The Maternal Mental Health Intensive:
Perinatal Loss and Grief

OVERVIEW OF PERINATAL LOSS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss three leading theoretical formulations of grief
- Discuss leading causes of perinatal loss

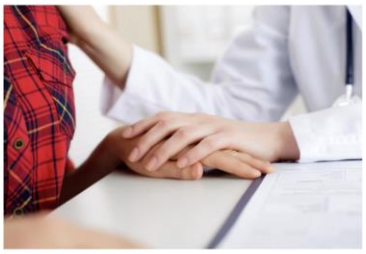
Note for Clinicians

Essential for clinicians to be informed:

- Leading edge theory
- Aware of own attitudes
- Clinical tools

Overview of Perinatal Loss

Types of Loss



- Miscarriage
- Stillbirth
- Neonatal death (before 28 days)

Overview of Perinatal Loss

Miscarriage

Miscarriage: Pregnancy loss prior to 20 weeks

Early Miscarriage: up to **10** weeks

Late Miscarriage: **10** to **20** weeks

- 80% occur in the first 7 weeks
- Prevalence: up to 20%
- Most miscarriages have no known cause (80%)

Overview of Perinatal Loss

Miscarriage

Possible Causes

- Most early miscarriages are believed to involve genetic abnormalities
- Other possible causes:
  - No gestational sac
  - Thyroid dysfunction
  - Hematological problems

Overview of Perinatal Loss

Recurrent Miscarriages

Recurrent miscarriages: 2 or more "spontaneous abortions" (SABs) or "failed pregnancies"

Prevalence:
- 1 miscarriage **20%**
- 2 or more consecutive miscarriages **5%**
- 3 or more consecutive miscarriages **1%**

- 50% to 75% of recurrent miscarriages: no known cause
- Remaining 25% to 50%: chromosomal abnormalities

Overview of Perinatal Loss

Stillbirth

Stillbirth: Pregnancy loss after 20 weeks

1 in **160** pregnancies end in stillbirth = **26,000** a year

- No known cause for more than one-half of stillbirths

Overview of Perinatal Loss

Stillbirth

Known Causes

- Placental abruption
- Preeclampsia
- Birth defect (chromosomal abnormality)
- Umbilical cord prolapsed or twisted
- Intrauterine growth restriction (IUGR)

Overview of Perinatal Loss

Neonatal Death

Neonatal Death: Death of baby before 28 days

- Most usual cause: Prematurity (before 37 weeks)
- 19,000 neonatal deaths/year
- No known cause for more than one-half of stillbirths

Overview of Perinatal Loss

Death of a Child

Death of an Infant or a Child

- Out-of-time death
- Parents at risk of ongoing distress
- Family functioning disrupted
- Risk for siblings or subsequent children: bear the burden of being a "replacement child"

Overview of Perinatal Loss

Assisted Reproductive Technology (ART) & Third Party Reproduction

Who Uses Fertility Technology?

- Infertile women and men
- Individuals and couples screening for genetic disease
- LGBTQ+
- Singles who want to build a family

Overview of Perinatal Loss

Assisted Reproductive Technology (ART) & Third Party Reproduction

Percentage of IVF (In Vitro Fertilization) Cycles Resulting in Pregnancy (by Age)

under 35	35-37	38-40	41-42	over 42
46%	38%	27%	19%	9%

The experience of losing pregnancies – especially an early miscarriage – is often not recognized as a "true loss"

Overview of Perinatal Loss

What Do We Know About Grief and Perinatal Loss?

- Not much! We live in a death-denying society, and it's imperative to understand the terrain of loss – for all losses
- Death is not part of our usual experience
- Reproductive loss is not recognized as a "real" loss: silence

Overview of Perinatal Loss

What Do We Know About Grief and Perinatal Loss?

- Families are often "unhinged," and there is a huge loss of innocence in their reproductive life
- In subsequent pregnancy: high risk for developing perinatal mood and anxiety disorders (PMADs)

Overview of Perinatal Loss

Developments in Understanding Grief

- Disenfranchised Grief
- Attachment Theory
- Continuing Bonds
- Dual Process Model
- Constructivist Approach
- Trauma and Grief

Consolidate Your Learning

- Consider ways your views about what grief is have changed after this lecture. What questions do you have?
- Consider what it might be like to experience a "silent loss." What might you find helpful?
- Consider what ways your knowledge about perinatal loss might change your expectations and assumptions about family building for those with whom you work clinically

OVERVIEW of MATERNAL PREOCCUPATION and INTERNAL REPRESENTATIONS INFLUENCED by PERINATAL LOSS

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Discuss three ways that maternal preoccupation and internal representations in pregnancy are influenced by perinatal loss
- Discuss ways that grief influences maternal preoccupation and internal representations in a subsequent pregnancy

Maternal Preoccupation

Attachment Begins to Form

- Normative experience
- Fosters bonding and attachment
- Creates willingness to care for the baby

Maternal Preoccupation

Attachment Begins to Form - Physical and Psychological Rupture

In perinatal loss

- Still look pregnant
- Lactation starts
- Heightened levels of oxytocin
- Loss of hopes and dreams and fantasies about baby
- Sense of emptiness
- Brain is resetting
- Can lead to distressing intrusive thoughts - shift to self blame or the sense that the body failed

Maternal Preoccupation

Understanding Grief: Internal Representations

- **Emptiness**
  Empty uterus & empty arms
- **Guilt**
  Cognitive distortion around responsibility for perinatal loss
- **Shame**

Maternal Preoccupation

Attachment Begins to Form

Normal or Maladaptive?

- Normal in late pregnancy and first months after delivery
- Becomes less specific
- After a pregnancy loss, maternal preoccupation can include obsessive thoughts about the baby who died
- Can shift into ruminations and potentially become maladaptive
- Internalized representations of self as inadequate or at fault can negatively impact attachment in relationships and subsequent pregnancies

Maternal Preoccupation

Ghosts in the Nursery

- Past losses and events "live" in the baby's nursery
- Unresolved conflicts and emotions from early relational difficulties or losses influence current dyadic relationship
- Can affect functioning and attachments (relationships) through life

Maternal Preoccupation

Understanding Grief: Internal Representations

- Emptiness
  Empty uterus & empty arms
- Guilt
  Cognitive distortion around responsibility for perinatal loss
- Shame
  Socially now the "face" of perinatal loss

Consolidate Your Learning

- Contemplate the internal representation(s) you have of yourself as a clinician and reflect on the ways that loss (not only perinatal loss) might have influenced your views of yourself and the ways you work clinically
- Then, consider a few ways that women, men, and families with whom you work might be affected by any "ghosts in the nursery." How might you and your work be affected?

DEFINING GRIEF

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss leading formulations of grief
- Describe three ways biopsychosocial implications of grief enhance understanding of normative grief

Defining Grief

Grief: the experience of one who has lost a loved one to death

Mourning: the process that one goes through in adapting to the death or the loss – a societal interaction

Bereavement: the state of loss

Defining Grief

Description

A natural process that is unique to each person, shared by many and shaped by the nature of the loss

- Who dies, and how, this shapes grieving
- Each person's grief is like all others'; each person's grief is like some others'; each person's grief is like no others'

Defining Grief

Understanding Normal Grief

Sadness and yearning
Anger
Guilt: "if only," "what if"
Anxiety
Fatigue
Helplessness
Shock
Numbness

FEELINGS

Defining Grief

Common Physical Sensations Experienced in Grief

- Hollowness
- Tightness in chest or throat
- Over sensitivity to noise
- Sense of depersonalization, or sense of nothing being real
- Breathlessness
- Extreme weakness

Defining Grief

Understanding Normal Grief

Disbelief
Confusion
Preoccupation
Rumination and the question: "Am I going crazy?"

