

MATERNAL GRIEF FOLLOWING MISCARRIAGE:  
INTRODUCING A GROUP THERAPY APPROACH TO SUPPORT BEREAVEMENT

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### **Dedication**

This thesis is dedicated to my mother, who walked this path before me, in a silence that I am privileged to break and transform. This is also dedicated to my children, those I have lost, and those who have shared my journey. To my peers, whose courage and perspective have freed me from my grief. Your encouragement and support has renewed my strength and hope for other women and their families. To my husband, we have lived through love, hope, grief and despair. Through the process of healing and inquiry, I am confident that our journey will bring hope to other couples and their families.

### **Abstract**

Perinatal loss is a common experience in contemporary society. While one in four pregnancies may result in a miscarriage, support for bereaved parents is still lacking. This thesis presents a group therapy approach to support the bereavement of miscarriage. The thesis will begin by describing the prevalence of perinatal loss and the impact of this experience on women and their families. This will lead into a review of the existing literature, exploring the link between miscarriage and psychological distress, in addition to theories of grief, therapeutic approaches, and the role of various factors in supporting and/or impairing the bereavement process. This thesis will explore the research related to miscarriage, while also considering the research related to ambiguous loss, disenfranchised grief and group therapy for marginalized populations. The thesis will highlight the connections between these constructs to develop a group therapy approach to support perinatal grief. This approach will include ten skills and/or techniques which may be incorporated within a group. The method of delivery will also be considered; including, frequency, duration, and guidelines for participation. The thesis will conclude by addressing strengths and limitations, in addition to providing suggestions for future research and implementation.

*Keywords:* perinatal loss, miscarriage, bereavement, group therapy, psychological distress, ambiguous loss, disenfranchised grief, marginalized populations

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## **Maternal grief following miscarriage:**

### **Introducing a group therapy approach to support bereavement**

#### **Chapter 1: Introduction**

##### **Introduction**

“Grief is like an ocean; it comes in waves, ebbing and flowing. Sometimes the water is calm, and sometimes it is overwhelming. All we can do is learn to swim” (Harrison, as cited in Mundy, 2017). Approximately one in four women will experience a miscarriage in their lifetime (Huberty, Matthews, Leiferman, & Lee, 2018). Feelings of grief are common, as miscarriage represents the loss of a pregnancy, the loss of a baby, the loss of a future child and the loss of motherhood (Bailey et al., 2015). Miscarriage is frequently kept secret, limiting the opportunity for mourning rituals and social support. Women find themselves surrounded by silence, due to limited disclosure of the loss (Randolph, Hruby, & Sharif, 2015). This silence is perpetuated by a cultural taboo against the public recognition and expression of perinatal grief (Markin & Zilcha-Mano, 2018).

##### **Background Information**

Miscarriage is common. Approximately 20% of all recognized pregnancies will result in a miscarriage (Kersting, Kroker, Schlicht, Baust, & Wagner, 2011). As a result, perinatal loss affects a large number of individuals. Huberty et al. (2018) suggested that approximately 25% of women will experience a single miscarriage in their lifetime. Furthermore, between 1% and 3% of all women will experience recurrent miscarriage (Ockhuijsen, van den Hoogen, Boivin, Macklon, & de Boer, 2014). With these powerful statistics in mind, it is surprising to discover that the research regarding perinatal loss has been limited until recent years.

The majority of the research on perinatal loss has taken place over the last thirty years. While preliminary studies focused on the etiology of miscarriage (Cosgrove, 2004), the research expanded to include several trends. The most prevalent trend is regarding the relationship between psychological distress and miscarriage. Several studies have demonstrated a significant correlation between miscarriage and many different forms of psychological distress. This includes studies regarding perinatal grief (Brier, 2008), psychological reaction (Adolfsson, 2011), anxiety and depression (Gaudet, 2010), and adverse mental health outcomes (Janssen, Cuisinier, Hoogduin, & De Graauw, 1996). This research laid the groundwork for researchers to consider the adverse effects of perinatal loss on maternal quality of life (Tavoli et al., 2018), self-esteem and personal identity (Wonch Hill, Cacciatore, Shreffler, & Pritchard, 2017).

A study by Bennett, Litz, Maguen, and Ehrenreich (2008), suggested that “perinatal loss is associated with considerable distress for some women, with greater severity primarily predicted by maladaptive coping skills, low social support and intense emotionality following the loss” (p.485). According to Lok and Neugebauer (as cited in Randolph et al, 2015, p. 4) “up to 50% of women who experience pregnancy loss also experience psychological symptoms following the loss.” Randolph et al. (2015) suggested that the most common mental health concerns related to perinatal loss are depression, anxiety, posttraumatic stress disorder, and obsessive-compulsive disorder. While the research regarding psychological distress is abundant, there is also a wide range of studies focused on supportive factors. Each of these factors have been considered in independent studies, over a similar period of time.

A study by Van (2012) indicated that maternal coping was positively influenced by the presence of connection; the opportunity to share one’s story with a compassionate person. Additional studies have demonstrated evidence for the protective role of social support

(Rowlands & Lee, 2010), validation (Brownlee & Oikonen, 2004), perspective taking (Nikčević & Nicolaidis, 2014), and mourning rituals (Markin & Zilcha-Mano, 2018). The factors which contribute to positive outcomes should be considered by the treatment modalities and approaches that are available to individuals grieving a loss.

There have been several theories that have been applied to support maternal grief following miscarriage. These theories have been utilized to inform the treatment options which are available to professionals and individuals. Some of the theories which have been applied include the medical perspective (Rowlands & Lee, 2010), psychoanalytic perspective (Lloyd Jones, 2015), community perspective (Sawicka, 2017), and feminist perspective (Carolan & Wright, 2017).

In addition, theories specific to grief, such as Parkes and Bowlby's phases of grief, and Swanson's theory of caring, invite a more specific lens which may be utilized for those who have experienced a loss during pregnancy (Lloyd Jones, 2015). According to Lloyd Jones (2015), Parkes and Bowlby's phases of grief include four processes: (a) shock and numbness; (b) yearning and searching; (c) despair and disorganization; and (d) reorganization and recovery. While these stages can be applied to individuals experiencing perinatal grief, they are not specific to individuals holding this unique experience. According to Adolfsson (2011), Swanson's caring theory was developed to guide professionals within the healthcare system to support the well-being of individuals recovering from perinatal loss. Swanson's caring theory included five processes: (a) knowing (striving to understand); (b) being with (emotionally present); (c) doing for (assist the patient with tasks they are unable to complete); (d) enabling (facilitating unfamiliar events); and (e) maintaining belief (Adolfsson, 2011). While Swanson's

theory was developed for healthcare professionals, these tenets may be helpful to anyone supporting an individual through perinatal loss.

Different therapies have been proposed to support individuals grieving a miscarriage, however, there has been very little research conducted to examine the effectiveness of these therapies. The majority of studies have focused on individual therapies, such as cognitive behavioral therapy (Kersting et al., 2011; Wenzel, 2017) and interpersonal psychotherapy (Johnson et al., 2016). A study by Bennet, Ehrenreich-May, Litz, and Barlow (as cited in Randolph et al., 2015) suggested that cognitive behavioral therapy (CBT) may be utilized to teach emotional regulation, encourage social support and improve self-efficacy in women who have miscarried. This study supports the normalization of intense emotions, in addition to a non-judgmental relationship with a counsellor. A study by Johnson et al. (2016) examined the efficacy of an adapted form of interpersonal psychotherapy (IPT), which was designed to treat a major depressive disorder, following a miscarriage or a stillbirth. Fifty women were randomly assigned to the IPT adapted group, or a CBT treatment group, coping with depression (CWD), which was not adapted for perinatal loss. Upon concluding treatment, participants in the IPT group reported higher levels of satisfaction with treatment, than the CWD group. The IPT group also reported lower depressive symptoms, and increased levels of social support. While there is research linking perinatal loss to CBT and IPT, research linking miscarriage to group therapies is sparse.

A study by Rich (2000) utilized the Perinatal Grief Scale, to determine the impact of support services following a perinatal loss. This study polled 249 bereaved mothers to determine which services should be included in future perinatal bereavement programming. The results indicated that grief support groups, couples counselling and family counselling were positively

correlated with positive mental health outcomes, however, this correlation was slight and not considered to be significant. The results may have been skewed as the researchers did not control for possible confounds; for example, only 42% of the participants received counselling services.

An internet survey by Sejourne, Callahan, and Chabrol (2010) indicated that out of 305 bereaved mothers, 64% of the women indicated wanting access to group therapy, following their miscarriage. While each of these studies indicated that group counselling may be beneficial, group counselling was defined as a broad term, without details of theory or support offered within the group. This thesis has identified a large gap in the existing research, testing the effectiveness of group therapy for individuals experiencing perinatal loss, in addition, to testing the effectiveness of different skills or techniques utilized within the group.

### **Thesis Statement**

While the research regarding miscarriage has grown and diversified over time, the research related to group therapy has remained sparse. This trend reinforces the culture of silence, by limiting the opportunity for community-based supports. An autoethnography by Porschitz and Siler (2017) asserted that women who experience miscarriage are marginalized by a lack of appropriate supports and/or services. The interaction of one's physical loss and the lack of social support, perpetuates feelings of trauma and grief. These experiences are not regarded as legitimate concerns. This experience may adversely affect maternal self-confidence, production and success (Porschitz & Siler, 2017). This thesis attempts to provide support to individuals by breaking the culture of silence, through a testable group model, specific to perinatal loss.

Group therapy represents a terrific opportunity to provide individuals with several of the protective factors which have been demonstrated by the existing research. Social support (Rowlands & Lee, 2010), validation (Brownlee & Oikonen, 2004), perspective taking (Nikčević & Nicolaides, 2014), and mourning rituals (Markin & Zilcha-Mano, 2018) are all protective factors which may be incorporated into group therapy. Individuals may also benefit from feeling connection with peers who have been through the same experience (Van, 2012).

Group therapy not only supports the individual. According to Rich (2000), the experience of perinatal loss may result in a developmental crisis, intensification of unresolved family of origin issues, a state of self-absorption, or promote the parent as protector of the fetus. These experiences may adversely affect the psychological adjustment of the parents, the children, or the family as a unit (Rich, 2000). Women and their families need access to services which are grounded in research for optimal development. Group therapy provides the opportunity to support the mother, her partner, their children and the relationships between the family members.

This thesis seeks to develop a group therapy approach for individuals who are grieving the loss of a pregnancy. Since research in this area is lacking, the thesis will focus on three related areas of research, including; factors which support/impair the bereavement process following perinatal loss, the relationship of ambiguous loss and/or disenfranchised grief to perinatal loss, and the aspects of group therapy which are supportive for marginalized populations. Through examining these domains in detail, this thesis will demonstrate valuable connections between the constructs and the existing research. This information will be utilized to develop a group therapy approach; including, skills, techniques, format suggestions, and guidelines for participation.

### **Purpose of the Paper**

This thesis will utilize a qualitative, transformative approach to present a group model of therapy, specific to supporting the bereavement of perinatal loss. The author will utilize research specific to perinatal loss, in addition to demonstrating connections between perinatal loss, ambiguous loss, disenfranchised grief and marginalized populations, to account for discrepancies within existing research. In doing so, this thesis will identify specific variables which may be incorporated into group therapy and tested by future research. In taking this approach, the thesis aims to provide information, awareness and strategies, which may be used to support the bereavement of perinatal loss. In addition, the thesis advocates to businesses, employee assistance programs, community health programs, institutions and government, by providing an evidence-based, cost-effective service aimed at supporting large numbers of individuals.

### **Definition of Terms**

Throughout this thesis, the terms miscarriage, perinatal loss, pregnancy loss, and loss of a pregnancy will be utilized interchangeably. These terms will refer to the loss of a fetus, between 2 weeks (conception) and 42 weeks (full-term) gestation. Infants that pass away following birth will not be included. In analyzing the existing research, this paper will identify studies which include data beyond this definition, to identify possible confounds or limitations to interpretation.

