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Therapeutic Approaches to Working with Perinatal Loss Clients: A Grounded Theory Study

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Therapeutic Approaches to Working with Perinatal Loss Clients: A Grounded Theory Study

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

by

Heather H. Olivier

B.S. Louisiana State University, 2015
M.S. Southeastern Louisiana University, 2017

May 2023

Dedication

To Owen, for lighting the fire in my soul and illuminating my path,
and
to Briggs and Barley, for keeping me grounded in my daily purpose.

Acknowledgments

This research is a culmination of countless unexpected experiences that would not have been survivable without the support of those that poured into my life. For those individuals, I am forever grateful. First, I would like to acknowledge the participants who volunteered their time and expertise to be part of this study. The passion for working with reproductive loss clients was apparent in every interaction, and the investment you all have in this field is admirable. Lives are being changed because of each one of you. Thank you for your commitment to forward-thinking; for your dedication to changing how our society views “wellness.”

Secondly, I would like to express my deepest gratitude for my dissertation committee. Dr. Belser, words do not fully articulate the many thanks I have for you stepping in as committee chair and pushing me to the finish line. I only hope I can make half the impact in the lives of my future students that you have made in mine. Dr. Watson, thank you for supporting my research from the very beginning, and for allowing me a safe space to learn about my professional identity as a professor and researcher. Dr. Jeffers, thank you for teaching me that showing up authentically as a researcher means to support individuals in using their own voices rather than speaking for them. Your love for maintaining the integrity of qualitative research changed the course of my research career. Dr. Williams, you taught me the art of truly holding space for clients. Thank you for teaching me about the intricacies of grief and for your continued pursuit in shifting the paradigm of how we experience grief.

Lastly, thank you to my loved ones who supported me in motherhood while embarking on my doctoral journey. Mom and Dad, as I reflect on this research, I cannot help but reflect on the many moments you encouraged me to challenge myself while continually reminding me that I am equipped to pursue any dream. Blake, life has brought on many challenges, and I thank you

for standing beside me so I do not have to face them alone. To the rest of my family members and friends that have loved me, and have loved my babies, “thank you” will never be enough. Emily, you have allowed me to experience what it feels like when someone truly holds space for another person, and for that I am eternally grateful. Victoria, I am filled with gratitude that our academic careers aligned as our friendship is one of the most treasured pieces I will bring with me from this doctoral journey.

Table of Contents

List of Figures	viii
List of Tables	ix
Abstract	x
Chapter 1: Introduction	1
Overview of the Study	1
Purpose of the Study	3
Significance of the Study	3
Conceptual Framework	4
Problem Statement	5
Methodological Approach	5
Research Questions	6
Methods	6
Limitations and Delimitations	7
Assumptions of the Study	8
Conclusion	8
Organization of Manuscript	8
Chapter 2: Literature Review	10
Socialization of Emotions	10
The Socialization of Perinatal Loss	17
Therapeutically Working with Perinatal Loss	27
Summary	32
Chapter 3: Methodology	34
Purpose of the Study	34
Research Questions	36
Methodological Approach	37
Methods	40
Data Collection Procedures	41
Role of the Researcher	44
Data Analysis	46
Establishing Trustworthiness	48
Summary	50
Chapter 4: Results	51
Methods	51
Validation Procedure Results	53
Data Analysis Results	65
Phase Model for Reproductive Loss	68
Findings by Research Questions	77
Summary	80
Chapter 5: Discussion	82
Philosophic Foundations	82
Research Findings Related to Literature	83
Limitations and Delimitations	87
Recommendations for Future Research	88
Conclusion	90

References	91
Appendix A: IRB Approval Letter	103
Appendix B: Informed Consent	104
Appendix C: Recruitment Email	106
Appendix D: Interview Protocol	108
Appendix E: Case Study	110
Vita.....	112

List of Figures

Figure 1: Initial Codes	66
Figure 2: Focused Codes and Conceptual Categories.....	67
Figure 3: Phase Model for Reproductive Loss	71

List of Tables

Table 1: Participant Demographics	54
Table 2: Case Study Responses of Symptoms	60
Table 3: Case Study Responses of Diagnoses	61

