strong feelings because of the danger of becoming "emotionally involved" with one's patients must be challenged. It is natural for medical caregivers who have participated in a pregnancy to feel loss, sometimes profound, at its demise. It is also a natural human response when you are with someone who is grieving to become sad, helping that person to feel that they are not alone and that you can share some of their pain. The bereaved need to know and see that their caregivers care. When caregivers share their sadness, they effectively legitimate grieving for their patients. This also provides an appropriate channel for caregivers to grieve, which, as long as its intensity does not drown out the loss of the bereaved, should lighten rather than add to the burden of the bereaved.

Medical caregivers frequently feel guilty, inadequate, helpless, and responsible after a pregnancy loss, even when they know they did nothing wrong medically. Placed in the role of making sure everything turns out right, they might have feelings of having failed. Viewing themselves as betraying their primary mission of producing a healthy baby, they may mistakenly believe that

there is nothing more they can do. They fail to recognize the enormous importance of their emotional response to their vulnerable patients. What medical caregivers say and do at the critical time of this loss is not forgotten. Heartfelt comforting words or touches can become sustaining memories that promote healing, just as callous indifference can make painful scars, sometimes irreparably damaging the patient–doctor relationship.

The ingredients of trauma (profound helplessness leading to feelings of being overwhelmed in the face of threats to one's life or well-being)[146, 147] affect not only families confronting perinatal loss but, to a lesser but real extent, medical caregivers as well.

A nurse recalls the exact room, blanket, and time of day when she first witnessed the death of a baby more than 20 years ago. As though it happened yesterday, she cannot get the image out of her mind, linked with her not being able to do anything for him.

Containing his fury, a grandfather describes how angry and hurt he was when his daughter's obstetrician informed him of the death of his granddaughter. The physician talked without feeling, avoiding eye contact, almost as if he weren't there, while seeming to want to leave as soon as possible.

Whether taking the form of unforgettable memories, returning as flashbacks, or blotting out feelings by psychologically removing oneself from an intolerable situation (*i.e.* dissociation), the repercussions of trauma on caregivers are often overlooked. The strains on caregivers who repeatedly deal with these losses can be debilitating, sometimes leading to burnout. This becomes costly and can lead to poorer job performance, increased absenteeism, and a range of psychological symptoms. Measures for resolving the occupational grief and trauma that affect medical caregivers need to be devised at individual, group, and institutional levels.[148]

Community Responses

Not too long ago, the support and understanding of friends and neighbors, usually accorded to other mourners, were frequently absent for parents suffering perinatal loss. Any talk about the baby was often replaced with a deafening silence that seemed to say, contrary to the parents' grief, that nothing had happened and no one had died.[7, 38] Well-meaning advice intended to comfort and distract the bereaved was more likely to impede mourning by encouraging suppression ("Just try not to think about it and you'll feel better"), reinforcing maternal guilt ("It was meant to be"), and denying the loss ("Try to have another child soon").

With increased societal recognition of the profound grief after perinatal loss, extended family and friends are more able today to extend sympathy to bereaved parents. While many forms of supportive behavior were provided (such as advice/feedback, practical suggestions, financial help, and opportunities to socialize), the most valued support was emotional understanding in the forms of being physically present, empathizing with grief and offering encouragement.[149] It is still common, nonetheless, to expect that bereaved parents should rapidly return to "normal," becoming their "old selves" within a few short weeks or months. There continues to be a lack of appreciation of the depth and duration of the grief after this loss, often extending through the

first year and sometimes beyond.[3, 5, 11, 19, 139] At the same time, emotional social support from one's extended family and friends is frequently cited as an important factor facilitating a quicker recovery from perinatal loss.[23, 149, 150]

It may be especially difficult for grandparents to tolerate their children's painful grieving. Frequently, grandparents will not want to talk about the baby so as not to "upset" the bereaved parents. Grandparents may also challenge the usual hospital practice of having contact with the dead baby, having learned the earlier approach of avoiding any reminders about the baby and suppressing grief. This often results in the parents feeling more isolated and misunderstood, and sometimes less able to grieve because of their own parents' lack of support.

The most beneficial source of community support and understanding for perinatal loss has sometimes been self-help groups in which bereaved parents reaffirm for one another the normalcy of grieving and find a place where those feelings may be freely expressed.[7, 139, 151, 152, 153] Support groups have been documented to confer not only psychological relief, but improved physical functioning with neuroendocrine, immunological, and virological benefits among a physically healthy population as well as those compromised by AIDS, cancer and other diseases.[154] Even though one study comparing support group attendance or not after perinatal loss revealed no significant differences in coping,[155] there are many methodological problems with this research (i.e. non-randomized group assignment with support group attendees possibly grieving significantly more before grief measurement and almost half of the support group attendees only going to one to three sessions). For those whose grief has abated, these groups may provide a valid channel for caring for others. After sufficient grieving, a valuable coping mechanism for the bereaved can be transforming self-preoccupation into altruism.[156] For some, developing their own virtual supportive community on-line became a valued way to give and receive understanding from other parents coping with perinatal loss.[157] It is important to remember, however, that only a minority of the bereaved will ever attend a self-help group. Recommending a support group should also never substitute for a caregiver listening and responding to parental grief.