This thesis was developed to introduce a group therapy approach for individuals bereaving a loss during pregnancy. The paper will focus on research related to complicated grief. Complicated grief describes a bereavement process which would not represent the typical bereavement process for an individual facing this form of loss. Brier (2008) considered the role of complicated grief for individuals bereaving a pregnancy loss. According to Brier (2008), miscarriage may result in feelings of numbness, disbelief, yearning, sadness and despair, which

occur over a period of less than six months. If the individual experiences anxiety, depression or stress beyond a six-month timeline, the individual's distress may be described as complicated grief and require enhanced supports.

This thesis will also refer to theories of grief and loss that will be discussed in light of perinatal loss; these include, ambiguous loss and disenfranchised grief. According to Betz and Thorngren (2006), ambiguous loss involves the loss of a person, object or event that is not recognized or legitimized by society. Ambiguous loss is typically characterized by a lack of rituals or social support. Similarly, disenfranchised grief refers to "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported (Doka, 1989, as cited in Hazen, 2003, p.149).

As noted, both ambiguous loss and disenfranchised grief involve a loss that is not recognized or supported by society. These constructs support a culture of silence which will be referenced throughout this paper. Markin and Zilcha-Mano (2018) asserted that there is a culture of silence in North America, regarding perinatal loss. Miscarriage is frequently kept secret, limiting the opportunity for mourning rituals and support (Markin, 2016). Women find themselves surrounded by silence, due to limited disclosure of the loss (Randolph et al., 2015). This culture supports the systemic oppression of individuals who are bereaving a perinatal loss. Individuals face barriers to supports and services that would enhance their mental health outcomes. This thesis takes a social justice approach in identifying the barriers to successful bereavement, the supports required, and the models/approaches which may be utilized to support bereaved parents.

This thesis will present several supportive factors for the bereavement of miscarriage, including the use of cognitive strategies, continued bonds and witnessing. Cognitive strategies

will refer to a change in perspective, or making meaning of one's loss through psychological exploration and understanding (Nikčević & Nicolaidis, 2014). Continued bonds will refer to different strategies which may be utilized to keep one's memory alive, through sharing memories or engaging in mourning rituals (Attig, 2004). Witnessing will refer to sharing one's story in an environment characterized by solidarity and non-judgment, to inspire the co-creation of new meaning and experience (Reynolds, 2002).

### **Significance of the Study**

It is imperative to expand the existing research regarding miscarriage and group therapy. The scarcity of this research promotes the long-term cultural taboo against the public recognition of perinatal grief. Through developing research in this area, researchers support the expansion of public knowledge and support options. This may promote public disclosure and recognition of perinatal grief, which in turn, may support bereavement for individuals. While individuals and families may be supported by this cultural shift; businesses, institutions and government may also benefit from this information. This promotes social justice for women who are marginalized by this form of loss. Research should promote development of a testable model, which in turn, would drive future research questions. This process has the potential to revolutionize support options through community health and/or employee assistance programs. For example, group counselling services may be a useful way of meeting the diverse needs of individuals and their employers. Group services may provide valuable sources of social support, disclosure and perspective taking, to promote a positive bereavement process for individuals. This model of support may also support employers by reducing costs and waitlists for counselling services.

### **Outline of the Remainder of the Paper**

Now that we have developed a basic understanding of the research problem, the research question and the purpose of this study, it is important to understand the direction for the remainder of the paper. This thesis will be presented over five chapters. The first chapter began with an introduction which provided an overview of the study; including, background information, thesis statement, purpose of the paper, definition of terms, significance of the study, and this outline. While the introduction provided an understanding of the research regarding perinatal loss to date, it also provided an awareness of the development of this research, and the implications for future research. This knowledge built an argument for the development of a group therapy approach for individuals grieving a miscarriage. The following three chapters will be utilized to research the components of a group therapy approach.

Chapter two, will focus on a thorough literature review on research that supports and/or impairs the bereavement process for individuals experiencing perinatal loss. This will include an in depth look at the role of culture, religion, society privacy rules, social support, mourning rituals, healthcare support, reproductive history, and making meaning of the loss.

Chapter three will present research regarding ambiguous loss and/or disenfranchised grief. According to Betz and Thorngren (2006), ambiguous loss involves the loss of a person, object or event that is not recognized or legitimized by society. Ambiguous loss is typically characterized by a lack of rituals or social support. Similarly, disenfranchised grief refers to “grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported” (Doka, 1989, as cited in Hazen, 2003, p.149). This chapter will focus on the research regarding ambiguous loss and disenfranchised grief, and how they relate to perinatal loss. This will include the analysis of research regarding

theories of grief and loss, maternal well-being, social connections, personal disclosure, coping strategies, mourning rituals and continued bonds.

Chapter four will examine research regarding group therapy for marginalized populations. This chapter will focus on the role of structuring safety, personal disclosure, considering differences within/between groups, narrative therapy, witnessing, and honouring acts of resistance. The author will also consider the method of delivery; including frequency, duration, and guidelines for participation. While these factors have not been studied specific to individuals bereaving a miscarriage, this thesis will utilize research to propose a model of group therapy for perinatal loss.

Finally, this thesis will conclude with chapter five. This chapter will summarize the previous three chapters, by highlighting connections between the research supporting miscarriage, ambiguous loss, disenfranchised grief, marginalized populations, and group therapy. The author will utilize this research to build an argument for a group approach which is comprised of variables that are supported in literature. While these variables have not been examined solely for individuals grieving a perinatal loss, this thesis will use existing research to provide suggestions for delivery. The thesis will conclude by examining strengths and limitations of this paper, followed by suggestions for future research and implementation. A complete list of references will be provided to promote information sharing.

## Chapter 2: The Psychological Impact of Miscarriage

### Introduction

According to Brier (2008), miscarriage “is a psychologically challenging event. There is no publicly acknowledged person to bury or established rituals to structure mourning and gain support, and often, relatively few opportunities are present to express thoughts and feelings about the loss” (p. 451). Bereaved parents often suffer in silence, without recognition, validation or support. Individuals may experience adverse emotional, psychological and/or physical reactions following a loss. For many people, the loss of a pregnancy represents the loss of an important attachment figure; this may coincide with severe and prolonged distress (Brier, 2008).

Brier (2008) suggested that various authors have attempted to define a normal grief reaction, in addition to abnormal responses to grief. For example, Prigerson et al. (as cited by Brier, 2008) suggested that a significant grief reaction may include feeling depressed, despairing, dejected, angry or fatigued. Individuals may withdraw themselves socially, experiencing critical self-judgement, feelings of hopelessness and/or concentration problems. Individuals may also experience physical symptoms, suffering from headaches or sleep disturbances. Brier (2008) supported this holistic definition, and provided his own explanation of a significant grief reaction. Brier (2008) suggested that miscarriage may result in feelings of numbness, disbelief, yearning, sadness and despair, which occur over a period of less than six months. If the individual experiences anxiety, depression or stress beyond a six-month timeline, the individual’s distress may be pathological and require enhanced supports.

This chapter will provide an in-depth analysis of the psychological impact of miscarriage. In doing so, the chapter will conduct a thorough literature review of the research that supports and/or impairs the bereavement process for individuals experiencing a perinatal loss. The

chapter will consider the role of culture, religion, society privacy rules, social support, mourning rituals, healthcare support, reproductive history and making meaning of the loss. Recurrent themes will be noted throughout the chapter. The chapter will conclude with a summary of the results. The information presented in this chapter will be utilized to construct a group model of therapy in chapter five of this thesis. This chapter will begin by exploring the impact of culture on the perinatal grieving process.

### **Culture**

Kofod and Brinkmann (2017) suggested that the experience of perinatal grief may be influenced by the norms within a culture. Contemporary Western culture provides “a landscape in which suffering is increasingly dealt with in psychiatric and medical terms and understood as an adverse and unnecessary condition to be overcome in order to maximize personal health, happiness, and well-being” (Kofod & Brinkmann, 2017, p. 519). Grief is not regarded as a normal, natural process, but a condition to be corrected (Kofod & Brinkmann, 2017).

Harvey, Creedy, and Moyle (2001) supported the notion that perinatal loss is regarded as a medical phenomenon; care is focused on the physical condition of the woman, rather than her emotional wellbeing. A study by Harvey et al. (2001) followed the experiences of three women in Australia who had experienced a miscarriage over the past twelve months. Through open-ended, unstructured interviews, Harvey et al. (2001) identified three major themes of loss; including, the loss of a child, the loss of motherhood, and the loss of the hopes and dreams that these women had for their babies. Harvey et al. (2001) suggested that these losses were exacerbated by negative interactions with family, friends and health professionals. The participants reported increased distress in relation to a lack of understanding by family and friends. They also reported increased levels of stress related to health professional’s negative

attitudes, the lack of information provided to them, and the lack of understanding or support. These results supported the cultural taboo against the public recognition and expression of perinatal grief in Western cultures. The results also supported the adverse effects of this taboo, on the affected individual.

A study by Wojnar, Swanson, and Adolfsson (2011) considered the role of silence and dismissal, upon grieving a perinatal loss. This study examined the experiences of forty-two women from diverse cultural backgrounds. The study utilized participants from Canada, the United States and Sweden. Wojnar et al. (2011) suggested that perinatal loss is experienced as an invisible loss in Western cultures. Individuals from diverse ethnic, geographical and sexual sub-cultures experience similar distress related to a lack of recognition, compassionate care or resources. There was one exception to the data, lesbian couples did not report guilt as a significant concern during the bereavement process. Wojnar et al. (2011) suggested that this variance may be attributed to the fact that lesbian women do not have the same opportunity to conceive naturally. Wojnar et al. (2011) concluded that guilt within the heterosexual portion of the sample may be linked to a history of infertility, including issues relating to blame, causality and personal culpability. With similar results from studies across Australia, Canada, the United States and Sweden; it is important to consider how collectivist cultures are similar or different with their cultural norms regarding miscarriage.

Batool and Azam (2016) conducted a study in Pakistan exploring the bereavement process for women after a miscarriage. Ten women were interviewed in response to their loss. According to Batool and Azam (2016) perinatal loss was associated with “emotional turmoil, confusion, shock, shattered hope, disbelief, guilt, fear, and vulnerability to anxiety/depression, anger, frustration, longing for someone to share their story with, and wanting recognition,

support, and validation of the loss from others” (p. 638-639). Upon analyzing the data, Batool and Azam (2016) suggested that women in Pakistan experience physical and emotional pain that is similar to that of women in Western cultures. Batool and Azam (2016) shared similarities in their research with Western cultures, however, they also advocated for research which reflects a collectivistic orientation, including consideration of the relationship with one’s in-laws, emotional response, social inclusion and spiritual growth.

In conducting their research in Pakistan, Batool and Azam (2016) considered the bereaved parent’s relationship with their in-laws. Within the sample of ten women, there were varying levels of support provided by the in-laws to the parents. Upon analyzing the results of the study, Batool and Azam (2016) suggested that the quality of support from one’s in-laws was positively correlated with recovery during the bereavement process. Similar to the studies noted above in Western cultures, Batool and Azam (2016) asserted that women in Pakistan may experience feelings of blame and guilt following a miscarriage. They were also more likely to isolate themselves socially. The researchers identified spiritual growth as a potential coping mechanism. Women identified positive experience from their trauma, through redefining their relationship with God. The research by Batool and Azam (2016) detailed similarities and differences between cultures, however, it also advocated for cross-cultural research that controls for cultural stereotypes and/or norms. While ethnicity and geographical location have been considered thus far, it is also important to explore the impact of religion on the bereavement process.

### **Religion**

“Although a large body of literature has examined the influence of religion on bereavement and grief, relatively few studies have explored the relationship between religion and

pregnancy loss” (Cowchok et al., 2010, as cited in Petts, 2018, p. 110). Petts (2018) suggested that religion may be used to support women to cope with a perinatal loss. By attending religious services, individuals are provided with a framework for understanding their loss, through a sense of meaning or purpose in life. Individuals are also provided with a support network that they can depend on for assistance. While religion may be a great support to persons following a loss, Petts (2018) noted that religion may also be a barrier when individuals feel abandoned, or blame God for their loss. Petts (2018) conducted a literature review on the existing research linking mental health outcomes to religious participation, after miscarriage. Petts (2018) noted several mixed results. Within these results, specific strategies were identified as possible mediators, this included “forgiveness, seeking religious support, belief in a loving God, and engaging in religious rituals” (Petts, 2018, p. 111).