THOUGHTS

Defining Grief

Understanding Normal Grief

Sleep disturbance
Appetite disturbance
Social withdrawal
Crying
Restless hyperactivity

BEHAVIORS

Defining Normal Grief

A Biopsychosocial Process

Will I ever feel OK or love again?

- Spiritual concerns often arise
- Can feel like a physical illness
- Affects psychological well-being
- Affects and interrupts social functioning

Defining Grief

Questions About Grief

Why Do We Grieve?

BIOLOGICAL BASIS | PSYCHOLOGICAL | CULTURAL/SOCIAL CONTEXT

Defining Grief

Ways Grief is Expressed

- Different patterns of grief
- Different strategies used to adapt to loss

Defining Grief

Adapting and Coping with Grief

INTUITIVE	BLENDED	INSTRUMENTAL
Often women – express grief more affectively (crying, venting feelings, seeking emotional connectedness)	Most people express grief using both at times but tend toward one or the other	Often men – express grief through taking action and figuring things out logically

Defining Grief

Description

Defining Grief

Understanding Normal Grief

Current understanding: Acute to Assimilated to Integrated into Life

Adaptive trajectories of grief (waves and phases)

Consolidate Your Learning

- What might change in your clinical approach with a pregnant woman with whom you have an ongoing therapeutic relationship and whom in the next session with you tearfully reports just having had a perinatal loss?

ATTACHMENT THEORY PART I

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify three ways that biological, psychological, and social factors are reflected in attachment theory and perinatal grief

Attachment Theory

At the Heart of Grief

- Attachment styles influence the ways we form relationships throughout life – including the ways we love and grieve

Attachment Theory

At the Heart of Grief

- Unique hopes and dreams about caregiving expectations might contribute to bereaved parents being at higher risk of suffering more, and potentially experiencing complicated grief or developing a PMAD

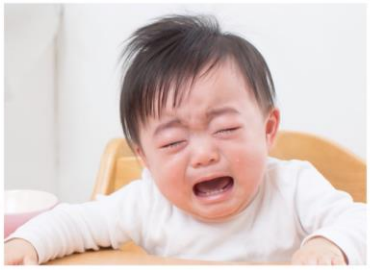
Attachment Theory

Biopsychosocial: Attachment Behavioral System

- Biological: *Attachment figures – safe harbor in times of distress. Proximity seeking in distress regulates emotion*
- Behavioral: *Exploratory behavior system – opposite of attachment behavioral system*
- Psychological: *Attachment orientation shapes ways that relationships are formed and maintained*

Attachment Theory

Separation Distress and Proximity Seeking



- The goal of attachment is to maintain the affectional bond and any situation that threatens this bond elicits actions or behavior designed to preserve the bond

Attachment Theory

Separation Distress and Proximity Seeking

- Separation distress of infant is mirrored in adult grief
- Proximity seeking

Attachment Theory

Notes for Clinicians

- Preoccupations and ruminations about the loss might be related to survival of the species
- Intense preoccupations and ruminations that don't diminish in time: potential risk factor for developing complicated grief or exacerbating depressive symptoms

Consolidate Your Learning

- Consider what we've discussed here about distress and seeking proximity as well as ways those with whom you work express distress and seek relief from others
- How does understanding the attachment and the intense behavioral activation and disruptions related to separation distress and seeking proximity inform your therapeutic approach, including conceptualizing and formulating effective treatment interventions?

ATTACHMENT THEORY PART II

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify attachment styles and ways attachment styles influence the grief process for bereaved parents experiencing pregnancy or child loss

Attachment Theory

Theoretical Foundation: Grief

Attachment Theory
as the "Umbrella" to understand Love and Loss

Attachment Theory

Theoretical Foundation: Grief

Attachment styles influence loving and grieving

- **Secure:** balance of independence and dependence
- **Anxious:** continual proximity seeking
- **Avoidant:** continual distance seeking
- **Disorganized:** confused & contradictory combination of approach/avoidance

Attachment Theory

Secure Attachment Style - Impact on Grief/Adaptation

- Safe haven (curiosity/learning)
- Emotional regulation – capacity to soothe and tolerate separation
- Separation occurs and then reunion = able to emotionally regulate (neurological changes)
- Balance of independence and dependency

Attachment Theory

Anxious Attachment Style - Impact on Grief/Adaptation

- Interrupts capacity to form internal representations representing safety. Internal representations: danger and intrusive thoughts
- Ghosts in the nursery – risk for subsequent pregnancy and difficulty with attachment – catastrophizing. Difficulty forming attachment with subsequent pregnancy – adversely affecting child development
- Risk of PMAD because of internalized fears and worries and expectations and difficulty regulating emotion – parent seeks proximity and has difficulty separating from preoccupations

Attachment Theory

Avoidant Attachment Style - Impact on Grief/Adaptation

- More likely to be isolated and not able to name or understand one's emotional responses
- Risk of PMAD in subsequent pregnancy: difficulty attaching and forming a bond with subsequent child

Attachment Theory

Disorganized Attachment Style - Impact on Grief/Adaptation

- Emotional and cognitive "shut down" so potential to develop complicated (stuck – emotions and thoughts become unspeakable and terrifying)
- Subsequent pregnancy – risk of developing PMAD because pregnancy is confusing and frightening
- Subsequent baby after loss: mother is afraid of baby and baby is afraid of mother – negatively influencing attachment, and cognitive and emotional development of the baby

Attachment Theory

Transformation: Earned Security

- Attachment style is not "fixed" or static in life – can be changed, often in relation to intentional reparative work
- Shifts possible in attachment styles from less adaptive to more adaptive
- Develop a mature narrative that includes cognitive and emotional flexibility
- Perinatal loss and grief can influence shift of security status to "earned security"
- Impact: moving through grief and adapting to loss while developing earned security
- Protective in subsequent pregnancies, family building

Consolidate Your Learning

- Consider the ways that perinatal loss and attachment styles would influence your case conceptualization and treatment planning
- In what ways do you think that the interaction of attachment styles, including earned security, might influence the grief process related to pregnancy and perinatal loss?

DUAL PROCESS MODEL OF GRIEF AND CONTINUING BONDS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss and compare and contrast ways that the Dual Process Model of grief and Continuing Bonds approach address adaptation in perinatal grief
- Describe three ways that these approaches differ in those who are perinatally bereaved and adapting to loss from those who are bereaved in the general population

Dual Process Model

Adapting and Coping with Grief

- Oscillating between the loss and a restoration focus – re-engaging in a meaningful and satisfying life
- Using both loss and restoration focus to help process the pain of grief and to find a new normal – as grief resolves, less loss focus and more restoration focus
- Grieving parents sometimes need help adapting to the pregnancy loss

The Dual Process Model of Coping with Grief

Continuing Bonds

- Loving in absence rather than adapting to it by severing the tie, letting go, and moving on
- Choosing to maintain an ongoing and loving bond with the deceased
- Question to ask: Is it more adaptive to maintain a bond? Is it more adaptive to let go?