PSYCHOLOGICAL MANAGEMENT OF PERINATAL LOSS

Hospital Practice

Most obstetricians today recognize that basic care of the family after perinatal loss involves facilitating the grieving process—a complete reversal of the "conspiracy of silence" that previously dictated the response to perinatal loss. Prior to 1980, medical caregivers typically tried to prevent parents from mourning a stillborn or neonatal death by prohibiting any contact with the dead child, disposing of the body unceremoniously and anonymously, prescribing tranquilizers for the parents to dull any expression of grief, advising them to forget the experience, and often

suggesting another pregnancy soon. Today, the exact opposite of each of these points is recommended. Crucial ingredients in the psychosocial care of families confronting perinatal loss include:

1. Keep the parents fully informed of the baby's medical condition.
2. After the baby dies, encourage contact with the baby, name and take pictures of the baby, and construct mementos of the baby (*e.g.* footprints, baby bracelet, receiving blanket, lock of hair) to validate the loss and promote memories that facilitate grieving.
3. Avoid sedating the mother.
4. Listen to and encourage parental expression of their grief.
5. Educate parents about their grief as a normal healing process.
6. Discourage attempts to become pregnant immediately as a means of replacing the dead child.

There is no question that the psychological management of perinatal loss has been dramatically improved. However, the manner in which new insights and interventions are implemented needs to be evaluated.

Avoid Regimentation of Caregiving by Individualizing Care

Caregiving recommendations have increasingly been codified into protocols for hospital care involving dozens of instructions, often with detailed checklists.[158, 159, 160] Such protocols were useful when they provided a basic standard of consistency in care, challenging the earlier denial of these losses and helping beginners develop a rudimentary knowledge and competence in this area. More recent guides tune into the importance of the caregiver-parent relationship, even if specific recommendations are provided.[161, 162]

However, specific instructions telling caregivers precisely what to do, what to say, and, ultimately, what to feel can interfere with genuine and spontaneous interaction with bereaved parents.[163, 164] Guidelines that are too specific may foster the erroneous impression that there is only one right way to give care to all families. As Furman observed, "Measures for helping therefore tend to be formally categorized rather than individually attuned to the needs of the particular family."[165] Similarly, "It is important to realize that every parent is different and a statement that comforts one may offend another."[166] Sensitive, effective caregiving will incorporate many, but not necessarily all, of the elements of a protocol, accommodating them to the specific needs of a family. Several empirical studies demonstrate that it is not the number of interventions made but how sensitively they were performed which seemed to most determine patient satisfaction with caregiving.[44, 56]

Increasingly, recommendations for caregivers after perinatal loss are organized not as much by protocols and checklists, but by providing an organization of empathic care including informing, guidance and support which focuses less on the content of action and more on the process of interaction between caregiver and bereaved couple, especially the sense of their grief being

shared, understood, and felt by the caregiver.[145, 164, 167, 168, 169, 170, 171, 172, 173, 174] Caregivers also need to remember that in this most critical and traumatizing crisis, compassionate words which helped, and thoughtless platitudes or avoidance which hurt, are usually indelibly impressed upon the parents' memories, not to be forgotten.[169, 175]

Following an intra-uterine death, women often fared better when labor was induced within 24 hours, but given sufficient time to absorb the painful news, come to terms with a usually recommended vaginal delivery and prepare to meet and say goodbye to the already loved baby.[41, 176] Collaborating with the couple as early and completely as possible in sharing the bad news and ensuring their participation in treatment decisions will reduce their sense of helplessness, thereby potentially reducing trauma.

The essence of optimal care for the bereaved is providing empathy, which is giving part of yourself to another. First, you listen. Accustomed to equating care with overt procedures, medical caregivers sometimes have difficulty appreciating how active and draining listening to intense feelings can be. Next, you attempt to put yourself in the shoes of that person, allowing yourself to taste what some of those feelings are like. This exercises one's brain as well as one's heart, by acquiring a cognitive understanding of the impact of the loss as well as emotionally resonating with those feelings. Finally, in your own words you communicate, with feeling, your understanding of what this loss means to them. The caregiver needs to be natural and authentic in choosing words that come from oneself and not canned lines from a 'cookbook'.

A couple in their late 30s is distraught over the mid-trimester intrauterine death of their baby, conceived via GIFT (gamete intrafallopian tube transfer). In addition to their obvious sadness over losing their daughter, they are furious over how unfair this is, having been unable—despite many years of infertility treatment—to have a child. They finally thought they would be able to be like "normal people," and now that dream has been taken away from them. Their obstetrician supports their anger, explaining how natural it is because of how hard they have tried to become parents. She observes that this seems to be an especially painful loss because there are so many losses coming together here: the death of their daughter compounded by the hurt, frustration, and isolation caused by the disappointment of their hopes of becoming parents.

By listening carefully, you may be able to sense how much the loss is experienced as the death of a child, a profound blow to self-worth, the disappointment of a failed dream, and/or an obstacle to becoming a parent. It is not appropriate to attempt a counseling session during this crisis. However, if one allows sufficient time, after the initial shock has begun to subside, parents may be able to help you understand the nature of who and what was lost. Because grief is meant to be shared, rather than experienced in isolation, it is natural to feel sad, or even tear up along with the bereaved parents. In one literature review, it was frequently cited that "Nurses who gave parents permission to cry, who used humor appropriately and who seemed to go out of their way to spend extra time with the family were viewed as particularly supportive ... Several parents

commented that when caregivers were themselves tearful, it felt honest and genuine and the tears seemed appropriate." [144] Bereaved parents described three aspects of empathic care–"accepting the parent's feelings and behaviors ... being there ... [and] sharing the experience" as most beneficial in coping with the loss of their nonviable premature infant soon after birth.[177]

Swanson's model of nursing care after miscarriage offers a similar approach.[167] She dissects caregiving into five ingredients: (1) *knowing* the personal meanings of the loss; (2) *being with* the bereaved emotionally; (3) *doing for* them in providing concrete protection and nurturance; (4) *enabling* them to experience their grief; and (5) *maintaining belief* that they will get through it whole. She concludes by stating, "The categories are offered as insights, not formulas. They are descriptions and interpretations—not prescriptions—and should be used accordingly."[167]