Petts (2018) conducted a study in the United States using the national longitudinal survey of youth (NLSY97), for data purposes. This survey tested youth between the ages of 12 and 17, in the years 2000, 2002, 2004, 2006, 2008 and 2010. While there were over 4,000 female respondents each year, the total sample size included 3,646 female respondents who experienced a miscarriage that could not be classified as an abortion or a stillbirth. The survey data presented a significant limitation to the research, as the study utilized adolescent respondents, yet generalized the data to women, representing a larger age range and population. The results indicated a significant correlation between religious participation and mental health outcomes, following a miscarriage (Petts, 2018).

Similar to the study by Petts (2018), Allahdadian and Irajpour (2015) reviewed the existing literature on religion and prenatal death, with Iranian women and their families. Allahdadian and Irajpour (2015) conducted their research over a similar timeline, reviewing data

between 1990 and 2013. While the study included a majority of Christian respondents, Muslim and Hindi cultures were also represented. The results indicated some similarities to the data provided by Petts (2018), noting positive correlations with belief in God's support, social support, and participation in ceremonies. Allahdadian and Irajpour (2015) identified a possible confound to the bereavement process, identifying the timeline of the miscarriage as a possible mitigating variable. Both of the literature reviews and studies above show consistencies in religious beliefs through social support. While social support appears to be instrumental in the healing process, there is a culture of silence, which places a barrier to support for bereaving parents.

### **Society Privacy Rules**

According to Markin and Zilcha-Mano (2018), there are cultural rules which define explicit and implicit rules for behavior, following a loss. "In stark comparison with other types of losses, when a pregnancy is lost here are no communal rituals for grieving, no customary religious or social gatherings, no condolences cards or flowers, nor is there even a death certificate, burial, or gravestone for the lost baby" (Markin & Zilcha-Mano, 2018, p. 20). Markin and Zilcha-Mano (2018) suggested that this results from a cultural taboo against the expression and recognition of perinatal grief. Miscarriage is not seen as an event, as the fetus is not regarded as a person. Bereaved parents are left without guidance or support to mourn. The researchers suggested that the lack of validation and support leads to adverse mental health outcomes. Markin and Zilcha-Mano (2018) advocated for family members, peers, and professionals to break the silence by validating the loss and providing a space to mourn within a supportive environment. Bereaved parents may benefit from an empathetic response, which

promotes mourning rituals. Mourning rituals uncover the cloak of silence, by providing the bereaved with strategies to recognize and work through their loss.

### **Social Support**

Throughout this paper, the effects of culture, religion and society privacy rules have been discussed in relationship to a bereaved parent's mental health outcomes. With each variable in mind, social support has been identified as a significant intervening variable. A study by Rowlands and Lee (2010) in Australia studied nine women who had experienced a miscarriage in the previous two years. The results indicated that social support, through engagement and acknowledgement of the miscarriage, was a positive aspect for the bereaved following miscarriage. Rowlands and Lee (2010) suggested that these results supported a wealth of research supporting social engagement as a protective factor during the bereavement process.

Randolph et al. (2015) reviewed the existing literature to discuss the role of social support, during the perinatal grief process. In doing so, Randolph et al. (2015) asserted a positive correlation between pregnancy loss and psychological distress. Randolph et al. (2015) suggested that social support is "imperative to the healing process for women and their partners after a pregnancy loss" (p. 5). According to Randolph et al. (2015), social support provided a nurturing environment, characterized by active listening and encouragement. The presence of social support has been noted in connection with many related variables within this paper. Social support is also an instrumental variable within mourning rituals, which will be discussed in the following section of this chapter.

### **Mourning Rituals**

Rajan and Oakley (1993) conducted a study to investigate whether social support, through mourning rituals, leads to more positive emotional and physical health outcomes in

bereaved parents. This study included a sample of 509 women, attending four pregnancy centres within the United Kingdom. Through analyzing the qualitative data, Rajan and Oakley (1993) suggested that mourning rituals supported individuals with recognition and validation, legitimizing their mourning period. Women who engage in mourning rituals are encouraged to see the bereavement process as natural and healthy. Rajan and Oakley (1993) concluded by suggesting that mourning rituals support the bereaved individual's self-esteem and identity, promoting a successful bereavement outcome.

A study by Brin (2004) acknowledged the loss of a pregnancy, as the loss of creation. Brin (2004) suggested that, in preparing for pregnancy, expectant parents get ready for the arrival of an infant. When miscarriage occurs, grief ceases the process of creation. Brin (2004) suggested that bereaved parents may promote healing through directing their participation to the creation of mourning rituals. "The powerful energy of ritual helps parents heal from the pregnancy loss by acknowledging the traumatic event, drawing to them the healing presence of their friends and family, and providing the comfort of tradition" (Brin, 2004, p. 124). While Brin's observations came from her work as a rabbi in Canada, she asserted that mourning rituals may benefit persons of all religious beliefs and/or practices. Brin (2004) asserted that participation in mourning rituals should be guided by the bereaved individual, encompassing their unique beliefs, values and strategies for practice.

### **Healthcare Support**

In Europe, Sejourne, Callahan, and Chabrol (2010) utilized a questionnaire to investigate women's experiences with the medical system following a miscarriage. This study also attempted to outline the supports women desire when seeking medical attention. Sejourne et al. (2010) questioned 305 women residing in France and Belgium. The results of this study

indicated that nearly all of the women felt that they required additional care from the healthcare system. The bereaved specified that they did not receive adequate information or emotional support within a medical setting. In particular, they did not feel prepared for the emotional impact of losing a baby. Sejourne et al. (2010) advocated for future bereaved parents by proposing medical supports which include “follow-up and service delivery for women experiencing miscarriage; care and assessment by health care professionals, provision of information, routine phone follow-up, risk of assessment of abnormal grief and support during subsequent pregnancies” (p. 409-410).

A study by McLean and Flynn (2012) followed six Australian women’s experiences within a hospital after miscarriage. The results of this study suggested that the women received an inconsistent medical response, lacking compassion, acknowledgement of the miscarriage, and/or information regarding testing or support. McLean and Flynn (2012) advocated for the participants by appealing to healthcare for “a more consistent and specialized hospital response, with timely access to diagnostic testing equipment as necessary, the offer of social work, information provision and staff to be compassionate in their care and to acknowledge their pregnancy loss” (782). The results of this study support the findings of Sejourne et al. (2010) in Europe. They also support the research of Markin (2016), who suggested that clinical errors in the treatment of miscarriage include, minimalizing the emotional impact of the loss and assuming that grief is resolved with a subsequent pregnancy.

### **Reproductive History**

Maker and Ogden (2003) suggested that miscarriage may be “considered a pivotal point in the lives of many women resulting in the reassessment of their past and future experiences” (p. 403). Maker and Ogden (2003) conducted a study in England which interviewed thirteen women

who had experienced a miscarriage within their first trimester. The results of this study indicated that the bereavement process was more positive for individuals who had never miscarried, and also for individuals who had living children. The researchers linked this result to a sense of hope, through the lack of experience with miscarriage, or the experience with a successful pregnancy.

A study by Brier (2008) conducted a literature review that examined the variables which are linked to perinatal grief following miscarriage. Brier suggested that individuals who become pregnant following a miscarriage, experience lower levels of grief, despair and difficulty coping. In contrast, women who experience recurrent miscarriage are at higher risk for distress during subsequent pregnancies and/or miscarriages (Ockhuijsen et al., 2014). Ockhuijsen et al. (2014) suggested that women who have previous experience with miscarriage, use social support and cognitive strategies, such as ‘bracing for the worst,’ to protect their mental health during the uncertainty of subsequent pregnancies. In addition to ‘bracing,’ individuals may utilize alternative cognitive strategies to support their mental health following a loss. One that has been studied extensively may be referred to as ‘making meaning.’

### **Making Meaning of the Loss**

Throughout the grieving process, there are several coping strategies that individuals may utilize to mitigate their distress. A literature review by Randolph et al. (2015), suggested that healthy coping strategies are the first step in the healing process; this includes making meaning of the loss. A study by Nikčević and Nicolaidis (2014) explored the correlation between making meaning and psychological outcomes in 127 women who had experienced a miscarriage. The researchers recruited participants from three different hospitals in London, England. Through a questionnaire, Nikčević and Nicolaidis (2014) assessed the results. The results indicated that

both female and male participants desired an explanation behind the miscarriage. Individuals who did not receive a cause for the miscarriage were more likely to engage in “why me” thinking, which was positively associated with symptoms of distress. Individuals who did not engage in “why me” thinking represented the minority of the sample at 23%. These women did not experience the same distress as the women who engaged in this manner of thinking.

Stinchfield and Pender (2014) conducted a study which examined the role of reflecting teams in supporting couples therapy after a miscarriage. In this study, Stinchfield and Pender (2014) identified additional ways of making meaning from one’s loss. The researchers worked with a couple who was receiving counselling from a university counselling centre in the Midwest. The participants were supported through the collaborative nature of the reflecting team process. This included using professional, respectful and nonjudgmental collaborative efforts to promote positive reflections of personal experience, and instill hope.

A study by Alves, Mendes, Goncalves, and Neimeyer (2012) in Portugal found similar results. Alves et al. (2012) conducted a case study, utilizing a narrative counselling approach. In concluding six sessions with one bereaved parent, the researchers identified several themes following a loss. The themes included, action, reflection, protest, re-conceptualization and performing change. Alves et al. (2012) concluded by suggesting that positive reflections and re-conceptualization reflect a cognitive behavioral approach, providing self-reorganization towards a new life story.

## **Summary**

This chapter presented a review of existing research that supports and/or impairs the bereavement process, following a perinatal loss. Several variables were studied, including the role of culture, religion, society privacy rules, social support, mourning rituals, healthcare

support, reproductive history, and making meaning of the loss. The following positive effects were noted. Social support was identified as a strong predictor of a positive bereavement outcome (Randolph et al., 2015; Rowlands & Lee, 2010). This positive association was found in reference to culture (Batoool & Azam, 2016), religion (Allahdadian & Irajpour, 2015; Petts, 2018), and society privacy rules (Markin & Zilcha-Mano, 2018). In reference to society's privacy rules, Markin and Zilcha-Mano (2018) identified that bereaved individuals are supported by a non-judgmental, empathetic approach, validating the loss. Similar to Markin and Zilcha-Mano (2018), Rowlands and Lee (2010) and Randolph et al. (2015) examined the variables which positively influence social support. The results from both of these research studies also asserted the positive affect of validation, through active listening and acknowledgement of the loss. Finally, a study by Rajan and Oakley (1993) supported the positive role of social support through engagement in mourning rituals. Rajan and Oakley (1993) asserted that mourning rituals provide the bereaved with validation and guidance with regards to the grieving process.

While social support was identified as a strong theme within his chapter, there are other variables which were identified as possible positive supports. In studying support from healthcare, information regarding the cause of the loss, and preparation for the emotional loss, were positively associated with positive mental health outcomes. In addition, positive experiences with reproductive health, including the existence of living children and a personal history absent of perinatal loss (Maker & Ogden, 2003). These variables were linked to a sense of hope. Additional cognitive techniques such as bracing for the worst (Ockhuijsen et al., 2014) and making meaning (Nikčević & Nicolaidis, 2014; Randolph et al., 2015) supported individuals through preparation, information support and/or change in perspective.

This chapter identified several variables which were positively associated with the bereavement process. However, it also raised instances in which these variables, as well as new variables, resulted in a negative association with mental health following a perinatal loss. For instance. With regards to social support, this paper identified a culture of silence which inhibits the expression and recognition of perinatal grief (Markin & Zilcha-Mano, 2018). Thus, culture may moderate an individual's access to, and perception of, social support following a loss.