Continuing Bonds

- Perinatal loss: complex internal representations/hopes and dreams. Attachment not from a lifetime of lived memories
- Recognition of a more adaptive response to grief when the relationship was cherished: To maintain an ongoing bond (internalized representation)

Dual Process Model

Acute Grief

- **Oscillating between loss orientation and restoration orientation is normative**
- **In acute grief:**
  More time spent in loss orientation
  "What if" questions and ruminations
  Guilt and self blame
  Shock, confusion
  Deep yearning and sadness dominate
  Parents are permanently changed

Consolidate Your Learning

- Consider the clinical vignette in this lecture used to illustrate continuing bonds – a specific theoretical understanding about the process of grief
- What other factors would you consider in creating a treatment plan for Elizabeth?

CONSTRUCTIVIST VIEW AND DISENFRANCHISED GRIEF

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Discuss and compare and contrast ways that the theoretical perspectives in the Constructivist view of grief and Disenfranchised Grief each address adaptation in grief
- Describe three ways that these approaches differ in those who are perinatally bereaved and adapting to loss from those who are bereaved in the general population

The Constructivist Approach

- Big role of language, meaning making, and story of a person's life
- Finding new meanings for life in a world challenged by loss, and rewriting the story of one's life
- Bereaved person's experiential world is the focus
- Grief is not an illness or separate from the meaning each person makes of loss

The Constructivist Approach

- Responses to perinatal loss are not all the same
- Essential to follow each person's world and story
- "Future chapters are "rewritten" to tell the story of the loss in a coherent way as well as revising and reestablishing identity
- Death changes the "story" so the bereaved are finding a "new normal" in the next chapters of life, and connections to past and future chapters

The Constructivist Approach

SELENI

- Challenge of grief – while acknowledging the reality of the loss and the pain of the loss, revising your assumptive world
- Loss of attachments challenges identity
- Grief is more than a coping mechanism or emotional adjustment

Some questions that come up

Next Chapters

Loss disrupts this story and future "chapters" now are "re-written" and new meanings emerge – and a new coherent life story potentially emerges

Disenfranchised Grief

- Concept of "Disenfranchised Grief" originated as the AIDS/HIV crisis unfolded: Partner not allowed to be part of the mourning process
- Social justice: a disenfranchised griever not viewed as entitled to be a mourner

Constructivist Approach and Disenfranchised Grief

CASE DESCRIPTION

Disenfranchised Grief

The loss is:

NOT SOCIALLY SANCTIONED

SOCIALLY NEGATED AND SILENT

SOCIALLY UNSPEAKABLE

Constructivist Approach and Disenfranchised Grief

CASE DESCRIPTION

Disenfranchised Grief

The loss is:

NOT SOCIALLY SANCTIONED | SOCIALLY NEGATED AND SILENT | SOCIALLY UNSPEAKABLE

Consolidate Your Learning

- Consider the clinical vignettes. Each was used to illustrate a specific theoretical understanding about the process of grief
- What other models might also be considered if you were creating a treatment plan for Elizabeth, Kyla, and Valentina?

DEFINING COMPLICATED GRIEF

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Describe various ways that complicated grief is similar and different from depression

Defining Complicated Grief

Normal Grief or Complicated Grief

- How long will this take? Six months? A year? Two years?
- Normative grief patterns and experiences vs. symptoms
  Stuck? Fresh and raw?
- Functioning:
  Impaired?

Defining Complicated Grief

What Arises in Complicated Grief?

- Pain is "fresh" and "raw" long after the loss
- Stuck in ruminative and negative cognitions
- Difficulties regulating emotions
- Both yearning and avoidance that interfere with adaptation to the loss

Defining Complicated Grief

Intergenerational Transmission

- Grief becomes unspoken and unresolved and implicitly present in the story of families
- Unresolved grief blocks adaptation and moving through grief, obstructs reconstruction of meaning and purpose or shifts in internal representations

Defining Complicated Grief

Intergenerational Transmission

- Grief becomes unspoken and unresolved and implicitly present in the story of families
- Unresolved grief blocks adaptation and moving through grief, obstructs reconstruction of meaning and purpose or shifts in internal representations

Defining Complicated Grief

Intergenerational Transmission

- Grief changes the ways we adjust: complicates the possibility of embracing life

Defining Complicated Grief

Acute to Integrated Grief

- How do we get to joy and satisfaction again?
- There's a movement from being engrossed in pain/loss to an integrated grief

Defining Complicated Grief

Integration of Loss

- Acute grief = normal, natural response to loss of attachment (pregnancy)
- Through Dual Process of Coping with Loss & Restoration -> Loss Integrated & Acute Grief subsides

Defining Complicated Grief

Integration of Loss

Complicated grief occurs when the loss is not integrated because:

- Blocked through cognitive distortions (e.g. around responsibility)
- Ineffective emotion regulation
- Social support or recognition of legitimate grief process

Defining Complicated Grief

The Question of Depression or Grief

- Grief is not depression (it can "look" like depression), and depression is not grief
- Overlapping symptoms: sadness, guilt, sleep, and appetite disturbances

Defining Complicated Grief

Distinguishing Depression and Complicated Grief

MAJOR DEPRESSION	COMPLICATED GRIEF
• Withdrawal from social connections / loved ones	• Intense preoccupation with the loss
• Pervasive loss of interest and pleasure	• Loss of interest and pleasure related to the loss
• Low self-esteem and sense of guilt and shame	• Self-blame, avoidance because of the loss

To help discern the difference between grief and depression: in depression, the self is empty. In grief, even complicated grief, the world is empty

Consolidate Your Learning

- In *Mourning and Melancholia* (written in 1917), Freud recognized mourning – grieving – as a conscious process and that is a healthy and normal process necessary for recovery following a loss. And, briefly, he viewed melancholia as an illness – an unconscious process, one that clearly resembles contemporary conceptualizations of depression
- As you consider ways that bereaved parents coming in to your practice might present, what are some ways you would be guided in distinguishing between normative grief, complicated grief, and depression?

DIAGNOSTIC CLARITY, CODING, AND PRINCIPLES OF PSYCHIATRIC CARE IN THE PERINATAL TIMEFRAME

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Describe various factors complicating diagnostic clarity around complicated grief or depression, and you will able to define three ways in which we assess the need for a psychiatric referral

Diagnostic Clarity and Coding

DSM-5 and the Bereavement Exclusion

- Grief professionals carried out research attempting to distinguish normative grief and complicated grief, to have complicated or prolonged grief included in DSM
- May 2013 publication of DSM-5 did not include complicated or prolonged grief as a diagnostic category and eliminated the bereavement exclusion from the diagnostic category Major Depressive Disorder
- Proposed conditions for further study "Persistent Complex Bereavement Disorder"

Diagnostic Clarity

Unresolved Grief in Subsequent Pregnancy

- Loss of innocence in subsequent pregnancy and fear/avoidance about pain of loss -> reluctance to bond or attach to subsequent pregnancy

Diagnostic Clarity

Unresolved Grief in Subsequent Pregnancy

- "Wanting to want" the attachment is the start of attachment
- Psychiatric referral: Question of depression or anxiety or grief

Diagnostic Clarity

Unresolved Grief Due To Perinatal Loss

- Narrative about the loss more likely to be disjointed, tangential, and lacking coherence and consistency
- Difficulty recognizing and regulating emotion – can influence decision making — next steps in building a family and in a subsequent pregnancy
- Anxiety: expected but not required
- Possibility of complicated grief

Diagnostic Clarity

Unresolved Grief Due To Perinatal Loss

- Difficulty being able to fluidly shift attention or tolerate uncertainty, both tasks associated with being able to function well
- Potential to interfere with the capacity to develop a psychologically mature account of the loss and make connections to early attachment experiences – a reflective stance

Diagnostic Clarity

Implications for Unresolved Grief

- Prolonged disturbance in family life and interpersonal functioning
- Expectations, meaning of life, and hopes negatively influenced by ongoing sadness, guilt, anxiety, and self-reproach – possibly developing complicated grief or depression
- Increased risk of suicide (suicidal ideation: 50% of bereaved adults versus 80% of bereaved parents)
- Elevated risk of developing perinatal mood and anxiety disorder (PMAD) in subsequent pregnancy (including distressing intrusive thoughts)

Principles of Psychiatric Care

When to Refer

- Question of normative grief or complicated grief or depression
- This question and other diagnostic questions should be addressed collaboratively

Principles of Psychiatric Care

When to Refer

- Disruptive and significant anxiety is often part of the clinical picture in subsequent pregnancy following perinatal loss – medication?