Perhaps the most important advance in hospital practice after perinatal loss is encouraging parents to view, touch, hold, and name their dead baby. In one of the longest-running perinatal loss support programs in the US at Shands Hospital at the University of Florida over 93% of babies were seen by one or both parents when given the option.[178] A review of studies of hospital practice after perinatal loss indicated that of the very high proportion of parents who had contact with their baby, the vast majority reported this to be a crucial aid in their grieving; regret, if voiced, was likely to be among those who chose not to view the baby or to have more time among those who did view.[171] Bereaved mothers sometimes criticized caregivers for enforcing very limited contact, as well as usually declining the wish to take the baby home in order to more clearly identity that child as a family member.[179] Only one out of 33 studies[171] reported five parents who felt that viewing their baby affected them negatively, resulting in increased sadness, but not the belief that viewing their babies was traumatizing.[180]

Such contact not only makes the loss more real and facilitates grieving by fostering a permanent identity for that child, but such interaction may also restore parental self-esteem by concretely providing an opportunity to demonstrate one's love for one's child and enabling an identification of cherished family features in the face and body of the child. When a bereaved couple is sharing their sad memories of seeing their dead baby during subsequent counseling sessions, it is not uncommon to see a temporary lifting of their spirits as they proudly describe how beautiful their baby was and how much it meant for them to have had that time—their only time—with their son or daughter.

Despite the good clinical sense and very positive feedback which powerfully validates the approach of offering and supporting the option of parents viewing and holding their deceased babies, it needs to be emphasized that this choice may not be suitable for all parents in all situations and should not be considered a universal approach.[164, 172, 173, 174, 181] Few studies have rigorously, quantitatively examined the impact of viewing the baby after perinatal loss. One

study in fact reported that viewing a stillborn is more likely to be associated with depression, anxiety, and symptoms of PTSD during the third trimester of the next pregnancy.[182] This surprising outcome may be explained by many methodological problems[183] such as:

1. not clearly providing the empathic care and support which is an indispensable part of offering this option;

1. assessing psychopathology at a time when anniversary reactions to the prior loss may be normatively intensifying the grief which was heightened by viewing the stillborn (the failure to find statistically significant elevated measures of depression, anxiety and PTSD at a follow-up one year later supports this possibility);

1. the absence of randomized assignment into viewing and non-viewing groups. Admittedly, this research design would probably not be possible due to the virtually universal expectation that the option of viewing be available,[4] which would prevent knowing if these two groups represent two very different populations (*i.e.* those less inclined to view may be resilient, less intense grievers[35, 68, 71, 72] who demonstrate less distress, while those choosing to view may be allowing their heightened grief more opportunity to be processed through the experience of getting to know and more openly grieving their child).

Yet under certain circumstances—especially pregnancy termination for fetal anomaly—parents may decide for their own good reason not to view or name their baby.

With much sadness, a couple chooses to terminate their mid-trimester pregnancy after learning of a serious genetic abnormality by amniocentesis. They make it clear to the labor and delivery staff that they do not wish to see the infant, believing it will be easier for them to cope with this decision and loss by viewing it not as the death of a child but as the loss of a potential. They become increasingly distressed and ultimately furious when obstetric staff repeatedly encourage such viewing despite their objections and explanations.

The sense of intolerable guilt resulting from attributing personhood to one's child ("I killed my son/daughter") may make it too difficult to personify their loss as is likely to occur in viewing. There are no easy or uniform answers here. Although some researchers suggest viewing the deceased may be an important component in resolving grief after this loss[184, 185, 186] and clinical experience validates this for some couples,[187] there is insufficient empirical evidence warranting the increasingly advised viewing of the deceased after pregnancy termination for fetal anomaly as is typically done after spontaneous perinatal loss.[188] Medical caregivers need to be particularly attuned and sensitive to the individual needs and differences of couples undergoing this exceedingly difficult loss and respect their wishes. Some couples will find viewing a necessary part of coming to terms with their decision, potentially magnifying their guilt but enabling an increased capacity to concretize and personalize their loss, possibly as a son or daughter. Other

couples will find the heightened guilt such contact entails as intolerable and unacceptable. While medical concerns may need to determine the means of termination chosen, psychological wishes to view the deceased or not should be taken into account in deciding whether to induce labor or have a dilation and evacuation (or dilation and curettage).

Similarly, when parents must decide whether to view and/or hold their living but non-viable baby, it is especially important to be sensitive to parental wishes. While a small, descriptive study indicated all parents eventually decided to see or hold their infant at some point, only one mother out of eight parents felt comfortable holding her baby at the time of death, with the remaining parents believing it could have been too painful to do so, fearing how intolerably helpless they would feel.[177] In another study, the majority of parents were persuaded by caregivers to see and hold their dying babies, but a few were clearly dismayed by such pressure:

"I didn't want to hold him. They [the staff] should have been a little more flexible and tried to show more empathy. I should not have had to reiterate it [not wanting to hold the baby] maybe ten times, because for each time I said it, I was feeling more and more ill at ease ,,, there was a little bullying of my husband too ... I can't say I became a mummy to him" [189]

All of the women who gave birth to very premature infants in fact decided not to care for the newborns, some not experiencing it as the loss of a baby.[189]

As part of responding to individual differences, it is important for caregivers to be aware of how differently subcultures may respond to perinatal loss.[190, 191, 192] In different cultures and historical epochs, grieving perinatal loss may be (or have been) atypical if religious beliefs steadfastly viewed it as the will of God or the results of evil spirits as in the Cameroon,[193] or, alternatively, quite commonplace whether in rural northern India[194] or early 20th Century Ireland.[195] Ultimately, whether and how pregnancy loss is experienced and grieved must be considered in its medical, historical and political context. Miscarriage in the US over the past century was viewed as a dangerous hazard when medical care was limited (about one hundred years ago), or a "blessing" (in the mid 1950s) in avoiding potential fetal deformity, or (perhaps today) when miscarriage becomes uniformly viewed as the loss of a baby in accordance with the pro-life perspective equating all fetal life with unborn babies.[196]

How openly grief is expressed both within and outside the family, religious beliefs about when life begins, the meanings of death and funeral rites, and the role of indigenous healers in bereavement are only a few of the factors that need to be considered in addition to the global differences in style of communication that can complicate working with families of different cultures. Being prepared to listen and learn is vital. Becoming familiar with aspects of pregnancy and death will be very helpful as long as it does not engender stereotypic expectations of all families of a subculture.