Batool and Azam (2016) also noticed discrepancies in the effects of social support following a loss. Batool and Azam (2016) suggested that these discrepancies may be linked to the quality of the relationship between the bereaved and the support person. In studying religion, Petts (2018) noted that while religion may be a positive support throughout the bereavement process; religious participation also has the ability to impair bereavement, when individuals feel abandoned or blame God for their loss. With regards to perspective taking, making meaning was considered harmful in situations where the individual questioned "why me," yet did not consolidate a reason for their loss (Nikčević & Nicolaidis, 2014). Through examining the inconsistencies in research, future research may continue to uncover the complex web of intervening variables at hand.

### **Application to Group Therapy**

In reviewing the variables that support and impair the bereavement process, social support, validation, information provision, mourning rituals, and cognitive strategies have all been identified as positive means of supporting individuals who have experienced a perinatal loss. These themes will continue to be considered throughout the content of this paper. The following portion of this paper, chapter three, will present research regarding ambiguous loss and disenfranchised grief. The author will link the themes discussed in chapter two, to both of these

constructs. These constructs will be discussed in light of positive and/or negative bereavement outcomes. In addition, new intervening variables will be explored. Once the literature review is complete, this material will be utilized to support an innovative approach to group therapy for individuals grieving a perinatal loss.

### **Chapter 3: Miscarriage Redefined as Loss and Grief**

#### **Introduction**

According to Betz and Thorngren (2006), ambiguous loss involves the loss of a person, object or event that is not recognized or legitimized by society. Ambiguous loss is typically characterized by a lack of rituals or social support. Similarly, disenfranchised grief refers to “grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported (Doka, 1989, as cited in Hazen, 2003, p.149). Disenfranchised grief may be thought of as a response to ambiguous loss. Both of these terms embody the culture of silence following a miscarriage, which was referenced throughout the first two chapters of this paper. While chapter one introduced a cultural taboo against the expression and recognition of perinatal grief, chapter two detailed the various ways the taboo shows up in contemporary society. This included a lack of validation, information provision, emotional support, social support, and/or mourning rituals (Markin & Zilcha-Mano, 2018). The third chapter of this thesis will present research regarding ambiguous loss and disenfranchised grief. The chapter will also consider how these constructs relate to perinatal loss and bereavement. This will include the analysis of research regarding theories of grief and loss, maternal well-being, social connections, personal disclosure, coping strategies, mourning rituals, and continued bonds.

#### **Ambiguous Loss**

According to Knight and Gitterman (2019), “ambiguous losses are confusing and typically defy closure. The lack of resolution places the bereaved in limbo, unable to move forward, and isolated, since the normal rituals of support that accompany death loss do not apply and therefore are unavailable” (p. 165). Research on ambiguous loss has focused on ambiguous

loss as a construct, and also on miscarriage as a form of ambiguous loss. The study by Knight and Gitterman (2019) focused attention on ambiguous loss related to missing persons, incarceration, military deployment, adoption, foster care, and chronic health conditions such as dementia. Additional researchers have focused on ambiguous loss related to immigration (Perez & Arnold-Berkovits, 2018), autism spectrum disorder (O'Brien, 2007), chronic illness (Boss & Couden, 2002; Zaksh, Yehene, Elyashiv, & Altman, 2019), in addition to many other forms of losses. The chapter will review literature regarding ambiguous loss, including research specific to perinatal loss. This research will be summarized in relationship to the results presented throughout this paper.

Pauline Boss (2006) wrote a book called *Loss, Trauma and Resilience: Therapeutic Work with Ambiguous Loss*. This book was written to summarize research and raise new questions regarding supporting individuals who are experiencing distress due to an ambiguous loss. Boss (2006) incorporated research and practice for therapists supporting victims of political violence, persons of low income, and elderly persons. While Boss (2006) introduced these specific populations, she also asserted that there are many different forms of ambiguous loss that will show up in counselling. In reviewing the existing research, Boss (2006) suggested that “ambiguous loss is the most stressful kind of loss. It defies resolution and creates long-term confusion... the persisting ambiguity blocks cognition, coping and meaning-making and freezes the grief process” (p. 17). Boss (2006) suggested that the stress created by ambiguous loss is above and beyond the normal human experience faced by families.

Boss (2006) suggested that it is important for therapists to understand how to support individuals through adverse experience related to ambiguous loss. According to Boss (2006), individuals who have experienced an ambiguous loss are at higher risk for couple/family

conflict, separation/divorce/cut offs, cessation of family rituals/celebrations, and mistrust/anger with professionals. Individuals are also more likely to experience anxiety, depression, substance abuse, violence, and suicide.

Boss (2006) utilized the information gathered through the literature review to outline therapeutic goals for counsellors and individuals working with perinatal grief. In doing so, Boss (2006) suggested that the focus of therapy should be resiliency, with the goal of moving toward ambiguity and uncertainty. Individuals should be supported to share their unique experience with loss, in a non-judgmental, empathetic environment. Therapeutic techniques may include finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope. With regards to finding meaning, Boss (2006) suggested that individuals may benefit from finding meaning in their experience; this may be through naming the problem, dialectical thinking, and/or the use of rituals or artistic expression. Individuals may also benefit through tempering mastery. Through tempering mastery, individuals learn that much in life remains unknown and unresolved. Individuals are encouraged to see adverse experience as a means of understanding themselves and growing as a person; this leads to the reconstruction of identity and the normalization of ambivalence. Finally, Boss (2006) suggested that individuals may be supported through loss by revising attachment and discovering hope. Individuals may revise attachment by moving from despair, to protest, to build a new connection with the lost person.

An article by Roos (2013) proposed a Gestalt method of supporting individuals who are coping with grief, following an ambiguous loss. While this article was written for individuals who are supporting a family member who has been diagnosed with Alzheimer's disease. Roos (2013) suggested that this method of treatment may be utilized to support all individuals who

face a major life disruption due to an unexpected, cataclysmic event. According to Roos (2013) individuals who are faced with this experience are left “forced to contend with a never-imagined, unchosen, and unrelenting loss of the expected, assumed, dreamed-of, or normative future” (p.230). Through applying Gestalt methods, Roos (2013) proposed a treatment for individuals grieving an ambiguous loss, including closure through relinquishing what was lost. This may include developing changes in perspective, attributions of meaning, philosophical growth, or new life experiences. Roos (2013) asserted that once a person achieves closure, they may move toward the restoration of resilience, through bearing witness, holding memories, integrating new understanding of the self, channeling stress into positive pursuits and developing an appreciation for compassion, empathy and the context of suffering. Roos (2013) concluded by suggesting that social support, social recognition and the use of mourning rituals may also be beneficial to the individual experiencing a loss.

An article by Betz and Thorngren (2006) also considered the role of ambiguous loss in regard to Alzheimer’s disease. In addition, the researchers explored ambiguous loss in regard to child abduction, military personnel and miscarriage. Betz and Thorngren (2006) utilized ideas proposed by family stress theory and narrative therapy to support individuals through the bereavement process. In regard to family stress theory, Betz and Thorngren (2006) suggested using the ABC-X model of family stress.

This model encourages counselors to help families define all aspects of their losses, assess what resources they are currently using and other resources they could use to cope with their losses, and provide families with ways to share their perceptions and beliefs about their losses. This last piece, sharing perceptions about loss, lends itself

to further therapeutic work in the form of helping families redefine or create new meanings and rituals surrounding their losses. (Betz & Thorngren, 2006, p. 363)

Narrative therapy is utilized along with the ABC-X model of family stress, to support individuals to share their stories or loss in an empathetic, non-judgmental environment. Individuals are encouraged to be the author of their own story, developing new perspective and/or meaning in response to their loss. Now that we have discussed research related to ambiguous loss as a construct, is important to explore the research related specifically to supporting individuals following a perinatal loss.

Sawicka (2017) conducted a study which analyzed the social processes of online bereavement communities for women who have experienced a miscarriage or a stillbirth. This study was completed using Polish discussion lists, and interviews with the moderators of these lists. The results indicated that persons who have experienced a perinatal loss are likely to describe their experience as “unclear, indefinite, or uncertain” (Lang et al., 2011, as cited in Sawicka, 2017, p. 230). Sawicka (2017) suggested that these uncertainties leave the individual in a state of “emotional and social ambiguity. This ambiguity is reinforced by the lack of a coherent set of cultural resources to guide the experience” (p. 231). Sawicka (2017) concluded that miscarriage and stillbirth represented a form of ambiguous loss. Individuals may benefit from reframing their emotional experience and their identity.

A study by McGee, PettyJohn, and Gallus (2018) explored the experience of miscarriage through ambiguous loss theory. The researchers suggested that while miscarriage has been defined as ambiguous loss in the past, current research was needed to examine the validity of this link. This study sampled ten females seeking support related to their miscarriage. The researcher identified six themes from the data, including: “emotional toll; stolen dreams; no one

understands; he loves me in a different way; why? I don't understand; and, in the end, I have my faith" (McGee et al., 2018, p. 1). McGee et al. (2018) suggested that miscarriage may be identified as ambiguous loss, due to a physical loss, accompanied by the psychological presence of a lost child. Individuals are faced with ambiguity and uncertainty through the lack of information, rituals, or social support following a loss. McGee et al. (2018) concluded by suggesting that healthcare professionals may support individuals by providing opportunities to shift perspective, find meaning and build hope, following their loss.

Palmer and Murphey-Oikonen (2019) wrote an article advocating for social work support for women who experience an early pregnancy loss (EPL) in the emergency department. The authors defined EPL as "the spontaneous death of a fetus experienced within the first twenty weeks of gestation" (Palmer & Murphey-Oikonen, 2019, p. 392). Palmer and Murphey-Oikonen (2019) referenced the culture of silence that many women experience in response to their experience with EPL. They suggested that these women are not only at risk for physical and psychological health concerns, they are also at risk for complications related to future pregnancies. Palmer and Murphey-Oikonen (2019) advocated for social workers in emergency rooms, for the purpose of providing compassionate, person-centered care; acknowledging and honouring the loss of each individual. Social workers may also assist with psychoeducation, assessing resources, referrals and providing additional information, as needed by the individual.

### **Disenfranchised Grief**

Palmer and Murphey-Oikonen (2019) described grief as a normal reaction to a significant loss. In contrast, the authors refer to disenfranchised grief as the reaction to a loss which is not acknowledged, supported or mourned. Palmer and Murphey-Oikonen (2019) suggested that the experience of a perinatal loss is often minimized or dismissed by the individual's loved ones and

society in general. Research on disenfranchised grief has focused on disenfranchised grief as a construct, and also on miscarriage as a form of disenfranchised grief. Researchers have discussed disenfranchised grief in reference to miscarriage, disenfranchised grief has also been studied in relation to infertility (McBain & Reeves, 2019), homelessness (Burns, Sussman, & Bourgeois-Guerin, 2018), substance-related death (Valentine, Bauld, & Walter, 2016), and home care workers' experiences of client death (Tsui, Franzosa, Cribbs, & Baron, 2019), in addition to other forms of disenfranchised grief. This portion of the chapter will review research regarding disenfranchised grief as a construct in general, prior to noting the research specific to perinatal loss. The research that is presented will be summarized in relationship to the research presented throughout this paper.

“Although our world is full of suffering, it is full also of the overcoming of it” (Keller, as cited in Attig, 2004, p. 197). An article by Attig (2004) explores the effects of disenfranchised grief, exploring the “nature of disenchantment as a denial of the mourner’s ‘right to grieve’ and analyzes the empathetic, political, and ethical failures involved in this denial” (p. 197). Attig (2004) suggested that the ‘right to grieve’ should include a person-centered response; individuals should receive direct, intentional support, without interference in the grieving process. Attig (2004) asserted that this right is an essential component of human dignity; by withholding supports and services for bereaved individuals, society maintains the oppression of persons experiencing disenfranchised grief. The author suggested that healthcare professionals may support individuals by validating their loss, supporting the individual to expand their focus, and by supporting resilience through a sense of hope. Attig (2004) concluded the article by asserting that bereaved individuals may keep the memory of their loved one alive, through sharing memories and finding different ways to keep their loved one’s memory alive. This introduced

the concept of continued bonds, which will be explored as a positive coping mechanism in this section of the chapter.