Principles of Psychiatric Care

Notes for Clinicians

- Collaborate with psychiatrists - in the best case, a reproductive psychiatrist - and other healthcare providers
- Recommended to make a psychiatric referral especially when patient considering a subsequent pregnancy, and/or if there is concurrent unresolved grief, and depression, or anxiety
- Address fear or resistance, have a direct conversation
- Remind patient: chance to gain more clarity, not necessarily a decision to take medication

Consolidate Your Learning

- What are your views about normative grief, complicated grief, depression, and psychiatric care?
- In what ways have your views about treating complicated grief and depression, including possible psychiatric referrals, been influenced by the information in this lecture?

CLINICAL INTERVIEW AND TREATMENT PLANNING

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Define three ways in which a clinical interview assessing grief in response to reproductive loss differs from a clinical interview conducted with patients in the general population

Clinical Interview & Treatment Planning

Introduction & Intake

Intake Interview:

- Developmental History
- Family History
- Psychosocial History
- Story of loss

The Clinical Interview

Entry to the Therapeutic Process - The Story

- What was the nature of the reproductive loss?
- What happened?
- Was it sudden?
- Was it following ongoing pregnancy complications?
- Are there troubling or deeply distressing aspects?
- Do you have a sense of why the loss occurred?
- Did you name the baby who died?
- If so, what is her/his name?

The Clinical Interview

Ongoing Stressors

- How has your life changed since this loss?
- How are you recovering physically?
- Are you lactating?
- Are you bleeding?
- What reminders seem to be most distressing?
  - *Baby strollers?*
  - *Seeing pregnant women?*
  - *Your approaching due date? Anniversary of death?*
- Medical leave now instead of maternity leave?
- Ongoing medical issues or tests?

The Clinical Interview

Spiritual

- Were there any rituals or a memorial? If so, what were these?

The Clinical Interview

Spiritual

- Has this loss affected your relationship with God (or other higher power you may define)?
- What do you believe about this loss?

The Clinical Interview

Ask: What is Helping Now?

- Family? Friends? Partner?
- How are you and your partner communicating? (Partners grieve differently!)

The Clinical Interview

Ask: What is Helping Now?

- What are any "sticking" points in your experience you would like help with?
- In other difficult times, what helped you?
- What are your strengths?

The Clinical Interview

Psychoeducation

- Listen to the story – be present and empathic
- Remind patient – self-care is important: eat well, sleep on a regular schedule, get moderate exercise, and drink alcohol in moderation
- Social connections – assess which friends are good "doers," "listeners," or with whom you can have fun ("respite")
- Remind patient – when you visit ob-gyn, let the receptionist know you just had a pregnancy loss and come to the appointment with something that will hold your attention

The Clinical Interview

Psychoeducation

- Emotions feel like a rollercoaster – compounded by hormonal and physiological changes that make you feel "out-of-whack"
- Physical recovery is a major factor – bleeding to lactating

The Clinical Interview

Psychoeducation

- Guilt and questions of "if only I had [or had not] done ..." can dominate your thoughts
- Anger is part of the grief response too
- Worry – what's next?? Normal!

Treatment Planning

Beginning Phase and Assessment

- What is the story?
- Meet your patient where she is. Early days? Has she been struggling for a time?
- Let the story around the loss guide the assessment process as you create a treatment plan that follows your patient's lead and acknowledges that there has been a loss
- Listen well – collaboratively assess any risk factors, strengths, values, and what is needed next

Consolidate Your Learning

- Think of writing an intake note and treatment plan for parents you have just met with for an initial 60-minute session following their pregnancy loss. What challenges might you face as you write this note?

PSYCHOTHERAPEUTIC APPROACH: THERAPEUTIC HOLDING AND ATTUNED PRESENCE

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Describe three ways that therapeutic holding and attuned presence reflect best practices in addressing grief and bereavement for parents experiencing pregnancy loss and child loss

Therapeutic Holding and Attuned Presence

Seleni Approach

- Therapeutic support for those experiencing loss is embedded within establishing a therapeutic relationship that provides holding and support
- Therapeutic holding – to provide solace as well as what are needed next steps

Therapeutic Holding and Attuned Presence

Notes for Clinicians

- Listen to the story
- Build trust and hold the acute pain of the loss
- Become the ground of listening and holding – an exquisitely attuned empathic presence – follow the client's lead
- Establish trust/therapeutic alliance
- What is needed now? Attend to the hierarchy of needs – are there funeral arrangements? Physical recovery? Listen for hopes and dreams and concerns and goals

Therapeutic Holding and Attuned Presence

Notes for Clinicians

- Therapeutic/empathic holding can help bereaved parents move through grief
- This can be reparative and can help parents recognize you know what they're going through
- Share what is normative and nonnormative

Therapeutic Holding and Attuned Presence

Seleni Approach

- Therapeutic support for those experiencing loss is embedded within establishing a therapeutic relationship that provides holding and support
- Therapeutic holding – to provide solace as well as what are needed next steps

Consolidate Your Learning

- Reflect on memories of the way your mother or father (or primary caregiver) responded to your physical and emotional needs. In what ways do you believe that your empathic capacity has been influenced by the ways your physical and emotional needs were met?
- And, in what ways do you imagine that your empathic capacity might be challenged when working with parents who have experienced pregnancy or child loss?

PSYCHOTHERAPEUTIC INTERVENTIONS: ATTACHMENT-INFORMED GRIEF THERAPY

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Utilize three patient care strategies from Attachment-Informed Grief Therapy in your practice with perinatally bereaved mothers and fathers

Attachment-Informed Grief Therapy

Complex Heart of Grief

- Emotional and physical experiences in bereaved parents' grief mirrors children's separation distress primary attachment figure
- Deep distress with crying (protest) and despair and normative social withdrawal – similar to a child's collapse when reunion does not happen

Attachment-Informed Grief Therapy

Complex Heart of Grief

- Pregnancy loss or death of a baby triggers the attachment behavioral system
- Behavioral system remains activated until the bereaved finds a way to either internally connect with the deceased or to live in the world without the deceased

Attachment-Informed Grief Therapy

Complex Heart of Grief

- In pregnancy and child loss, because there is not a lifetime of lived memories, it can be confusing to find an internal connection
- Deep tension between trying to relinquish the specific internal representations connected to this pregnancy and this baby while also learning to live without these hopes and dreams – and no living child

Attachment-Informed Grief Therapy

Attachment Styles Shape Therapeutic Style

- Heart of the work is the relationship between the patient and the clinician
- Therapeutic alliance most effective if the attachment orientation style of the patient (and the clinician) is incorporated into the clinician's strategy