There has been a tendency to pathologize intense grief reactions in earlier quantitative studies that often considered powerful reactions and feelings, even soon after a perinatal loss, as high-risk factors for unresolved grief.[18, 19, 128, 129] Such research may be echoing our culture's prohibition against any intense expression of grief. The phrases we use to refer to sobbing in grief—breaking down, falling apart, going to pieces, losing it, losing control, going into hysterics—are pejorative terms, suggesting a destructive process rather than a healing one. A strong argument has been made against modern psychiatry interpreting normative grief reactions following a variety of losses as depressive disorders, thereby pathologizing typical human adaptation to adversity.[197] Mental health researchers, therapists, and the pharmaceutical industry (i.e. proliferation of anti-depressant medications) benefit from an expanding clinical population and diagnosis, promoting medical and professional treatment for what might be more accurately considered an integral part of the human condition (*i.e.* normal sadness or grief), ameliorated by social support and coping.[197] Most studies using Lasker and Toedter's Perinatal Grief Scale[5, 22] reported, in fact, that initially intense grief ("active grieving") involving sadness, crying, and longing for the baby did not portend the psychological difficulties associated with "difficulty coping" (often associated with depression and interference with daily functioning) and "despair" (often indicative of long-term difficulties in self-esteem).

We need to be careful not to restrict the range of normal grieving to a modal reaction. Bereaved parents will often be chastised if they do not grieve in the socially acceptable manner, whether their grief is viewed as too profound and extended or not enough and "in denial." One study reported that "grief guilt" (*i.e.* bereaved parents perceiving themselves as not grieving in the socially appropriate manner) exceeded other forms of guilt after the death of a child, such as survivor guilt or recovery guilt (guilt over beginning to feel better).[198]

Empower Parents

We often overlook the fact that most unanticipated perinatal loss is traumatizing. "Psychic trauma occurs when a sudden, unexpected, overwhelmingly intense emotional blow or a series of blows assaults the person from outside … he or she feels utterly helpless during the event."[146] Because helplessness is such an important ingredient in trauma, assisting parents to regain a sense of control is vital. It is natural and valuable for caregivers to provide direct guidance, because parents are initially often confused, sometimes disoriented and looking for direction. However, it is crucial to avoid lecturing to the bereaved parents and to avoid giving them a flood of suggestions that increase their passivity and sense of helplessness.[164]

One qualitative Swedish study[169] eloquently described how mothers facing the death of their newborns—a potentially traumatizing situation—are empowered when their empathic caregivers create a sense of confidence, comfort and understanding. Through caregivers providing information, gentle guidance and offering emotional closeness, mothers felt much more able to decide what treatment to pursue (or not) and to have contact with their dying babies. Conversely,

when caregivers stubbornly cling to their expectations of how all parents should grieve (*i.e.* by holding their baby) or institutional protocol (*e.g.* when it was permissible to visit the nursery), bereaved mothers often felt alone, misunderstood, violated and insecure.[169] This study crucially underscores how much the sense of helplessness or empowerment—and the ensuing degree of trauma—is based not only on the specific circumstances of the medical crisis but the matrix and outcome of parental-caregiver interaction.[175]

Providing options along with the time and assistance for parents to decide what is best for them counts more than directly or covertly telling them what you think they should do. This may not be easy for experts to do when they have been accustomed to having the right answers and have genuine wishes to help parents who have been hurt so badly. Couples are often told soon after a pregnancy loss not to attempt another pregnancy for at least six months, giving them enough time to grieve this death. One study reported, however, that fewer than 25% of women follow this advice; most are unhappy about being told how long to wait but many appreciate a discussion of the advantages and disadvantages of waiting.[199] For example, attempting a pregnancy that coincides with the time of year of the last loss may be expected to heighten the anxiously feared repetition of the prior loss because of the greater difficulty in separating the two pregnancies. However, with older women with declining fertility or women especially worried about being able to successfully conceive, waiting may promote more anxiety and/or damaged self-worth (along with later guilt over having waited too long if a pregnancy does not occur). Furthermore, the dangers of a subsequent child being primarily viewed as a replacement for a prior perinatal loss—the usual reason for recommending delaying the next pregnancy—may be exaggerated and not supported in more recent research.[45, 200]

Bereaved parents are in the best position to teach caregivers what helped and what was not useful. Once sufficient time has elapsed for them to deal with their feelings, they should be invited to provide feedback either anonymously or, if they are comfortable, directly. Those caregivers who are willing to listen and respond to bereaved families constructively criticizing their hospital experiences will be on the cutting edge of developing improved practice.

Whenever possible, bereaved parents should also be included as advisers and participants on the support team after perinatal loss. As a couple who has “been there,” they offer a unique perspective on normalizing reactions to perinatal loss. As volunteer counselors, they will need to be screened and trained to be sure they are suited for this role. Such support will not replace what medical caregivers can supply. In fiscally difficult times, it will be especially valuable to have such support, which is priceless while costing virtually nothing.

Including bereaved parents in educational and counseling roles provides beneficial empowering opportunities in the latter stages of coping with their grief, sometimes years after the loss. Perhaps more importantly, it acknowledges and uses the very real contribution they can make in the improvement of practice after perinatal loss.