Susan Mortell, a mental health nurse, published a set of guidelines in 2015, that could be utilized by mental health professionals supporting an individual with disenfranchised grief. While Mortell (2015) was not specifically referring to grief related to perinatal loss, she did provide categories of disenfranchised grief, including, relationships not recognized, loss not acknowledged, and deaths which are characterized by stigma. These categories embody the experiences of persons grieving a perinatal loss, as described within the first three chapters of this thesis. Mortell (2015) suggested that persons experiencing disenfranchised grief are often socially isolated, lacking the opportunity to engage in mourning practices or rituals. Mortell (2015) asserted that individuals who are experiencing grief that is disenfranchised may benefit from specific supports and services.

Mortell (2015) advocated for tools and interventions, including, providing empathy, sharing new perspectives, making meaning, participating in mourning practices or rituals, and attending support groups to recover from the loss. Mortell (2015) asserted that these strategies may potentially liberate individuals who have been oppressed by the silence encompassing disenfranchised grief. While the research described thus far has focused on the general construct of disenfranchised grief, the remainder of this section will describe research which relates disenfranchised grief specifically to miscarriage.

Hazen (2003) conducted a study which explored societal and workplace responses to individuals who have experienced a perinatal loss. Hazen (2003) asserted that there is a culture of silence in the workplace, as topics regarding reproduction and mothering are discouraged by career theory, management and organizations. This culture of silence supports disenfranchised

grief through the avoidance of bereaved persons at work, limited time off work, and a lack of understanding or acknowledgement of the employee. Hazen (2003) suggested that these processes may invoke shame or guilt in the mother, promoting further isolation and withdrawal of supports. Hazen (2003) also utilized theories of attachment and trauma to describe the adverse psychological impact on the bereaved parent. Hazen (2003) conducted a qualitative study, using open-ended interview questions. Hazen (2003) followed the experiences of fourteen women, who experienced a miscarriage, stillbirth, or death following birth. Hazen (2003) concluded that all of the women in the study experienced disenfranchised grief. Women who experienced the highest levels of secrecy and shame, were the most isolated. Hazen (2003) suggested that mothers may benefit from validation, social support and efforts to bond with their lost child. In doing so, women may remain in contact with their community, supporting self-confidence and competence, and encouraging hope for the future.

Throughout this thesis, there have been several studies which have supported the positive impact of validation and social support in response to perinatal loss. A study by St. Clair (2013) utilized the term witnessing, to describe a process of counteracting disenfranchised grief. This process provides an empathetic environment which acknowledges the individual's loss and their right to grieve. The witness provides testimony to others, limiting the culture of silence associated with the individual's grief. St. Clair (2013) referenced a newly designed tool, called the Witnessing of Disenfranchised Grief (WDG). St. Clair (2013) tested the twenty-two-item questionnaire on a sample of 201 people who experienced loss by a death or a miscarriage. "The WDG was found to be a statistically sound measurement of the witness variable" (St. Clair, 2013, p. 408). The results indicated that individuals who perceived their loss as witnessed, were less likely to manifest adverse grief symptoms, including depression and social isolation. St.

Clair (2013) concluded that individuals who feel they have been witnessed, are more likely to engage in interactions with family and friends.

### **Summary**

This chapter reviewed the role of ambiguous loss and disenfranchised grief, in relationship to perinatal loss. In reviewing the role of these constructs, the chapter identified several variables which may impact the emotional, psychological and/or physical health of the affected individual. This summary will commence by describing the research on ambiguous loss and disenfranchised grief in general, prior to exploring the research specific to perinatal loss. By acknowledging the commonalities and differences across these domains, this paper will support the relationship between ambiguous loss, disenfranchised grief and perinatal loss. The discrepancies will be utilized to guide further inquiry and study.

In studying the effects of ambiguous loss and disenfranchised grief, the general results provided support for a person-centered approach (Attig, 2004; Roos, 2013) utilizing empathy (Boss, 2006; Mortell, 2015; Roos, 2013) and acknowledgement of one's loss (Mortell, 2015) to validate the individual (Attig, 2004), assist by encouraging new perspectives (Attig, 2004; Boss, 2006; Mortell, 2015; Roos, 2013) and support resilience through hope (Attig, 2004; Boss, 2006; Roos, 2013). The chapter also identified specific interventions for bereaved individuals, including, social support (Mortell, 2015), referrals to supports and services (Attig, 2004; Mortell, 2015), attending support groups (Mortell, 2015), making meaning of one's loss (Boss, 2006; Mortell, 2015; Roos, 2013), participating in mourning practices/rituals (Mortell, 2015), and developing legacies and/or continued bonds with their loss (Attig, 2004; Roos, 2013). Individuals are provided with the right to grieve; through witnessing (Roos, 2013), ambiguity

dissipates (Boss, 2006) and disenchantment may be resolved. This process may assist individuals with reestablishing their identity (Boss, 2006; Roos, 2013).

In studying the effects of ambiguous loss and disenfranchised grief, in relationship to miscarriage; the following similarities were uncovered. Palmer and Murphey-Oikonen (2019) advocated for a person-centered approach, utilizing empathy (St. Clair, 2013) and acknowledgement of one's loss (Hazen, 2003; Sawicka, 2017; St. Clair, 2013) to validate the individual (Hazen, 2003; St. Clair, 2013), assist by encouraging new perspectives (Sawicka, 2017) and support resilience through hope (Hazen, 2013; Sawicka, 2017). The chapter also identified specific interventions for bereaved individuals, including, social support (Hazen, 2003; Sawicka, 2017; St. Clair, 2013), referrals to supports and services (Palmer & Murphey-Oikonen, 2019), attending support groups, making meaning (Sawicka, 2017), and participating in mourning practices/rituals (Sawicka, 2017). Individuals are provided with the right to grieve; through witnessing (St. Clair, 2013), ambiguity dissipates (Sawicka, 2017) and disenchantment may be resolved. This process may assist individuals with reestablishing their identity (Sawicka, 2017).

Through comparison of the existing literature there are important differences to note. While reviewing the research to ambiguous loss and disenfranchised grief, there is one variable which was identified as a support in the research specific to miscarriage, which was not identified in the general research. This variable was information provision, referring to information regarding the reason for one's loss, and/or information support following a loss. Information support following a perinatal loss may include knowledge regarding potential emotional, psychological and/or physical effects following a miscarriage. Within the general research, while these forms were not specifically represented, information provision was

identified through making meaning (Boss, 2006; Mortell, 2015; Roos, 2013), and referrals to supports and services (Attig, 2004; Mortell, 2015). Information provision should be considered specific to the form of loss and the population being studied.

It is also important to note the variables which were identified in support of the general research, which were not identified within the research related to miscarriage. This includes information regarding support groups and maintaining memories through continued bonds. Through noting this discrepancy, future inquiry and research may be completed. The next portion of this paper will consider these constructs, as the forth chapter of the paper considers the role of support groups for marginalized populations, including those specific to perinatal loss.

### **Application to Group Therapy**

In reviewing the variables that support ambiguous loss and disenfranchised grief, social support, empathy, acknowledgement, validation and witnessing have all been identified as positive means of supporting individuals who have experienced a perinatal loss. Individuals may also benefit from cognitive strategies, information provision, referrals to supports and services, and/or attending support groups. Finally, bereaved parents may wish to consider making meaning, participating in mourning rituals and/or continued bonds, to foster resilience and hope. These themes will continue to be considered throughout the content of this paper. The following portion of this paper, chapter four, will analyze research regarding group therapy for marginalized populations. The content from this chapter will be utilized in chapter five to support an innovative approach to group therapy for individuals grieving a perinatal loss.

## **Chapter 4: Group Therapy for Marginalized Populations**

### **Introduction**

According to Gold, Boggs, Mugisha, and Palladino (2012), “pregnancy is a common event but its significance is often minimized by family, friends, and the community, leaving bereaved parents with unmet needs for support” (p. 1). This theme is reflected throughout this thesis, as a culture of silence surrounding perinatal loss. Gold et al. (2012) suggested that bereaved parents may meet their needs through group support. The researchers conducted a study which explored the perceived benefits of internet support groups for women who had experienced a perinatal loss. Gold et al. (2012) conducted 1039 surveys, with participants from 18 different support groups. The results of this study indicated that the participants reported increased satisfaction through feeling heard and receiving social support. Gold et al. (2012) concluded that individuals may benefit from connecting to other people who have experienced the same form of loss.

The study by Gold et al. (2012) represents one of the few research studies exploring group support for perinatal bereavement. As a result, this thesis has utilized research regarding perinatal loss, ambiguous loss, and disenfranchised grief, to demonstrate similar support needs for different marginalized populations. This chapter will begin by presenting research regarding group therapy for perinatal loss, before exploring research regarding other marginalized populations. In exploring marginalized populations, this chapter will describe various models and/or techniques that may be utilized in group therapy; including, structuring safety, personal disclosure, differences within/between groups, narrative therapy, witnessing, and honouring acts of resistance. The paper will also consider the structure of group therapy; including, frequency, duration, and guidelines for participation. Recurrent themes will be noted throughout the chapter.

The chapter will conclude with a summary of the results. The information presented in this chapter will be utilized to construct a group model of therapy in chapter five of this thesis.

A study by Cote-Arsenault and Freije (2004), explored support groups for individuals who have experienced a perinatal loss. The results of this study indicated that “the groups helped members recognize their perceived commonalities, remember their babies who died, develop caring relationships, and learn new coping skills” (p. 650). A similar study by Cacciatore (2007) explored the role of support groups in mitigating trauma for women who experienced a stillbirth. The results of this study suggested that participants attending a support group experienced a reduction in post-traumatic stress symptoms. Cacciatore (2007) concluded that social connections, in addition to developing a sense of meaning, coping skills, and/or honouring their child through supporting others, may mitigate an adverse psychological outcome following a perinatal loss.

A study by Gold, Normandin, and Boggs (2016), explored potential similarities and differences between individuals participating in internet versus face-to-face support groups for pregnancy or infant loss. The results of this study indicated that there were no significant differences between the groups in terms of depression outcomes. Additional studies by Cote-Arsenault and Freije (2004), and Cacciatore (2007), supported these results. In each of the studies, the majority of the respondents were well-educated, white women, limiting the generalizability of the results.

The studies by Cote-Arsenault and Freije (2004), Cacciatore (2007), and Gold et al. (2012), supported the use of group therapy for individuals grieving a perinatal loss. These results indicated that group therapy may provide individuals with acknowledgement, validation, social support, coping skills and/or ways of honouring their child, which have been described

throughout this thesis, as valuable resources for supporting individuals who have experienced a perinatal loss. According to Gold et al. (2016), while group support for diverse marginalized populations has been studied extensively, research specific to perinatal loss is sparse.

### **Models/Techniques**

There are a number of different models/techniques which have been studied in regard to group therapy for marginalized populations. While some of these models/techniques have been studied in relationship to perinatal loss, others lack available research to date. This portion of the paper will focus on research supporting diverse models/techniques within stigmatized and/or marginalized populations. The paper will highlight research specific to perinatal loss and connections between other marginalized groups, through the common factors in the research. The paper will begin with considering the role of structuring safety within the support group.

### **Structuring Safety**

In an article by Vikki Reynolds (2012), Reynolds (2012) presented an ethical framework to support justice-doing in community work and therapy. This article was based on Reynolds' experience working with survivors of torture from several countries, in addition to indigenous survivors of political violence through residential schools. Reynolds (2012) described structuring safety as an anti-oppressive form of social activism which may be utilized to supporting marginalized populations that have increased risks of transgressing safety. "There are no perfectly safe helping relationships, as there are always risks of transgressing safety. We contest the binary of 'safe or unsafe' when we co-create relationships of 'enough safety.' Or a 'safe-r' conversation and relationship" (Bird, 2006, 2002, as cited in Reynolds, 2012, p. 27). Reynolds (2012) suggested that developing safety requires an analysis of power and critical supervision. "Structuring safety is comprised of acknowledging that we are involved in risky

conversations, resisting replicating dominance, acknowledging the limits of accountability, and being open to critique of our most closely held ideas and theories” (Reynolds, 2012, p. 28).