Attachment-Informed Grief Therapy

Some Principles and Assumptions

- Early attachment impacts neural development and attachment styles
- Early attachment experiences inform development and close relationships
- Early attachment experiences influence the capacities related to mentalizing – the capacity to be aware of the internal mental and emotional states of others – and emotional regulation

Attachment-Informed Grief Therapy

Some Principles and Assumptions

- Recovery of emotional balance is facilitated through the dyadic relationship between patient and the therapist similar to emotional recovery in infancy
- Difficulties in attachment styles can complicate the grief process

Attachment-Informed Grief Therapy

Therapeutic Alliance: Trust and Emotional Safety

- Through therapeutic alliance, clinician establishes safety and nurturing while finding what a patient needs now

Clinician Note

Kosminsky and Jordan write that "While virtually all approaches to psychotherapy acknowledge the importance of the therapeutic alliance, only some see it as the primary 'active ingredient' in treatment, even though a robust body of empirical research supports this proposition"

Attachment-Informed Grief Therapy

Empathic Attunement

- Empathic attunement allows the clinician and the patient to collaborate
- Clinician flexibly addresses the patient's shifting attachment needs

Attachment-Informed Grief Therapy

How the Story of Loss is Conveyed

- Coherence: suggests a secure attachment and that grief is resolving
- Capacity to shift from describing memories to evaluating what these memories and experiences mean suggests resolving grief
- Less flexibility and coherence can suggest insecure attachment orientations (anxious, avoidant, or disorganized)
- Less flexibility and coherence in the person's story suggests acute grief
- Tangential telling of the story can suggest the possibility of complicated grief

Attachment-Informed Grief Therapy

CASE DESCRIPTION

Attachment-Informed Grief Therapy

Safety to Confront Mother

- Elizabeth's grief begins to resolve and as she gains perspective and is able to mentalize – that is, to see her mother's point of view (as a bereaved grandmother)
- Importance of therapeutic work incorporating awareness of patient's attachment style (and significant others, too) in interaction with grief process

Attachment-Informed Grief Therapy

CASE DESCRIPTI

Attachment-Informed Grief Therapy

Core Technique of AIGT: Establish Safety - A Safe Haven

- Disorganized attachment style can result in terror and dissociative response to grief and loss
- Safe haven – safety in the therapeutic relationship – allows a compassionate exploration of terror and trauma and grief
- Build on prior strengths and shifts in attachment style suggesting an earned security status

Attachment-Informed Grief Therapy

Core Technique of AIGT: Establish Safety - A Safe Haven

- Goal of attachment-informed grief therapy is not simply reduction of distress, but integration of the loss in a way that allows for more coherence around the loss and being more able to reengage with life

Clinician Note

Therapeutic bond helps patients find their way through grief to an integrated grief and to identify possibilities and hopes for the future. And a future with enhanced core capacities of emotion regulation, mentalization, and handling stress while also experiencing mastery and pleasure in life

Consolidate Your Learning

- Consider the unique attachments formed in pregnancy. What aspects of attachment styles might be amplified in perinatally bereaved parents?
- In what ways might attachment styles – yours and your patients' – influence your therapeutic approach and strategies?

COPING WITH GRIEF: TASK BASED MODEL

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify and utilize three patient care management strategies from Worden's task based model

Task Based Model

Notes for Clinicians

- This task-based model is not a model of grief, but a model of coping with grief
- Just as there are identifiable phases in grief, there are identifiable tasks that can help with coping with loss

Task Based Model

Adapting and Coping with Grief

Four Tasks

- Comprehending the death
- Working through the pain
- Adjusting to a changed world
- Embarking on a meaningful life while remembering

Task Based Model

CASE DESCRIPTION

Task Based Model

Task 1

- Funeral or memorial can help bereaved parents accept the reality of the death

Task Based Model

Task 2

- Guide parents through painful second task so the pain doesn't get carried through life
- Possible to pass grief on to the next generation – intergenerational transmission of unresolved grief

Task Based Model

Task 3

- External adjustments
- Internal adjustments

Task Based Model

Task 4

- Embarking on next steps in their lives while remembering and finding an enduring connection with the deceased
- Next consideration of this model needs to include the idea that it's OK to relinquish or maintain an enduring bond with the deceased

Consolidate Your Learning

- Consider the ways Worden's task based model of grieving might influence your case conceptualization and your therapeutic approach

COPING WITH GRIEF: DUAL PROCESS MODEL AND THE CONSTRUCTIVIST APPROACH

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify and utilize three patient care management strategies from the Dual Process Model of Grief and the Constructivist Approach

The Dual Process Model

Task Based Model

Adapting and Coping with Grief

Four Tasks

- Comprehending the death
- Working through the pain
- Adjusting to a changed world
- Embarking on a meaningful life while remembering

Dual Process Model

- Revisiting (in small doses) and oscillating between loss and restoration orientation – essential to visit pain and loss so this doesn't become "unspeakable" or maladaptively avoided
- Developing personal goals – essential to focus on hope: not getting stuck in loss
- Addressing present and future (relationships, personal goals, family building, career goals) to rebuild sense of meaning

Constructivist Approach

Assumptions

- Grieving: Reconstruct the meaning that is challenged by the loss
- Finding a "new normal"
- Meaning is both personal and social, implicit and explicit, and created in interaction with significant people in life as well as societal norms and values
- Gaining clarity, articulating and renegotiating life narratives disrupted by loss – the central goal of grief therapy (in the constructivist approach)

Dual Process Model and Constructivist Approach

CASE DESCRIPTION

Constructivist Approach

Dreams

- Clues to changing story
- Unfreezes frozen metaphors

Consolidate Your Learning

- Consider the ways that the Dual Process Model and Constructivist approach might influence your case conceptualization and your therapeutic approach

COMPLICATED GRIEF

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify and utilize three clinical techniques to address unresolved or complicated grief related to perinatal loss

Grief Challenges

What Can Interrupt the Grief Process?

- Unable to face emotional pain that goes beyond adaptive and defensive exclusion of pain
- Difficulty in acknowledging the loss
- Persistent state of intense emotional activation and preoccupation with the loss
- Ongoing maladaptive ruminations, often focused on guilt and uncertainty

Notes for Clinicians

- If a bereaved parent presents with a co-occurring depression or suicidality, it's important to assess which problem is most pressing and start there
- Unresolved grief around perinatal loss increases the risk of suicide and developing a PMAD or significant perinatal emotional distress in a subsequent pregnancy and parenthood
- A complex pregnancy history, including use of Assisted Reproductive Technologies, also increases the risk of unresolved grief, potentially increasing risk of developing perinatal emotional distress or a PMAD in a subsequent pregnancy and parenthood

Complicated Grief

CASE DESCRIPTION

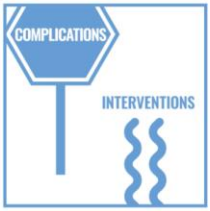
Maria – Complicated Grief

Treatment Approach and Goals

- Intentionally oscillating between loss and restoration
- Developing a coherent narrative of the loss
- Address emotional flooding: tell the story in small doses
- Find meaningful emotional connections
- Identify strengths and hopes for the future while also identifying positive emotions and memories – not all memories are about the loss
- Build on the restoration focus: Building hope and confidence and joy in life that includes remembering without emotional flooding