Follow-Up Care

A neglected but vital practice

A serious deficiency in the management of perinatal loss is the lack of or insufficient hospital follow-up. Because parents are usually in a state of shock when this sudden, unexpected death occurs, they are often unable to clearly understand or remember what they were told in the hospital. A follow-up appointment within a week is necessary to address any questions and concerns they have. This is a suitable time to review with them the course and variability of grief, typical differences between maternal and paternal reactions, how children often respond, and medical information about the loss and future pregnancies.

Research has repeatedly emphasized both the value of follow-up contact and how often it is overlooked. One early study revealed that parents who were given a 15–40 minute phone call within 10 days of a neonatal death, reviewing the loss and their grief, reported significantly less loneliness, depression, and guilt, and fewer questions about the death 2–6 months postloss than did parents without telephone follow-up.[201] Other investigations have indicated that approximately 75% of parents who suffered a perinatal loss wanted to discuss the details of the death or come in for a follow-up appointment 2–4 months after the loss.[202, 203] A report of a national maternal health survey stated that more than 50% of the sample experiencing perinatal loss wanted more information on many issues. This was twice the number of the next most commonly given complaint—unresolved questions about the loss, frequently because of inadequate explanations.[204]

The stakes and potential repercussions are even higher when there is no follow-up after a miscarriage. It is becoming increasingly clear that there is significantly greater dissatisfaction with caregiving after a miscarriage compared to a later gestational loss,[8, 52, 56] caused, in part, by the lack of medical recognition of how emotionally difficult, and potentially traumatic, this loss can be.[55, 58] Most women report wishing for and benefiting from follow-up appointments after a miscarriage.[55] In fact, half of the participants in one study believed a follow-up appointment after a miscarriage should be obligatory, because they reported a significant decrease in satisfaction with both the emotional support received and the information they received from time of hospital discharge to three months later.[205] The psychic need for recognition of the importance of this loss may be so keen that even participation at two weeks postloss in a structured, easily administered phone research interview by nonmedical staff resulted in inadvertent therapeutic benefits evidenced by significantly lower symptom levels at six weeks and six months for only those women reinterviewed.[93]

Guidelines for Counseling

Because a sizable number of parents will be at risk for psychological difficulties, counseling over the next year is needed to provide support, facilitate grieving, discuss autopsy results, and make referral for psychotherapy when appropriate. Such a series of three to four meetings (or more if

necessary) has long been recommended by caregivers and researchers[7, 13, 38, 108, 139, 183, 201, 202, 206] and has been associated with fewer cases of unresolved grief[207] and less prolonged grief.[208] More recent studies indicate the value of interventions after perinatal loss in ameliorating grief when using measures of patient satisfaction,[209] comparison with a live-birth group,[210] and comparison with a nonintervention bereavement control.[211] While meta-analysis of the broad range of bereavements indicate that grief counseling is not always warranted, and indeed, in some instances may be counterproductive, this does not apply to traumatic, complicated losses which are most likely to benefit from such interventions.[87, 212] The unexpected and usually multifaceted nature of pregnancy loss is likely to make some amount of counseling useful if not necessary.

Such counseling is best accomplished in office visits, highlighting the importance of face-to-face meetings rather than brief phone calls. Such a series of meetings tells patients that we mean what we say: grief is a process that is not accomplished all at once but takes time and work. Charging a fee for an office visit is also warranted, communicating the importance and value of such meetings. Such counseling is most effectively provided by the physician who has established a trusting relationship with the woman prior to the loss, reinforcing the principle of continuity of care.[213, 214] Ideally, both partners should participate, although an unwilling father should not preclude individual meetings with the mother. It is important that this counseling be presented to the family as a routine and basic part of medical care; they should not be made to feel that they are being singled out for special psychological treatment because they are “messed up.” Medical caregivers without mental health training must, of course, be careful not to attempt psychotherapy required by earlier mental health problems or more severe psychological disturbance. Medical caregivers need to become familiar with the basic elements of grief counseling[215] and applying counseling in medical settings.[216]

The importance of providing empathy, individualizing care, and empowering parents discussed in guiding hospital practice is just as critical in conducting counseling. With the availability of more time and greater emotional distance from the crisis of the loss, it is now possible to explore in greater depth what this loss means to the couple. Although a cardinal rule of grief counseling is understanding the nature of the relationship of the bereaved with the deceased, it is especially striking how often the feelings of the pregnancy—the hopes, fears, and often unspoken misgivings—get overlooked. It can be explained to the bereaved couple that you want to understand what this pregnancy and loss has meant to them, including how experiences in their past, growing up, marriage, and so forth, may have influenced their feelings about this pregnancy. Learning about possible prior unresolved losses that have become associated with this death, earlier and long-term emotional problems, and the lack of social support both within and outside the marital relationship, may explain why this grief can become so extended and unyielding.

Exploring how the couple is coping with their potentially different styles of grieving as well providing guidance in understanding and managing their other children's reactions is also necessary.

To understand the couple better, it is necessary to obtain psychosocial histories that consider past losses, their own and parental obstetric history, relationships with important others (especially spouse, parents, and siblings), prior difficulties, and coping skills. This is most effectively presented as a way of getting to better know them as people as opposed to a formal, psychiatric intake. When counseling ends, the door should always be kept wide open for the bereaved couple to return to discuss any problems that may later develop. It is common for a subsequent pregnancy to be laden with anxiety over another dreaded loss, requiring more support, as discussed later.