A research study by Bishop and Cregan (2015) examined the role of patient safety culture in health care organizations. In this study, many of the patients and family members described feeling silenced, unheard, misunderstood and/or a lack of attention to their concerns or their needs. Bishop and Cregan (2015) suggested that trust, effective communication, empathy and a collaborative relationship with the care provider supports individuals by providing a culture of safety for the patient and their family. These results support the research presented throughout this thesis regarding acknowledgement, validation, social support, witnessing, and access to information and/or referrals.

### **Personal Disclosure**

Personal disclosure has been studied as an intervening variable in various marginalized populations, including, individuals who have experienced infertility, an eating disorder, and/or persons bereaved by suicide. A study by Knoll and Bronstein (2014) examined patterns of self-disclosure and anonymity through infertility blogs. The researchers suggested the internet may be a valuable resource for information sharing, amongst cultures where avoidance and suppression impacts marginalized individuals. Knoll and Bronstein (2014) suggested that self-disclosure promotes sharing of thoughts, feelings and experiences, supporting personal development and relationship formation. Knoll and Bronstein (2014) acknowledged that there is risk of vulnerability or rejection with this process. The researchers suggested that individuals may choose to provide or censor their name and/or demographic information to mitigate the risks associated with personal disclosure through internet groups.

A study by Williams, Russell-Mayhew, and Ireland (2018) examined the role of online eating disorder communities in supporting individuals who are impacted by an eating disorder. The researchers suggested that individuals who live with an eating disorder often fear that disclosing their challenges may lead to increased anxiety, judgment and/or stigmatization. Williams et al. (2018) suggested that internet communities may provide a safe place for individuals to disclose their personal experience without fear of adverse consequences. Williams et al. (2018) suggested that online communities provide stigmatized individuals with a sense of closeness to others and increased social support. Williams et al. (2018) also asserted that online communities may increase individuals access to information, resources and referral support.

A study by Krysinska and Andriessen (2015) suggested that grief following suicide is unique from many forms of loss, as it includes the experiences of “guilt and shame, social stigma and isolation, as well as the desperate search for the meaning by the bereaved” (p. 20). Krysinska and Andriessen (2015) suggested that online bereavement groups support individuals by providing a safe and empathetic environment to share one’s unique story. The results of this study suggested that bereaved individuals are provided with the opportunity to disclose a wide range of emotional, cognitive and behavioral reactions to their grief, in an environment marked by empathy, validation and valuable resources for coping with their loss.

### **Differences Within/Between Groups**

While supporting persons who identify with a marginalized group, it is important to acknowledge that each individual represents a unique combination of cultures and sub-cultures, which results in the intersection of multiple identities (Arthur & Collins, 2010). Arthur and Collins (2010) suggested that an individual’s identity may include cultures related to age, gender, ethnicity, religion, sexual orientation, socioeconomic status, physical/mental ability, in addition

to many more categories. Harris (2001, as cited in Arthur & Collins, 2010) acknowledged the significance of intersectionality in understanding individual differences. Harris (2001, as cited in Arthur & Collins, 2010, p. 141) suggested that professionals need to be “cognizant about differences that exist between dominant and non-dominant groups in our society and to be sensitive about individual and within-group differences.” Arthur and Collins (2010) concluded that it is important to incorporate a social justice approach, by assessing for power differentials and inequities that may impact an individual’s thoughts, feelings and experience.

### **Narrative Therapy**

In describing narrative therapy as a form of therapy for marginalized populations, Monk and Gehart (2003) suggested that individuals may utilize storytelling to draw comparisons between themselves and other people; this provides individuals with the opportunity to develop new meanings and/or perspectives of their experience. Brownlee and Oikonen (2004) wrote an article proposing a theoretical framework for social workers to utilize in support of perinatal bereavement. In this article, Brownlee and Oikonen (2004) suggested that a narrative model may be implemented to support storytelling, making meaning, and integrating personal experiences and goals to allow for a flexible model of perinatal recovery. This model may include input from others, in addition to the wishes, hopes and dreams of the individual. Through narrative storytelling in a group model, individuals may receive social support, acknowledgement, validation, and the ability to co-create new meanings based on access to diverse experience and perspectives within the group.

Dumaresque et al. (2018) utilized a series of case studies to explore narrative therapy as a means of interpreting broader political and social narratives that underlie an individual’s personal struggles and experience with distress. These case studies included persons from populations

who have faced oppression for their ethnicity, gender, or sexuality. Dumaresque et al. (2018) suggested that narrative therapy “rejects the psychiatrization of human experience as pathologization of individual distress” (p. 115). This approach highlights the importance of understanding the experience for the individual and their unique response to distress. Through exposing alternate truths, individuals receive social support, acknowledgment and validation, to develop an alternate discourse (Dumaresque et al., 2018). Dumaresque et al. (2018) suggested that this approach supports individuals by mitigating blame, guilt or isolation.

### **Witnessing**

A study by Thirsk and Moules (2012) examined the role of witnessing as a grief intervention with families. The researchers suggested that witnesses play a significant role beyond observing an individual’s grief. According to Thirsk and Moules (2012), witnesses provide the opportunity for individuals to access new stories, beliefs and/or experiences which may provide a change in perspective, which facilitates healing. Witnesses also provide access to and/or reminders of personal strengths and resources to promote support. Richardson (2012) wrote an article describing the use of witnessing in supporting life transitions in family therapy within Métis culture. Richardson (2012) suggested that “acknowledgement of significant life changes can offer support, connectedness, dignity and a sense of belonging. When change involves loss, as in the case of separation and divorce, the grief can be witnessed ritualistically in ways that provide comfort and support for the shifts in social identity or status” (p.68).

Reynolds (2002) suggested that witnessing may be utilized as a form of political activism, to provide a meaningful response to oppression. Reynolds (2002) conducted an exploratory study with a lesbian cultural witnessing group, to illustrate the practice of witnessing within a culturally stigmatized group. In supporting this group, Reynolds (2002) called attention

to the significance of safe and reflective practice, through liberty, connection and belonging.

Reynolds (2002) suggested that individuals achieve a sense of justice through solidarity.

Witnessing provides individuals with the opportunity to share their story, without judgment,

allowing for the opportunity to co-create new meaning and experience. Reynolds (2002)

suggested that witnessing also provides individuals with the opportunity to examine the role of society in perpetrating oppressive meanings and practices.

### **Honouring Acts of Resistance**

A research article by Barton (2017) suggested that sociocultural narratives may influence the way in which an individual experiences childbirth. Barton (2017) conducted a study which explored the influence of sociocultural narratives on birth stories, for individuals and couples.

Barton (2017) suggested that narrative practice supports individuals to re-author their birth story, through deconstructing their experience with birth, understanding the cultural and systemic issues, and developing alternative storylines based upon a collaborative practice highlighting personal strengths, resilience and acts of resistance.

Sen (2019) wrote an article describing narrative therapy interventions which may be utilized to support survivors of gender based violence in India. In particular, Sen (2019) described “how narrative practices helped to honour their acts of resistance and bring forth their skills and knowledges for survival, presenting an alternative to the pathologizing accounts of their lives” (p. 41). Sen (2019) asserted that these techniques support oppressed populations by utilizing a strength based approach that limits the re-traumatization of marginalized individuals. Sen (2019) suggested that every story of oppression carries a parallel story of resistance.

Through sharing one’s unique experience, individuals may uncover micro-levels of resistance,

supporting individual determination and autonomy. Sen (2019) suggests that this process supports an individual to re-author their story, inviting hope and healing.

### **Structure of Therapy**

In addition to the models/techniques utilized in group therapy, the structure of the therapy is also an important dynamic to consider. This section of the thesis will focus on the frequency and duration of the group, in addition to the guidelines for participation.

#### **Frequency**

Cote-Arsenault and Freije (2004) conducted a study which explored the experiences of individuals participating in two established pregnancy after loss support groups in large metropolitan areas in the United States. Both of these programs supported couples who lost a child through miscarriage, elective termination, stillbirth or neonatal death. The membership of the programs varied from meeting to meeting, as individuals chose to access and let go of the group. While one support group was offered weekly, the other was offered monthly. In consultation with seven sessions over eight months, the data collection included participant observation, individual interviews and a mailed-out survey. The results of this study indicated that individual choice, group stability and predictability were the most significant measures of participant satisfaction. “Those who had weekly meetings could not imagine having them less often, and those with monthly meetings liked that schedule too” (Cote-Arsenault and Freije, 2004, p. 662). Cote-Arsenault and Freije (2004) noted that it was important for individuals to attend regularly without missing sessions.

#### **Duration**

An article by Lorentzen, Fjeldstad, Ruud, and Hoglend (2015) compared the effectiveness of short-term versus long-term therapy in a group of 167 outpatients with a DSM-

IV access I diagnosis. Participants were randomly selected to receive either twenty or eighty weekly, ninety minute sessions of short-term or long-term group therapy. After a three year and a seven-year follow-up, the results indicated that there was no significant difference between the two groups, however, they did note better outcomes for individuals who are self-punitive, through the long-term group. The results of this study supported the research by Cote-Arsenault and Freije (2004), by suggesting that it may be important to have different options available to meet the unique needs of individuals.

In the research study by Cote-Arsenault and Freije (2004) noted above, there were two pregnancy loss support groups, one lasting ninety minutes with a consistent start and finish time, and the other lasting two hours, with an informal ending time. The results of this study indicated that both groups felt supported by, reconciling their loss, learning new coping skills, and becoming empowered to advocate for themselves and to get through each day. Women in both groups reported feeling supported through an honest, open and welcoming environment which helped resolve concerns, through shared perspective. Cote-Arsenault and Freije (2004) noted that some individuals found it difficult to listen to other women's stories, impacting their own emotional distress. This study supported positive outcomes for women who experienced a pregnancy loss, through ninety minutes and two hour timed sessions. The article by Lorentzen et al. (2015) also supported ninety minute sessions for individuals who were diagnosed with a significant mental health concern.

### **Guidelines for Participation**

The research article by Cote-Arsenault and Freije (2004) provided some guidelines for participating in a pregnancy loss support group; including, information pertaining to participants, facilitators and other professionals connected to the group. In reference to participants, Cote-

Arsenault and Freije (2004) suggested that all participants should have their own experience with perinatal loss. Group members should be greeted by the facilitator, who is responsible for leading the group. Members may light a candle, introduce themselves, share their story, or provide other information which is relevant to the group. Trust may be earned through a process of self-disclosure and interactions with the group. Facilitators provide the group with knowledge, experience, leadership skills, timekeeping, counselling, and resources. Participants benefit from a facilitator who is open, approachable, caring, and sensitive; providing a person-centered approach to each individual and their family. Facilitators recognize commonalities and assist with learning new skills, promoting reconciliation and self-development over time. Cote-Arsenault and Freije (2004) assert that facilitators should be available for contact with families outside the group, through telephone consults and/or collaboration with other professionals. This approach encompasses a social justice approach, which integrates social work and counselling into group support. According to Cote-Arsenault and Freije (2004), the community plays a role in access to the group, through referrals from nurses, physicians, or alternate resources and/or applicable professionals.

### **Summary**

This chapter reviewed the role of group therapy for marginalized populations, including: structuring safety, personal disclosure, differences within/between groups, narrative therapy, witnessing, and honouring acts of resistance. The chapter also considered the structure of group therapy, including: frequency, duration, and guidelines for participation. In reviewing the role of these constructs, the chapter identified several variables which may impact the outcome of group therapy for individuals who have experienced a perinatal loss. This summary will commence by

discussing the models/techniques before describing the structure of therapy. Throughout the summary, the paper will highlight reoccurring themes throughout this thesis.