Central Principles of Working with Complicated Grief

Therapeutic Holding in the Context of Supportive Companion



- Healing is a process of addressing complicated problems
- Patient uses self observation and reflection in the context of a supportive companion
- Explore avoidance behaviors
- Carry out loss and restoration experiences by oscillating between loss and restoration, remembering to have loss or trauma story told in small doses

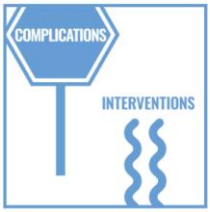
Grief Monitoring Diary

DAY	HIGHEST GRIEF	SITUATION	LOWEST GRIEF	SITUATION	AVERAGE GRIEF
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

- Self observation with support of clinician
- Use to track of feelings and waves of yearning, and discern what is grief and what is not grief
- Grief intensity rated daily on a scale of 1-10. Note what was happening at that time

Treatment Interventions- Restoration Focus

Some Tools



- Use "defensive exclusion" meaning, going to yearning and sadness and then setting it aside (but not avoiding). Aim for being able to flexibly oscillate between loss and restoration
- Use imagery exercises. Engages implicit memory
- Find ways to experience positive emotions along with painful emotions – it's physically healthy to experience positive emotions
- Build a bridge not only based on suffering but that can include love and some "proud moments": Were there proud or happy moments in pregnancy? Name these
- Ask: How are you doing? Developing personal goals is essential. And the answer helps you both know more about what is needed next

Consolidate Your Learning

- Contemplate the ways that the loss orientation and the restoration orientation each serve a particular purpose in grief. When thinking of a patient with whom you are currently working, how might incorporating the concept of oscillating between loss orientation and restoration orientation benefit your patient?

TRAUMA INFORMED INTERVENTIONS

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Demonstrate your awareness of three unique clinical techniques utilized to address trauma in perinatal loss

Trauma

Important Considerations

- Life of mother or the baby was at risk – and in pregnancy loss, there was a death
- The trauma is perceived or actual – the body and mind respond the same way
- Traumatic experiences in pregnancy loss can interfere with being able to move through grief

Trauma

Loss of Safety

- Those experiencing trauma experience symptoms rather than memories
- In trauma the limbic systems in the brain that helped us to survive now override the rational understandings that stem from the frontal cortex
- Emotional activation reactivates feelings of danger – physiological responses out of conscious control and creates vulnerability – and we crave safety

Trauma

Loss of Safety

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- In trauma the limbic systems in the brain that helped us to survive now override the rational understandings that stem from the frontal cortex
- Emotional activation reactivates feelings of danger – physiological responses out of conscious control and creates vulnerability – and we crave safety

Clinician Note

It's important to distinguish between exposure to trauma and lasting adverse effects such as being fearful to discuss or consider anything related to the trauma. Not everyone exposed to trauma develops Posttraumatic Stress Disorder (PTSD)

Trauma

Loss of Safety

- All experiences become dangerous and interfere with being able to discern safe and unsafe signals through neuroception and prosody
- Neuroception is the unconscious recognition of facial expressions suggesting safety or danger and prosody is the unconscious recognition of the tone of voice suggesting safety or danger
- Part of trauma response is the more conscious process of mentalization (understanding what is happening internally as well as in others)
- Distinguishing between what is safe or dangerous or life-threatening becomes impossible and facing this is "unthinkable and unspeakable"

Diagnostic Clarity

Distinguishing Trauma and Complicated Grief

- Complicated grief is not Posttraumatic Stress Disorder (PTSD) because separation distress (yearning and pining), which dominates experience in complicated grief, is not usually present in PTSD
- Anxiety is more prominent in PTSD than in complicated grief

Clinicians Note

In complicated grief, we work toward a transformation of the bond, reorienting rather than trying to reduce a fear response that occurs in response to trauma. In complicated grief, personal safety is not usually challenged. And, in complicated grief, avoidance is avoiding the pain of the absence rather than avoiding the pain of a threat

Clinical Approach

Establish Safety

- Psychotherapist is a transitional attachment figure – through emotional connection – establish safety through right brain to right brain connection
- When working with a bereaved or traumatized woman who has had a pregnancy loss, help her tolerate emotions

Clinical Approach

Establish Safety

- Identify areas where thinking is "stuck" on trauma – especially around safety – trauma is a fear/anxiety response that occurs in addition to and usually in contrast to separation/anxiety response in bereavement
- Helpful to identify new ways of thinking about experiences – body and mind and internal representations of this experience as well changed experiences of the world
- Maintaining a "window of tolerance": Safe, but not too safe yet we can't go too quickly. Often there's a learned unworthiness or unlovability or sense of being invisible needing to be addressed

Clinical Approach

Processing and Containing

- Important to balance processing and containing to avoid re-traumatizing through repeated uncontrolled exposure to trauma
- Processing in small doses, which also helps develop a coherent narrative where a previously fragmented and confusing experience becomes understood and integrated and heard by someone
- Containment is therapeutic holding to help patient build capacity to hold her emotional responses
- Also focus on daily routine, social supports, and self-regulation
- Oscillate between processing and containing

Trauma Informed Interventions

CASE DESCRIPTION

Joanna - Clinical Application

Trauma Focus

Recommended Interventions

- Psychoeducation — specific points around why event is difficult to tolerate
- Behavioral and body-based interventions to reduce overall anxiety
- Self-care skill building (to build confidence in ability to keep self safe)
- Therapeutic holding
- Cognitive and emotional/psychological reprocessing
- Imaginal exposure

Joanna: Clinical Application

Trauma Focus: Psychoeducation

Main Points

- You've been through a life-threatening situation
- So your body is on high alert to try to keep you safe
- You're not crazy. We know what's happening
- You will get better and feel more like yourself again

Treating Trauma

Promoting Health and Resilience

- Explore ways to support and maintain physical health and promote good sleep and eating well because both support a healthy body
- Good sleep and eating well are at the root of resilience
- Explore ways to minimize stress as well as developing ways to manage stress through techniques related to mindfulness such as conscious breathing or conscious walking

Treating Trauma

Resource Based Approach and Imaginal Exposure

- Revisit through telling traumatic story repeatedly – in small doses
- Brain becomes habituated to and less triggered by memory

Treating Trauma

Resource Based Approach and Imaginal Exposure

- Clinician should "dose" exposure to elicit affect without flooding. Can use grounding and body-based interventions to do so
- Ensure that affect is reduced prior to end of session/patient feels safe to leave

Treating Trauma

The Iceberg and the Present Moment

- Understanding trauma in the context of the present moment using the image of an iceberg
- What part do we see? The part under water? That's like the past, like the bottom 90% of the iceberg

Treating Trauma

The Iceberg and the Present Moment

- Or, the top? That's like the present moment, like the top 10% of the iceberg that's visible

Treating Trauma

The Iceberg and the Present Moment

- Circling back to the present moment helps move trauma from being an experience that's experienced over and over again in the past to being a bad memory in the present moment

Treating Trauma

Ensure Safety at Close of Each Session

- Essential to ensure that affect is reduced prior to the end of the session
- Let her know you are making the transition from being in the session to returning to the next steps in her life
- You might ask: Can you feel your feet? What are you doing next?
- Support return of pleasure and mastery

Consolidate Your Learning

- Consider the biological and psychological experiences of trauma and the loss of safety. In what ways does the concept of establishing safety manifest in your treatment interventions?