Related Reproductive Losses

Miscarriage is an especially variable loss. While several studies reveal either no significant increase in emotional distress[217] or almost 50% of subjects reporting no reactions after miscarriage,[72] there is ample evidence indicating that a large proportion of women who miscarry experience painful grief and traumatic reactions likely to precipitate, respectively, depressed feelings and anxiety, although most longer term studies report remission by the end of the first year postloss.[89, 90, 91, 92, 93, 94, 95, 96, 218] Miscarriages may result in post-traumatic stress disorder soon after the loss, especially in later losses with enduring traumatic memories of seeing the fetus/baby expelled.[219] Futhermore, the risk for later maladjustment may be compounded by the difficulty caregivers often have in responding to a loss that may entail more ambiguous interventions (i.e., with no actual baby to grieve what is one to do?) and more insidious blows to self-esteem. In managing the woman who miscarries, the caregiver needs to be aware of the multiple pathways (and combination of reactions) which may lead to: (1) anxiety and confusion related to the challenges to one’s identity, view of one’s world, and pinpointing what exactly was lost;[220] (2) grief, especially with later miscarriages, associated with the loss of the baby who becomes more difficult to mourn if not seen, identified, and personified; (3) social isolation, estrangement, and bitterness, especially if there are no surviving children, with the intense frustration of not being able to parent; (4) depression, which may be magnified by earlier difficulties in self-worth exacerbated by blaming oneself and feeling a failure due to this loss; or (5) little emotional reaction to a pregnancy loss that may be more a disappointment than a major life event and crisis. Indeed, perhaps both the frequency of miscarriages and the not infrequent minimal reaction by the woman miscarrying may sadly reinforce some caregivers too often adopting a callous attitude overlooking how devastating and complicated this loss can be. Miscarriage compels the caregiver to suspend uniform assumptions about how patients usually respond and try to tune into what this event means to this particular woman now, prepared to recognize how different her reaction might be to another woman treated yesterday or this very

same woman who miscarried last year. What should, however, be universally applied in the management of miscarriage is the elimination of the usual medical term, "spontaneous abortion,"[221] because of its association with early, elective abortion in the popular mindset. This confuses an often traumatizing loss outside of one's control with a chosen medical procedure that is unlikely to elicit a grief reaction,[222, 223] potentially increasing self-blame by the woman who miscarries, potentially exacerbating depressive reactions.

As earlier reported with perinatal loss, prospective fathers sometimes indicated more chronic and disabling grief following miscarriage than did their partners,[123, 224] likely due to the inhibition of their grieving, and social isolation from maternal grief. This may result in a double-bind where he is expected not to share his sadness with his wife (lest that upset her), while viewed as uncaring if he shows no emotion.[225] Finally, with the earlier, increasingly routine use of high resolution ultrasound displaying a very detailed and magnified image of the tiny fetus, pregnancies are now experienced as babies much earlier with heightened parental attachment[226, 227] and greater potential grief if a miscarriage results. Acceleration of parent-fetal attachment due to ultrasound (and resulting grief should a miscarriage ensue) may be a more powerful factor for men than their partners, due to the absence of the more usual visceral experience of pregnancy available to the expectant mother.[120, 224, 228]

Undoubtedly the least clearly understood and most overlooked pregnancy loss is ectopic pregnancy. While ectopic pregnancy is now more common than perinatal loss, not one empirical investigation has studied this loss in its own right, despite evidence that it may lead to protracted, unresolved grief.[5] Because of the life-threatening emergency requiring immediate intervention, the psychic consequences of this loss may be shoved aside and neglected by both the couple and caregivers. In fact, the single qualitative study of women's reactions to ectopic pregnancy describes how often the woman blunts both her physical and emotional pain, making it difficult to grieve her loss.[229] Tubal damage, especially when surgical intervention results in tubal removal, may exacerbate the psychic experience of a damaged self when the body is literally wounded. The danger of compromised fertility for the future may become an additional depressive burden, intensifying felt inadequacy and interference with becoming a parent if there are no surviving children. There continues to be an unmet need both to better understand and address the particular consequences of this increasingly frequent pregnant loss which may be associated with more chronic difficulties.[5]

Perinatal loss accompanied by infertility presents additional challenges. The strain of grieving perinatal loss is compounded by the stresses of infertility,[230, 231, 232, 233] with both losses magnifying the developmental interference in achieving parenthood as well as assaults on self-esteem.[234, 235] The frustration and disappointment of involuntary childlessness can also be profoundly compounded by the stigma of infertility, compelling the infertile couple to adapt to a denigrated status and the accompanying social intrusion, isolation, minimization,

misunderstanding, and mocking.[79, 236, 237, 238] Women who experience miscarriage after infertility suffer the additional burden of not knowing if they will be able to become pregnant again.[239] One clinical study describes how the grief of perinatal loss is often deepened by a prior history of infertility when a perinatal loss has a psychic gestation of many years of repeated attempts rather than solely the physical gestation of many months.[240] For many couples, the death seemed especially senseless, further shattering their sense of any justice in the world or religious faith in a benign God: "After all these years, why did I become pregnant in order for this to happen?" or "Just when I was ready to move on and adopt, I became pregnant and lost the baby. Now I feel I am back to square one and don't know what to do." Bitterness may be particularly keen with the knowledge that this pregnancy may have been their last possible chance for a baby. Ironically, while infertility typically intensifies grieving perinatal loss, perinatal loss may soften the impact of infertility, even within the same person later on in counseling. When there has been a complete inability to conceive, any pregnancy, even an ultimately unsuccessful one, often gives hope for the future. If it is a late-term loss in which a baby has been seen, held, and named, the identification of their child as a permanent family member confers the status of parent, even if bereaved, which has been desperately sought. The extended grieving of perinatal loss amplified by infertility as well as the protracted period of decision-making and potentially attempting further pregnancies may increase the need for counseling or psychotherapy[240] as well as making couple therapy an especially valuable modality.[241]