In studying the relationship between models/techniques and group therapy for marginalized populations, this paper provided support for structuring safety (Bishop & Cregan, 2015; Reynolds, 2012), personal disclosure (Knoll & Bronstein, 2014; Krysinska & Andriessen, 2015; Williams et al., 2018), differences within/between groups (Arthur & Collins, 2010), narrative therapy (Brownlee & Oikonen, 2004; Dumaresque et al., 2018; Monk & Gehart, 2003) witnessing (Reynolds, 2012; Reynolds, 2002; Richardson, 2012; Thirsk & Moules, 2012) and honouring acts of resistance (Barton, 2017; Sen, 2019). This chapter also identified variables related to the structure of therapy, including, frequency of group sessions (Cote-Arsenault & Freije, 2004; Lorentzen et al., 2015), duration of sessions (Cote-Arsenault & Freije, 2004; Lorentzen et al., 2015), in addition to guidelines for participation (Cote-Arsenault & Freije, 2004; Lorentzen et al., 2015).

Through comparing the information in this chapter to the rest of this thesis, it is important to note commonalities in the research. The research by Bishop and Cregan (2015) regarding structuring safety, highlighted the value of trust, empathy, acknowledgement and validation in a therapeutic environment. In discussing the role of personal disclosure, both Knoll and Bronstein (2014), and Williams et al. (2018) suggested that internet forums may be a valuable resource for social support and relationship development, for individuals who experience a culture of silence associated with their loss. The study by Krysinska and Andriessen (2015) supported the relationship between online bereavement groups and social support, while also noting the positive effects of empathy, validation, and access to information and resources to support one's loss. Monk and Gehart (2003) highlighted the relationship between storytelling, making

meaning and developing new perspective. Meanwhile, Dumaresque et al. (2018) noted similar positive intervening variables, in addition to the role of acknowledgement, validation and social support. Through witnessing, Thirsk and Moules (2012) provided support from social support, a sense of connectedness, acknowledgement of loss, and the use of rituals in recovering from a loss. This chapter was unique in providing research relating to social justice, through structuring safety within groups (Reynolds, 2012; Reynolds, 2002) and honouring acts of resistance to oppression as a strength (Barton, 2017; Sen 2019).

### **Application to Group Therapy**

In reviewing the variables that support group therapy for marginalized populations, social support, empathy, trust, acknowledgement, validation and witnessing, have all been identified as positive means of supporting individuals who have experienced a perinatal loss. Individuals may also benefit from information provision, and/or referrals to supports and services. Finally, bereaved parents may consider storytelling, making meaning, developing new perspectives, skill development, and/or participating in mourning rituals, to support their recovery process. While these themes have been discussed throughout this thesis, chapter four highlighted new information specific to structuring safety, honouring resistance, and specifics related to the structure of group therapy. The following portion of this paper, chapter five, will support an innovative approach to group therapy for individuals grieving a perinatal loss.

## Chapter 5: Group Therapy Approach to Support Perinatal Loss

### Introduction

El Hachem et al. (2017) published a research article exploring recurrent pregnancy loss in Canadian and European women. According to El Hachem et al. (2017), miscarriage is “a relatively common event, occurring in 15%-25% of pregnancies and increasing in prevalence with maternal age” (p.331). The researchers suggested that the risk of miscarriage may rise from as low as 9% in women under 35 years of age, to as high as 50% in women over the age of 40. The data supports a high prevalence of miscarriage in Canadian and European societies, however, as Wojnar et al. (2011) suggested, there is a culture of silence within Western populations, that inhibits the public expression and recognition of perinatal grief.

Chapter one of this thesis provided a thorough literature review of the research regarding miscarriage to date. In doing so, this chapter noted that the area with the most research is the relationship between miscarriage and psychological distress. This chapter described a wide variety of adverse psychological outcomes that may be experienced by the bereaved parent, including variables related to, perinatal grief (Brier, 2008), psychological reaction (Adolfsson, 2011), anxiety and depression (Gaudet, 2010), mental health outcomes (Janssen et al., 1996), maternal quality of life (Tavoli et al., 2018), self-esteem and personal identity (Wonch Hill et al., 2017), intense emotionality and maladaptive coping skills (Bennett et al., 2008). Individuals may also be at increased risk of posttraumatic stress disorder and obsessive-compulsive disorder (Randolph et al., 2015).

While chapter one focused on research regarding the impact of miscarriage on the bereaved parent, studies exploring the effects of perinatal loss on the couple, their children, and/or the family system was limited. It is important to acknowledge the adverse impact that

miscarriage may have on a couple, their children and the family, to gain an understanding of the significant impact that perinatal loss may have on society. In regard to couples, Conway and Russell (2000) suggested that miscarriage is a significant event for most couples, with women and their partners experiencing significant grief symptoms for more than four months after the event. Serrano and Lima (2006) supported these results, noting that couples also experience sex differences related to satisfaction with changes in the quality of communication (for women) and sexual changes (for men). Volgsten et al. (2018) provided support for a stronger grief reaction in women, and suggested that this relationship may be linked to maternal guilt related to infertility, previous miscarriage and/or the outcome of the pregnancy. Nelson et al. (2017) linked experience with miscarriage to anxiety, rumination and negative emotions regarding future conception, for both women and men, being more poignant in women. Finally, a study by Al-Maharma et al. (2016) indicated that perinatal grief may be negatively related to the attachment with a subsequent child. These studies indicate a variety of ways that perinatal grief may present itself through adverse challenges with couple interactions, future pregnancies and parenting.

This thesis has demonstrated a high prevalence of miscarriage within Canadian society, in addition to a plethora of widespread personal, relationship and life course challenges. This chapter seeks to present a group therapy approach, designed to support the bereavement of perinatal loss. The chapter will begin by describing the skills and techniques which may be incorporated into therapy to support complicated grief resulting from perinatal loss. Each skill/technique has been explored throughout this research, many of which have been connected by the research regarding miscarriage, ambiguous loss, disenfranchised grief, marginalized populations, and group therapy; including ten key themes across each of these research areas: social support, person-centered support, acknowledgement/validation, storytelling/witnessing,

information provision/referrals, cognitive strategies, mourning rituals/continued bonds, differences within/between groups, resilience through hope, and honouring acts of resistance. The chapter will offer suggestions on the use and structure of these domains. The chapter will briefly describe factors related to frequency, duration, and guidelines for participation, based upon the research provided within this thesis. Finally, the chapter will conclude with strengths and limitations, in addition to suggestions for future research and implementation.

### **Supporting Perinatal Grief**

The following skills and techniques have been researched extensively throughout this thesis. Each skill/technique may be incorporated within group therapy, to support individuals who are grieving a pregnancy loss. While some factors may be integrated within each session, other factors may be incorporated within specific, targeted sessions. Future research is imperative, to provide evidence and rationale, for the structure and use of each factor, within group sessions.

#### **Social Support**

Throughout this thesis, social support has been identified as a significant factor in supporting individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. The culture of silence in Western societies, places barriers for women seeking social support following a perinatal loss. Group therapy provides individuals with access to social support from peers and professionals who share similar experience and/or access to valuable information or supports. Group therapy also provides individuals with the opportunity to include family members and friends in the bereavement process. Individuals receive the opportunity to access social support through attending and participating in regular, ongoing sessions. They also receive the opportunity to

network with other people, with the possibility of developing new social connections, friendships, activities and events outside of group therapy.

### **Person-Centered Support**

Person-centered support incorporates key principles of Carl Roger's humanism. According to Bankart (2007), humanism refers to a non-directive approach which assists individuals to gain greater self-awareness and self-acceptance through a compassionate, empathetic, non-judgmental response. Throughout this thesis, each of these variables have been identified as significant factors in supporting individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. Empathy, compassion and non-judgment may be modeled by the group facilitator and practiced by group members. Person-centered support may be provided within each session, and practiced throughout the duration of therapy.

### **Acknowledgement/Validation**

The culture of silence in North America, opposes the public acknowledgement and validation of perinatal grief. This thesis provides evidence that both acknowledgement and validation are significant factors in supporting individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. An individual's experience with perinatal loss may be acknowledged by attending group therapy, sharing of personal experience, and participating in group activities. An individual may receive validation through interactions with the group facilitator or their peers. Individuals may also receive acknowledgement or validation through indirect sources, such as receiving correspondence or sharing information about the group. Both acknowledgment and validation of loss may be practiced within and between group sessions.

### **Storytelling/Witnessing**

Storytelling has been noted throughout this thesis, as a significant protective measure for individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. Individuals appear to benefit from the opportunity to share their loss. Group therapy provides individuals with the opportunity to explore their unique experience, including thoughts, feelings and behaviors, in addition to their interactions with family, friends and the world around them.

The act of witnessing has been studied in populations who have been impacted by ambiguous loss or disenfranchised grief. In chapter four, witnessing was described as a significant, positive support to group therapy for marginalized populations. Witnessing provides individuals with an audience to hear their story, in a safe and respectful environment, based on guiding principles of person-centered support. The manner in which storytelling and witnessing is incorporated into group therapy may vary widely. Within a closed group, individuals may choose to share their personal story at the first session, with future sessions focusing on specific information, skills training, and/or activities. With an open group, there may be time set aside at each session, for newcomers, or ongoing members to share their personal experience. Additional research is required to provide guidance for the structure of therapy in this regard.

### **Information Provision/Referrals**

Information provision has been regarded throughout this thesis as a supportive factor for individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. Individuals who experience a miscarriage appear to benefit from information regarding their experience, including: an explanation for their loss, expectations for the healing process, and resources for support in the future. Group therapy

offers individuals supportive information throughout the grieving process. Research is required to determine what information to provide, how to provide the information, and when to incorporate these resources. Referrals to additional supports and/or services has been noted as a significant protective factor in supporting pregnancy loss, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. Referrals may be provided at each session, or they may be implemented at specific, targeted sessions. It is imperative that the supports offered, are designed to provide individuals with enhanced support in the community, to promote personal growth and support optimal health. These supports will differ based on the community. Cross-community research may assist with providing general themes in referrals and/or outcomes, based upon personal demographics, community demographics, and/or specifics regarding the service provided. As with information provision, research is required to test out different methods of incorporating referrals into this approach.

### **Cognitive Strategies**

There are several cognitive strategies which have been studied, in regard to perinatal loss. In specific, two strategies, creating new perspectives and making meaning, were highlighted throughout this thesis. Both strategies have been regarded throughout as supportive factors for individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations. In group therapy, through storytelling, witnessing and interacting with group members, individuals are exposed to new thoughts, feelings and perspectives. This provides individuals with the opportunity to reframe negative cognitions associated with their loss. Individuals may also have the opportunity to find new meaning for their loss. Cognitive strategies may be incorporated at regular ongoing sessions. While the group facilitator could model and teach some of these strategies, the natural support within the

group would provide additional collaborative opportunities among peers. Future research is required to study the effectiveness of these skills, in addition to alternative cognitive strategies, which may be implemented as part of the structure of a group format.

### **Mourning Rituals/Continued Bonds**

This thesis describes a lack of mourning rituals for individuals who have experienced a miscarriage, ambiguous loss, disenfranchised grief, and/or group therapy for marginalized populations, in contemporary, western societies. While individuals seem to benefit from these rituals; the presence, availability, and support of these rituals is sparse. Group therapy provides the opportunity for individuals to honour their loss in a safe, supportive environment, by sharing photos, clothing or memories, creating keepsakes, or engaging in a ceremony or ritual. Group therapy also provides individuals with the opportunity to engage in social support, person-centered support, acknowledgement, validation, and incorporating cognitive strategies while engaging in mourning rituals. Individuals may be introduced to the concept of continued bonds. Continued bonds were presented in the third chapter, as significant, positive opportunities for healing, through verbal and/or physical expression of love and remembrance. Throughout this thesis, continued bonds have been noted as a positive support for both ambiguous loss and disenfranchised grief, future research is required to explore the relationship between continued bonds and the bereavement of miscarriage. Both, mourning rituals and continued bonds may be incorporated through regular or targeted sessions. Future research is required to provide guidance on the optimal way to incorporate these variables within group sessions.