EXPANDING OUR FOCUS: YOUNG PARENTS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Demonstrate your awareness of three unique clinical techniques to address perinatal grief in young parents (adolescent mothers and fathers and partners)

Unique Challenges for Perinatally Bereaved Young Parents

Biological and Emotional Issues

- Many differences between adults and adolescents – brain development, psychological development, capacity to form and develop relationships, consolidating identity…
- An adolescent usually does not want to be different. Pregnancy loss or the death of a child or losing custody of a child all are sources of profound grief and can create a sense of being different
- Oscillate between loss orientation and restoration orientation but more likely to move quickly away from loss orientation to restoration orientation because of peer pressure. It might be considered "childish" to cry or be sad

Grieving and Re-grieving

Grief Evolves as does the Developmental Process

- Perinatally bereaved young parent grieves and moves through the developmental phases of her life, there is a process of grief and re-grief
- Process of emotional and cognitive maturation, a circling back around to the loss – re-grieving incorporating evolving biological and emotional development

Grieving and Re-grieving

Grief Evolves as does the Developmental Process

- Unresolved grief and trauma at any phase of the developmental process can result in intergenerational transmission of grief and trauma
- Ongoing unresolved grief can interfere with developmental tasks in each developmental phase of life – such as the capacity to have sustaining and nurturing relationships
- Unresolved grief can blunt bereaved young parents' capacity to cope, learn, or reach out to others, and make good friendships and social connections

Conceptualizing Perinatal Loss from a Trauma Focus

Many Adolescents Live with Trauma as a Norm

- Many adolescents have experienced other traumatic events such as being in foster care or having a baby or child placed in foster care – can result in unresolved trauma
- Additional trauma often seen in adolescent parents includes housing insecurity
- Educational challenges – not having success experiences in school

Conceptualizing Perinatal Loss from a Trauma Focus

Many Adolescents Live with Trauma as a Norm

H.A.L.T.

- Insecure attachment styles: lonely – difficulty creating nurturing and sustaining peer relationships and adult relationships
- Fatigue due to worry about safety – hypervigilance and hyperarousal resulting from unresolved trauma and loss often interferes with being able to relax and sleep well

Resource-informed Focus in Trauma Interventions

Address Resilience

- Address sleep and good nutrition – both of which are powerful sources of developing resilience
- Interventions that are focused on processing grief while focusing on other activities – such as creative activities – fun resources – can be more palatable for adolescents

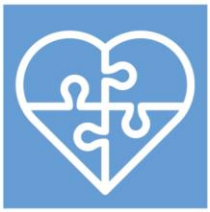
Keisha – Psychotherapeutic Interventions

Building Safety and Empathy

- Therapeutic holding
- Resource-informed approach focusing on building and using her strengths (her resources), also addressing her most current concerns
- Follow her lead: By sticking closely to what she was willing to discuss and letting her take the lead, established a safe place for her and allowed her to feel understood

Keisha – Psychotherapeutic Interventions

Resource-informed Approach and Psychoeducation



- Psychoeducation provided around how sleep can support resilience (sleep = "resilience blanket")
- Using her strengths in designing interventions: Using art to address grief and trauma of betrayal

Address Unique Challenges

Resource-informed Approach

- Address unique challenges for adolescents: Possible interruption in education and major developmental tasks associated with identify formation, learning to form relationships; learning to emotionally self-regulate
- Also focused on helping her move through perinatal grief and launch into a productive young adulthood

Consolidate Your Learning

- Consider the unique worries that an adolescent experiencing perinatal loss would be describing. In what ways would your case conceptualization and treatment planning be influenced by these unique worries and her pregnancy loss?

EXPANDING OUR FOCUS: TRADITIONAL AND NON-TRADITIONAL FAMILY CONSTELLATIONS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify various ways that traditional and non-traditional family constellations experiencing perinatal loss present similarly and differently from traditional and non-traditional families in the general population

Traditional and Non-Traditional Families

Fathers

- Important to recognize that fathers experience vulnerability and identity shift during family building and perinatal loss
- Fathers struggle to find their role – giving support yet can feel marginalized in their bereavement (disenfranchised)
- Style of bereavement might be significantly different from his partner

Complex Picture: Grief Expression

Men: Often Instrumental

Influences family and couple relationships – mother might not recognize that the father is actually grieving by "doing"– taking actions and taking care of business

INTUITIVE	BLENDED	INSTRUMENTAL
Often women – express grief more affectively (crying, venting feelings, seeking emotional connectedness)	Most people express grief using both at times but tend toward one or the other	Often men – express grief through taking action and figuring things out logically

LGBTQ + Families

Ways of Building a Family

- Many ways to build families and many ways that each person will grieve
- "Non-traditional" ways of building a family: stigmatized in family building efforts, and perinatal loss often not acknowledged
- ART (trans/non-conforming/non-binary people)
- Adoption and foster parenting
- Same-sex marriage now legal but family building is complex
  Donated egg/sperm
  Adoption
  Surrogacy

Clinician Note

Additional factors that can be stigmatizing or disenfranchising:

- Language choices – important to represent many different experiences along spectrums of gender identity and sexual orientation – non-binary, queer, etc
- Heterosexist language common in forms and physical set up of offices
- Assumptions by healthcare providers about roles in relationships or families

Non-traditional Family Constellations

CASE DESCRIPTION

LGBTQ + Families

Ways of Building a Family

- Many ways to build families and many ways that each person will grieve
- "Non-traditional" ways of building a family: stigmatized in family building efforts, and perinatal loss often not acknowledged
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  Adoption
  Surrogacy

Family Life Cycle

Influence of Loss

- Families go through life cycles – and perinatal loss influences life cycle as a family
- Each person in a family may have different values and communication patterns

Clinician Note

In all family work, each person in the family influences all other family members. Grief needs to be understood within the framework of all the influences from the whole family constellation – past and present. It is important to recognize that families vary in how much they can tolerate and express feelings. And, it's important to recognize that unresolved grief – including perinatal grief – can shift relationships. Grief also can shift internal representations, perhaps raising the question: Am I a parent?

Family Functioning Influenced by Loss

An "Out-of-Time" Loss

- Can "unhinge" family functioning. May be the most intense, long-lasting grief sustained in comparison to grief following a more "expected" loss
- Parents are left to adjust or adapt to their ongoing lives without the hoped for child
- Parents' identity is brought into question
- Raises stresses in their marriage/partnership and family life
- Part of moving to an integrated grief and a return to healthy family functioning includes the capacity to express emotions and experience normal vulnerability that is part of living a satisfying life

Consolidate Your Learning

- Consider your family of origin. What influences the way that intense experiences such as grief are expressed and integrated in your family? How does your understanding of your own family experiences affect your therapeutic work with families?

EXPANDING OUR FOCUS: IMMIGRATION AND ACCULTURATION

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Demonstrate your awareness of three unique challenges related to issues associated with cultural norms, immigration, and migration in relation to grief and perinatal loss

Immigration and Acculturation

Stressors

- Stress of immigration and acculturation, including financial (underemployment, low SES) – LOSSES – are known risk factors for developing mental illness (depression)
- Multiple losses: Perinatal loss one of many losses = bereavement overload
- Possibility of intergenerational transmission of grief and trauma

Immigration and Acculturation

CASE DESCRIPTION

Sophia – Acculturation Challenges

Unique Forms of Loss and Challenges in Coping

- Ambiguous loss – uncertainty around her newborn's death
- Non-death related losses: A safe homeland, close family and friends who would be natural supports through life challenges, culture, language, favorite foods, style of clothing, color of the sky
- Cultural norms: Sophia's mother most likely would not have confided in a mental health provider – she would have been much more likely to share with a close or trusted family member

Acculturation Challenges

Societal Expectations

- There are often different expectations for the societal roles men and women fill in different societies as well as the ways that grief is understood

Acculturation Challenges

Societal Expectations

- For example, in the Latino culture, grief incorporates a sense of pain and sorrow that encompasses the body and mind. In Spanish: *"perdidas y penas"* – losses and sorrows – grief is a unified concept including body and mind

Acculturation Challenges

Societal Expectations

- This concept of grief is seen in cultures where there is less value on the individual and more on the collective culture

Therapeutic Approach

What to Address First?