Pregnancy termination because of fetal anomaly results in profound grief, similar to the emotional response to perinatal loss.[242, 243] There is often a threefold trauma based on the shock of getting the bad news of the fetal abnormality, having to make such a difficult decision under severe time constraints, and undergoing the termination procedure. In fact, this reproductive loss may be even more difficult to manage than perinatal loss, because it demands addressing many added psychological burdens, including the moral and marital challenges in making the decision of whether to terminate, the quandary of whether a pregnancy or a life has been ended, the intensified shame and reluctance to share this loss with others because of societal controversy about elective abortion, and the anxiety and guilt in telling (or not) one's own children about the nature of this loss.[244, 245] These complicating factors, especially the heightened guilt and shame which often drive couples into greater silence and secrecy, thereby depriving themselves of beneficial support from others, may make this an especially vulnerable group, suitable for counseling.[187] Studies report strikingly different outcomes to these losses. Research in the Netherlands indicated most couples who received caregiver help in viewing and saying goodbye to their dead baby demonstrated no significant grief or distress by six months postloss.[186] One study in Germany reported that 2–7 years after a termination for fetal anomaly mothers remained as traumatized as women only 2 weeks after the loss.[246] Perhaps the much greater societal acceptance in the Netherlands of such terminations (as one of the few countries in the world which legalized euthanasia) contrasted with the more deeply conflicted response

among Germans (due in part to the troubled eugenics history of Nazi Germany) may account for how differently this loss may be discussed, processed and resolved in one cultural milieu or frozen as a silent trauma in another. Medical caregivers need to provide the emotional support and understanding for this often overlooked reproductive loss, making use of handbooks[247] normalizing powerful reactions.

The Subsequent Pregnancy

The pregnancy after perinatal loss combines hardship and healing. Numerous studies report heightened anxiety based on the fear of another pregnancy loss[248, 249, 250, 251, 252, 253, 254, 255, 256] as well as increased social isolation.[257] As was found in the initial response to perinatal loss, depressive reactions and intensified grief during this pregnancy as well may stem from the self-blame and feelings of inadequacy of women vulnerable to difficulties in self-esteem.[258, 259] An early qualitative study sensitively documented that such pregnancies tend to be serious and task-oriented, with the usual joys and pleasures of pregnancy replaced by a blunting of emotions with coping designed to minimize risks and get through the pregnancy one day at a time.[260] A more recent account aptly portrayed this subsequent pregnancy as, “One foot in—One foot out,” describing the attempts to balance reliving the past loss with the current wishes for a healthy child tempered by dampened expectations which at times lead to dreading the worst.[261] At the same time, this same pregnancy can be healing, increasing the resolution of prior perinatal loss,[19, 21, 83, 84] especially if that earlier loss can be grieved in the subsequent pregnancy.[262] Rather than interfere with grieving a prior perinatal loss, the subsequent pregnancy may facilitate adapting to that loss by mitigating the despair and difficulty coping more commonly found in women who had a prior perinatal loss but did not become pregnant.[85] Studies examining the long-term adaptation to perinatal loss frequently report that the subsequent birth of a healthy child is associated with a significantly reduced expression of grief and overall better functioning,[5, 21, 35, 84] with only one study suggesting that becoming pregnant less than a year after a stillbirth was associated with significantly more depression, anxiety and PTSD symptoms than mothers conceiving more than a year after their loss.[130, 252] Most women do become pregnant within the year after their pregnancy loss[84, 251] with the bulk of this research indicating that the risks associated with becoming pregnant sooner than a year may be exaggerated and the benefits associated with that pregnancy underestimated. Overlapping the perinatal loss with a new pregnancy may intensify grieving and anxiety if the two pregnancies become conflated, sometimes experienced as "one big pregnancy." It may also more rapidly restore maternal self-worth and satisfy the profound wish to parent, thereby easing other sources of distress.

Both qualitative[256, 260, 261, 263, 264] and quantitative[249] studies report that after a perinatal loss prenatal attachment is diminished in the subsequent pregnancy. However, this appears to be based on a self-protective muffling of parental love for one’s child in order to avoid another traumatizing, devastating grief rather than a disinterest in the pregnancy. A similar dynamic may

explain the significantly reduced grief among couples coping with recurrent *versus* a single miscarriage[265] and the commonly reported finding of prior pregnancy loss not being a significant predictor of more intense grief in a subsequent pregnancy loss.[5, 21, 84, 228] The adaptive capacity to suspend one's prenatal attachment thereby preventing another traumatizing grief when loss does occur does not mean, however—as research on the subsequent pregnancy testifies—that a prior loss is an unimportant factor. Nor is there any evidence to suggest that this temporary blunting of attachment is likely to become an ingrained emotional detachment from one's infant. Instead, an anxious overprotectiveness suggestive of a heightened investment in their children is commonly reported by mothers after the births of healthy children after perinatal loss.[199, 260, 266] While one study reported that initial distress, depression, and anxiety in coping with an infant after perinatal loss diminished over the first four months,[267] there is mounting evidence to suggest that unresolved grief due to pregnancy loss in the mother is significantly associated with disorganized attachment in the subsequent child, an important risk factor in child development.[268, 269, 270] These detrimental repercussions to subsequent children appear to apply only to the relatively small subset of women who did not resolve the prior perinatal loss.[270]

The medical caregiver does his patient much good by riding out the inevitable ups and downs, anxieties and dejections that come with a typically wished for but concurrently dreaded pregnancy after perinatal loss. Family and friends who mean well but do not understand will often be inclined to try to actively talk them out of their fears or change the subject, not wanting to listen. Either way, it will leave the anxious couple feeling more alone and isolated rather than comforted. Instead, taking their concerns and anxieties seriously and legitimating how understandable they are based on their own experience of loss can go far in normalizing their experience as opposed to covertly implying they are losing control, going crazy, or irrationally anxious or "paranoid." Once the couple feels their anxieties and fears are heard and accepted, it may be possible to quietly and supportively voice the optimistic belief of a better outcome this time, even though of course there are no guarantees. Patiently offering the availability of additional ultrasounds to assure the anxious woman that her pregnancy is fine may be very comforting and necessary. Anticipating that their anxiety is likely to intensify as the anniversary of the loss (either actual date and/or gestational age) approaches with the understandable fear of a repeated loss helps explain their rising distress and its anticipated subsiding after the anniversary. Similarly, increased grieving over the course of this pregnancy is typically a reliving of that loss triggered by the experience of being pregnant again. It is not a sign of unresolved or relapsed grief, but another opportunity to gain increased closure on a trauma that could not be processed the first time around. Finally, it may ease the guilt over not feeling so much for this coming baby if it is understood that it is natural to want to protect oneself from feeling again the intolerable pain resulting from how much one did allow oneself to love the last baby (and that there will be plenty of time to thaw those frozen feelings when it feels safe to love again).