### **Differences Within/Between Groups**

Chapter four of this paper presented research regarding group therapy for marginalized populations. This chapter acknowledged significant variance in individuals within and between

groups, based on their unique composition of cultures and subcultures. Arthur and Collins (2010) acknowledged that the composition and intersectionality of different cultural groups may be utilized to understand individual differences and experience. Grzanka, Santos, and Moradi (2017) critiqued the existing research on intersectionality, within counseling psychology. Grzanka et al. (2017) suggested that exploring the composition and interactions may actually limit the exploration of the impact on the individual. Grzanka et al. (2017) suggested that therapy may benefit from widening the lens, to consider the role of systemic oppression and privilege. In a group therapy format, individuals may be provided the opportunity to present and/or explore their personal location within the group. Chapter four of this paper suggested that marginalized individuals benefit from personal disclosure within group formats, through social support and information sharing, in an environment marked by empathy, validation and resources for support. Personal disclosure may be incorporated into a variety of formats, including, storytelling at the first session, or opportunities for discussion throughout ongoing sessions in therapy. Future research is required to understand the impact of different methods of personal location and/or exploration of systemic factors.

### **Resilience through Hope**

Throughout this thesis, there is a strong theme of resilience through hope. Chapters two and three link a sense of hope to positive bereavement outcomes. In regard to miscarriage, a sense of hope may be influenced by protective factors within the person's life. For example, Maker and Ogden (2003) suggested that variables such as positive experiences with reproductive health, existing living children and a personal history absent of perinatal loss are all linked to a sense of hope and positive bereavement outcomes. In regard to ambiguous loss and disenfranchised grief, Boss (2006) asserted there is a link between resilience and hope,

suggesting that both may be fostered through a person-centered approach, including cognitive strategies such as making meaning or exploring personal identity. Thus, a sense of hope may be incorporated into group therapy through skills and techniques which have been presented as key principles in this approach. Future research is needed to determine how hope may be encouraged and fostered in group therapy, including content, delivery and the outcomes associated with implementation.

### **Honouring Acts of Resistance**

Honouring acts of resistance was introduced within chapter four of this paper, in regard to group therapy for marginalized populations. In exploring the use of this skill within a wide variety of groups, this thesis suggested that honouring acts of resistance may be considered a strength-based, person-centered approach to working with oppression. Honouring acts of resistance may be supported through storytelling and witnessing, in a social environment. Individuals may be supported to engage through acknowledgement, validation, information provision and cognitive strategies. Individuals may also be able to explore continued bonds, through self-advocacy and/or activism in the community. Thus, while it is clear that this approach may support the other skills and techniques provided by this chapter, the relationship with these variables, the implementation of these skills, and the outcomes with regard to perinatal loss, require future research.

### **Group Therapy for Perinatal Grief**

Chapter four of this paper presented the structure of group therapy, including: frequency, duration, and guidelines for participation. This portion of the thesis will summarize the results of this chapter, in regard to the development of a group approach specific to perinatal loss and bereavement.

**Frequency**

Chapter four of this thesis, presented research by Cote-Arsenault and Freije (2004), which examined group support for individuals bereaving a perinatal loss. The researchers explored the use of weekly and monthly models. The results of this study suggested that the frequency of the sessions did not impact the outcomes of the therapy. As a result, Cote-Arsenault and Freije (2004) suggested that individual choice, group stability and predictability were significant predictors of outcomes. With this research in mind, a group therapy approach for perinatal loss may include either weekly or monthly sessions. The timeline of therapy may be flexible as well. Future research is required to test the effectiveness of different types of models, such as a closed program, which has a defined beginning and end date, and ongoing sessions, which provide individuals with the opportunity to join and leave therapy, as they need access to support. Future research is also required to test the effectiveness of weekly versus monthly sessions, with regard to this specific model of group delivery.

**Duration**

In addition to the frequency of sessions, the study by Cote-Arsenault and Freije (2004) also considered the duration of therapy sessions. Cote-Arsenault and Freije (2004) explored the use of ninety minute groups with a fixed ending time, and two-hour groups with no set end time. The results of this research indicated that there were not significant differences in outcomes for the groups. A similar study presented by Lorentzen et al. (2015) explored the duration of therapy for groups supporting perinatal loss, by comparing short-term therapy (twenty sessions) with long-term therapy (eighty sessions). The researchers suggested that there was no significant difference between the groups in terms of outcomes. Thus, similar to the frequency of therapy, there appears to be flexibility with regard to the time of each session, and the number of sessions

provided to individuals. Future research is needed to explore a wide range of timelines both within and between therapy sessions.

### **Guidelines for Participation**

This thesis provides some basic guidelines for participation of group members and the facilitator. The research presented by Cote-Arsenault and Freije (2004) suggested that all participants should have their own personal experience with loss. The researchers also suggested that introductions, personal disclosure, rituals, information provision and referrals to appropriate professionals/resources are key to supporting positive bereavement outcomes. This thesis outlined several areas where more research is needed, specific to group therapy for perinatal loss. For example, locating oneself personally, and exploring systemic structures of power and oppression, need further research, to enhance safety within the group and beyond the therapeutic environment. Future research is also needed, to explore the role of confidentiality, consent, and the manner these work together in a therapeutic environment, within a community.

### **Strengths and Limitations**

This thesis provides a literature review approach, analyzing research specific to perinatal loss, ambiguous loss, disenfranchised grief, and group therapy for marginalized populations. The strengths and limitations of this approach will be discussed in the following sections, in detail.

#### **Strengths**

This thesis was developed through an exhaustive literature review which explored the available research on miscarriage to date. In completing this review, it became evident that the majority of research regarding miscarriage has been published in the last thirty years. Through this process, this thesis was able to identify the focus, trends and results that were present in

existing literature. This provided the opportunity to uncover gaps, along with similarities and differences across common variables. In doing so, the thesis identified a gap, being the development of a group therapy approach specific to the bereavement of perinatal loss. The thesis identified commonalities between the needs of individuals recovering from miscarriage and the supports offered within a group model, to provide rationale for developing a group approach. Commonalities across related domains, such as ambiguous loss and disenfranchised grief were utilized to build support connections across the categories; supplementing the research available and driving suggestions for future implementation and research.

The thesis provided statistics supporting a high prevalence of perinatal loss within the general population. The thesis provided a variety of acute and chronic concerns that may affect the individual, their roles, their relationships, and their participation in society. This laid the groundwork to present a social justice, transformational approach for developing and supporting group therapy for perinatal loss. This thesis provides ten skills and/or techniques which may have empirical support for utilizing with this population. These skills can be incorporated and tested within various formats of group delivery. This thesis attempts to break the culture of silence, by providing information, advocacy and rationale for supporting a large number of people, through a cost effective, sustainable approach. While future research is required to support development, implementation and adaptation of this model, this thesis provides a wide range of suggestions where research is lacking.

### **Limitations**

As noted above, this thesis was developed through an exhaustive literature review which explored the available research on miscarriage to date. While this review brings forward many strengths, it also brings forth certain challenges. In identifying gaps, the thesis draws upon

connections to other domains, through relative constructs, such as ambiguous loss and/or disenfranchised grief. The purpose of doing this is to provide support for similar experiences across these domains. In providing commonalities between the variables, these commonalities may be used to suggest possibilities, based on research available across the domains. This provides information relating to miscarriage, in areas where research is lacking. For the purpose of this paper, these categories included research regarding witnessing, continued bonds, differences within/between groups, honouring acts of resistance and the application of group therapy. While this discussion provided support for the development of a new group therapy approach, it does not provide evidence for the outcomes and/or implementation of this approach. Future research is required to support the outcomes, implementation and adaptation of this approach. In addition, it is important to note that the research presented throughout this thesis, is primarily based on a Western perspective of loss and grief. Future cross-cultural research, in addition to research across domains is required to provide additional suggestions for this model.

### **Future Research and Implementation**

Through discussing the ten skills and techniques which may be implemented into a group therapy approach, there were several suggestions for future research and implementation. These ideas will be summarized and expanded upon for future consideration.

#### **Suggestions for Future Research**

Through an exhaustive literature review, several research areas were identified as lacking empirical evidence or support. This included group therapy specific to perinatal loss, occupational support following a loss, and the integration of modern therapies or approaches, such as utilizing eye movement desensitization and reprocessing (EMDR) therapy to support individuals bereaving a loss. Another current area which requires more research is considering

the role of family systems, attachment and/or identity development within the individual and their family. While this thesis provided research pertaining to group therapy, these domains, among many others provide a variety of areas where future research is needed.

Throughout this chapter, a group model is proposed, based on the literature review completed by this thesis. This process of review, analysis and development, prompted many questions for application and research. In regard to social support, future research is required to understand the role of group therapy in supporting individuals, their spouses, children, family members and friends. Future research is also needed to determine if networking within the group, is related to positive health outcomes for individuals bereaving a loss. In regard to person-centered support, future research is required to determine the qualities that define person-centered support within the group environment, the outcomes related to this support and the intervening variables. For instance, does a person's perception of the quality or authenticity of the support influence the outcomes? Acknowledgement and validation are similar to person-centered support, in that their use may be subjective, variable and difficult to identify. Future research is required to provide insight on the assessment of these variables and their relationship to the outcome of therapy.

Additional variables such as storytelling/witnessing, information provision/referrals, cognitive strategies and mourning rituals/continued bonds, require additional research. This may include, the frequency of presentation, the way they are incorporated into therapy, and the outcomes associated with the results. With regard to frequency, these variables may be incorporated at each session, or within specific targeted sessions. The manner in which they are incorporated into therapy, may include education, skills and/or activities. The outcomes associated with different methods of application are too vast and numerous to mention. In

providing suggestions for future research, the possible confounds are extensive. Key considerations may be cultural differences within and/or between groups based upon variables specific to the therapy, the individual or the community involved. Finally, it is important to note that the principles of resilience through hope and honouring acts of resistance are subjective constructs and require qualitative analysis to understand the use and impact of each construct within group therapy. In particular, honouring acts of resistance is a new area of research, with regard to perinatal loss.

In regard to group support for perinatal loss, this area is lacking research specific to the structure of group therapy, including frequency, duration, and guidelines for participation. Future research is required to test various methods of implementation and delivery. This may include in-person, online and mixed-format groups. This may also include exploring different levels of credentials and/or training for the facilitator of the group. Finally, this may include additional relevant research such as the provider of the group and/or referral process.

### **Implementation of this Approach**

This thesis sought to develop a group therapy approach to support perinatal bereavement. Through a literature review and analysis of the existing research, this thesis outlined ten key skills/techniques which may be provided within a group format, including; social support, person-centered support, acknowledgement/validation, storytelling/witnessing, information provision/referrals, cognitive strategies, mourning rituals/continued bonds, differences between/within groups, resilience through hope, and honouring acts of resistance. The thesis also provided research related to the structure of therapy, including, duration, frequency, and guidelines for participation. The manner in which these variables may be incorporated into the group, could vary widely. While future research is needed to continue to develop and support

this approach, a model must be proposed in order to be tested. Through implementation, evaluation, research and adaptation, this model may potentially be developed into an evidence based approach to support perinatal grief.

## **Conclusions**

This thesis conducted a thorough literature review of the research regarding miscarriage over the last thirty years. In doing so, the thesis identified several variables which support and/or impair the bereavement of perinatal loss. Social support, acknowledgement and validation were all demonstrated repetitively throughout the literature, as significantly related to a positive bereavement outcome. Each of these variables may be delivered through a group format, to a large proportion of individuals, reducing wait times and costs for support services. In reviewing the research, studies regarding therapeutic supports or interventions, including group therapy, were sparse. In contemporary, Western society, there is a cultural taboo against the public expression and recognition of perinatal grief (Markin & Zilcha-Mano, 2018). This taboo is reinforced by the lack of appropriate research and approaches to guide therapy. Group therapy may represent one method of supporting individuals within their community, limiting the experience of isolation which is commonly associated with perinatal loss. At present, the scarce availability of group models and/or research reinforces the systemic oppression of perinatal bereavement in society. Through developing this thesis, the author attempts to provide a social justice approach, by breaking the culture of silence, with evidence-based support. This thesis outlined a model marked by ten skills and techniques which may be utilized to support individuals within a group format; this includes, social support, person-centered support, acknowledgement/validation, storytelling/witnessing, information provision/referrals, cognitive strategies, mourning rituals/continued bonds, differences between/within groups, resilience

through hope, and honouring acts of resistance. While this model was developed specific to groups, individuals, families, and society, can utilize this information to support individuals following a loss. Future research is required to implement, test, and refine this model.

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