- Following the "affect trail"
- Unresolved trauma
- Family secret + rebuild trust
- The emotional pain of the miscarriage
- Revised life narrative

Therapeutic Approach

Help to Create New Narrative through Mentalization

- Process of mentalization: understand your own inner life as well having a sense of the other person's inner life
- Able to shift perspective and have a more empathic understanding about others – family history and heritage

Consolidate Your Learning

- Consider the cultural norms described here. In what ways would these shape the treatment with those with whom you work? What problems might you address first?

CLINICIAN USE OF SELF: BURNOUT PREVENTION

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify actions that contribute to burnout and actions that are protective

Being an Effective Clinician

A Few Hints: How to Avoid Burnout

- Knowing your limits
- Leave space to "come up for air"
- Keep therapeutic structures intact
- Allow yourself to feel sadness or grief
- Awareness – less reactive and more effective

Being an Effective Clinician

A Few Hints: How to Avoid Burnout

- Make sure that life is rich and satisfying: friends and loved ones
- Allow yourself to nurture and sustain loved ones as they nurture and sustain you
- Consult with trusted colleagues and utilize supervision

Being an Effective Clinician

A Few Hints: How to Avoid Burnout

- Recognize your limits and recognize this can change depending on the circumstances in your life

Being an Effective Clinician

Clues to Emerging Burnout

- Dragging yourself in to work
- Being relieved when there are cancellations
- Self care goes out the window – working too many hours without enough sleep or good nutrition
- Losing track of your accomplishments and satisfactions in life, making the therapeutic work the sole source of satisfaction

Being an Effective Clinician

Clues to Emerging Burnout

- Losing track of what is meaningful in your own life
- Engaging in a "one-way" style of intimacy with friends and loved ones
- Forgetting that friendships are bi-directional – it's not all about them – you are in the mix as well

Being an Effective Clinician

Case Description

- "Stale" clinical notes were a clue that the clinician was starting to experience burnout
- Recognizing potential burnout helped clinician reach out and get needed support

Being an Effective Clinician

Case Description

- Clinician able to find ways to reconnect with a sense living life well – and meaningfully
- Addressing sources of unresolved stress, personally and professionally, usually means patient care improves

Notes for Clinicians

- It's important to make use of professional colleagues and seek regular supervision. This grounds your work and supports you as a person and is protective against burnout
- Recognize that grief is not something you can fix – we as professionals can feel stymied in our attempts to help – and this can be hard. As Bowlby mentioned, we can feel impotent. By being with rather than trying to "fix it," this is what facilitates movement through grief

Notes for Clinicians

- It's important for us as clinicians working with perinatally bereaved patients to recognize that pain is inevitable and cannot be avoided yet pain does diminish through emotional and cognitive processing
- Recognizing that our work does make a difference can help prevent burnout

Consolidate Your Learning

- Consider ways you respond to life when your efforts have not made a difference. What is your coping style? Do you keep trying? Do you get angry? Discouraged? In what ways do you believe your coping style might protect or contribute to you developing burnout?

CLINICIAN USE OF SELF & SUPERVISION

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Describe the ways that being aware of your attitudes about death and dying facilitates your clinical effectiveness
- Identify two countertransferential vulnerabilities related to your loss story
- Describe various ways that supervision ensures the effectiveness of your patient care and integrity of the therapeutic relationship for your future clinical practice

My Loss is Not Your Loss

The Importance of Knowing Your Story

- No matter how much experience we have working with the bereaved, ongoing personal exploration around our own grief and loss is the key to keeping clear

My Loss is Not Your Loss

The Importance of Knowing Your Story

- Knowing the difference also allows a clinician to be open to what your own assumptions are about life and loss
- As we listen to our patients we will learn things we did not know – be willing to be teachable

Your Loss History

Countertransferential Issues

Some questions to consider as you explore your loss history:

- What is your own life-story in relation to death or loss?
- How have you adapted?
- What is the source for the attitudes you bring with you about life and death – perhaps from family or societal influences?

Ethical Practice

Includes "Death Competence"

- Death competence is the clinician's specialized skill in tolerating and managing issues and topics related to dying, death, and bereavement
- Death competence is a part of a multifaceted, hierarchical model of professional competence that is cognitive and emotional
- As a cognitive variable: Academic training, supervised learning experiences, and proven proficiencies – in short, what the clinician knows
- As an emotional variable: Intellectual knowledge. Doesn't guarantee emotional readiness

Effective Listening

Suggestions

- Listening involves focused attention
- Clear your head and "turn off the evaluator!" However, do think about what you are saying and stay close to the patient's words and images
- In a certain way, listening with an attuned presence is the most important tool – more important than responses!
- Formulating a response while listening is the "kiss of death" to effective listening

Effective Listening

Suggestions

- Stay in close contact with a trusted colleague – a supervisor – we, as clinicians working with loss, can be more open and able to use our own responses to guide our work
- If our "issues" are unresolved or unclear, we can know that too – and come back around to our own issues some other time – and not with the patient
- Gamino and Ritter write, "grief counselors know well their own loss history and use it creatively to inform their practice, but they do not impose their own raw grieving on the therapy encounter"
- Clinicians working with women, men, and individuals who are perinatally bereaved need to develop their ability to be present with bereaved parents' pain and suffering and to develop active listening skills so that we – each clinician – can help patients move from confusion and sorrow to coherence and finding the next right steps

Exploring in Supervision

"Pro-symptom" Stance

- How to work with self-judgment – by taking a "pro-symptom" stance – that is, difficulties or symptoms reveal the patient's – and the clinician's – perception of the difficulty, of herself, and of the social world
- Rather than trying to "get rid" of the symptom, let that difficulty reveal the emotional truth of the situation

Exploring in Supervision

"Pro-symptom" Stance

- In supervision, this idea can encourage open exploration of the conscious and unconscious situation the clinician brings
- The pro-symptom stance can help create a safe place in supervision and in our therapeutic work with patients – and is essential because considering death and dying is especially personal and powerful work

The Guest House

Rumi

This being human is a guest house.
Every morning a new arrival.

A joy, a depression, a meanness,
some momentary awareness comes
as an unexpected visitor

Welcome and entertain them all!
Even if they are a crowd of sorrows,
who violently sweep your house
empty of its furniture,
still, treat each guest honorably.
That guest may be clearing you out
for some new delight.

The Guest House

Rumi

The dark thought, the shame, the malice.
Meet them at the door laughing and invite them in.

Be grateful for whatever comes.
Because each has been sent
as a guide

– Jelaluddin Rumi,
Translation from *The Essential Rumi* by Coleman Barks

Consolidate Your Learning

- Think about the ways your attitudes (thoughts, feelings, and beliefs) about loss have influenced your therapeutic approach. And, then, consider what visitors are knocking on your door waiting to be explored with a trusted supervisor?

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