Professionally facilitated support groups may also fulfill an important function by helping women with a prior perinatal loss get through the subsequent pregnancy, typically heightened by anxiety and revived grief.[152] The support group structure may be a particularly powerful vehicle when the usual societal norm of pregnancy associated with birth, a baby, hope and an emotional and public experience is challenged by the support group's shared understanding of the additional paradoxical meanings of the next pregnancy as signifying, respectively, death, no baby, fear and a detached and private experience.[152]

The Role of Psychotherapy

Soon after the loss, it may be impossible to precisely predict individuals and couples who will encounter later psychological problems.[4, 11, 74, 203] In the immediate aftermath of perinatal loss, substance abuse or the development of severe psychosomatic problems warrants psychiatric consultation. Suicidal behavior or serious intent (not solely thoughts of dying, which are common) is potentially fatal and requires immediate attention. While the majority of women report the intense distress and grief of perinatal loss dissipates over the first year, a significant minority (about 15%) may have unresolved grief enduring indefinitely if significant alleviation of anxiety, depression or impaired functioning has not begun to occur by eight months postloss.[271, 272] Prior mental health problems—especially depressive difficulties with low self-esteem—and inadequate social support, especially between the partners, have most powerfully been associated with later maladjustment in quantitative studies.[4, 5, 21, 22, 73] The majority of couples appear to adapt within two years without psychotherapy, indicating that recommending extended counseling for all couples experiencing perinatal loss is unwarranted[183] and may be detrimental based on findings challenging the universal benefits of grief counseling.[70, 87] Nonetheless, anyone in sufficient distress to be motivated to seek additional psychological help at any time should not be discouraged. During the year after the loss, psychotherapy may prevent the development of further disturbance by facilitating grief and addressing maladaptive reactions based on earlier emotional difficulties. In subsequent years, psychotherapy may effectively address emotional difficulties, often depressive in nature, based on earlier unresolved perinatal loss or an earlier pregnancy loss that has become associated with a prior unresolved loss.[11, 64, 65, 273] Finally, the relatively briefer trajectory of perinatal grief must be clearly distinguished from the typically extended intense grieving over the usually traumatic death of the older child which often endures for over five years, with a lower level of functioning usually resuming than occurs with perinatal loss.[36, 274, 275]

Empirical studies have not determined the optimal outpatient model for treating perinatal loss in psychotherapy.[183] However, based on the much discussed indispensability of empathic care being the cornerstone of therapeutic medical caregiving and social support, a model which incorporates such empathic understanding is likely to be effective.[26] Alternatively, "interconceptional" counseling has been developed to help bereaved parents master the grief, anxiety, and lowered

self-worth that typically follow perinatal loss, while offering support in the planning and experience of the subsequent pregnancy, usually fraught with increased anxiety and revived grief.[276] Finally, a recent guideline to social work practice advised that the usual silence and avoidance of discussing pregnancy loss be challenged by incorporating questions about such losses routinely into psychosocial assessments, empowering the client to discuss the loss in her own terms (*e.g.* whether a pregnancy or baby was lost, normalizing the intense reactions to these losses while mindful of particularly complicating circumstances) and examining the often anxious aftermath in looking to the future.[277]

With the increased use of selective serotonin reuptake inhibitors (*e.g.* fluoxetine, sertraline, and paroxetine) which have fewer side effects, antidepressants are increasingly being prescribed for depressive reactions associated with bereavement. If the bereaved is able to form an effective therapeutic alliance, medications usually are not necessary, because considerable symptomatic relief is achieved over the course of short-term psychotherapy. In the presence of immobilizing depression or serious suicidal risk, antidepressants may be needed. When medications are required, there is often prior major depression, serious personality disorder, or a history of trauma rather than solely a severe reaction to perinatal loss. Antidepressants without regular psychotherapy are not the appropriate treatment for maladaptive grief reactions. Medication cannot do the necessary grief work or address the complicated psychological issues caused by these losses. For those who are adverse to considering anti-depressants due to concerns about side-effects, potential contraindications with attempting pregnancy and general reluctance to take medications, an aerobic exercise program should be considered. This approach has demonstrated significant efficacy in reducing depression, sometimes comparable to that of anti-depressants,[278] especially for those motivated to exercise and susceptible to encouragement.[279] Short-term psychotherapy is usually the optimal intervention when professional help is needed or sought the year after perinatal loss. Even when long-standing mental health problems exist, many motivational and psychological factors interfere with planning effective long-term psychotherapy at this time.[11, 65] After substantial resolution of the perinatal loss, a client sometimes chooses additional, more open-ended therapeutic work on related, but usually more chronic, issues.

Many women who seek psychotherapy after perinatal loss describe significant unresolved childhood loss, disappointment, or deprivation, especially with their own mothers, that have been awakened by this loss. Although insight is valuable in psychotherapy, the crucial healing ingredient again appears to be an empathic bond that enables the bereaved to grieve in an atmosphere of support and understanding, repairing losses spanning the generation that came before as well as the generation coming after.

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