Abstract

Perinatal loss (i.e., miscarriage, stillbirth, termination, and infant death) is commonly referred to in the literature as an invisible loss, non-loss, and even medical event. It is an ambiguous loss exhibiting the dialectical contradiction between the physical absence and psychological presence of the baby accompanied by disenfranchised grief, a reaction to a loss that is unacknowledged by society. Despite the likelihood of mental health clinicians working with clients who have experienced perinatal loss, there has yet to be a therapeutic model designed specifically for the unique grief and trauma reactions presented in this population. Existing grief models do not address the traumatic nature of the loss, and oppositely, trauma models do not address the life-long grief symptoms experienced subsequent to perinatal loss. Lack of clinical trainings and cultural norming processes that do not acknowledge the significance of the loss leave clinicians without resources, tools, and interventions to effectively work with this population. Thus, the purpose of the study is to co-construct a therapeutic model to utilize when working with perinatal loss clients. Exploring therapeutic approaches employed by mental health clinicians, the grounded theory study utilizes three forms of data: (a) intensive interviews, (b) elicited documents (i.e., case studies), and (c) extant documents (i.e., perinatal loss specialty training agendas). The qualitative study includes 11 participants certified in perinatal mental health (PMH-C) to ensure participants' clinical experience in working with the perinatal loss population for at least two years. Additionally, the qualitative study investigates the following three elements informing therapeutic approaches applied to this population: (a) cultural perceptions of perinatal loss; (b) how the cultural perceptions impact the therapeutic relationship regarding establishing goals, measuring client change, and determining effectiveness; and (c) identification of barriers within the therapeutic process. The findings of the study are significant to not only

mental health clinicians working with perinatal loss clients and the existing perinatal loss research, but they also illuminate the nature of the therapeutic process for this population to decrease ambiguity surrounding the loss and enfranchise the griever.

Keywords: Perinatal; reproductive loss; trauma; grief; therapeutic approaches

CHAPTER 1

Introduction

The following chapter introduces the study by outlining the overview, purpose, and significance of the study. The conceptual framework synthesizes symbolic interactionism and Relational-Cultural Theory to situate the problem of the study within the cultural context in which it occurs. An overview of the researcher's interpretivist, subjectivist epistemological stance, which informs the use of a constructivist approach to grounded theory methodology, is discussed. Bounds of the study are outlined in the limitations, delimitations, and assumptions of the study. After defining key terms, the chapter will conclude with the organization of the document.

Overview of the Study

Perinatal loss is one of the most traumatic and existentially disturbing types of loss individuals experience (Bennett et al., 2005; Gold, 2007; Markin, 2018). Inconsistent terminology among the literature causes discrepancies in defining what constitutes a perinatal loss (Diamond et al., 2021; Wright, 2011). Most commonly defined as being loss through miscarriage (i.e., fetal death before 20 weeks' gestation), stillbirth (fetal death at 20+ weeks' gestation), or infant death (i.e., death of infant up to one year of age) (Centers for Disease Control and Prevention, 2017; 2020), research on perinatal loss often neglects any other form of pregnancy loss (Leon, 2017; Ramdaney et al., 2015). For the purpose of this study to be inclusive of all perinatal losses, the content presented in this manuscript will be representative of any loss occurring from conception until one year after birth, elective or non-elective.

Often viewed as a medical event as opposed to the death of a child (Lang et al., 2011; Martel, 2014; Neiterman, 2013), the literature provides evidence for the pervasive impact of

perinatal loss as studies reveal grief and trauma symptomology permeate into bereaved parents' marriages, workplaces, future pregnancies, and even religious practices (Fernandez-Ordonez et al., 2021; Hazen, 2009; O'Leary, 2005; Wright, 2011). Contrary to the unfortunate misconception of perinatal loss as being less traumatic than other forms of loss (Lang et al., 2011), studies reveal the psychological impact of these losses persist for many years (Gold et al., 2016; Kokou-Kpolou & Nieuviarts, 2018), and for some bereaved parents for the duration of their lives (Cacciatore et al., 2008).

Perinatal loss is ambiguous in nature as bereaved parents experience the contradiction of the psychological presence and physical absence of their babies (Boss, 2010; Cacciatore et al., 2008; Lang et al., 2011; Shannon & Wilkinson, 2020). The ambiguity of perinatal loss is compounded by bereaved parents' disenfranchised grief, a grief that is unacknowledged by society (Doka, 2002; Lang et al., 2011; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). The concept of disenfranchised grief explicates the role of cultural norms in governing the acceptability of grief expressions following loss. Perinatal loss is categorically among losses not acknowledged by our culture, consequently causing bereaved parents' grief expressions to fall outside the normative bounds of grief rules.

One differentiating factor between perinatal loss and other losses is the posttraumatic stress symptomology interwoven with complicated grief (Bennett et al., 2005; Markin & Zilcha-Mano, 2018; Randolph et al., 2015; Shannon & Wilkinson, 2020). The combination of grief and trauma symptomology not only complicates the therapeutic process for the bereaved individual, it also poses a challenge for mental health practitioners who are not able to identify grief and trauma symptomology separately and concurrently. Of particular importance to the study, mental health practitioners must also be aware of their own biases regarding grief and trauma during the

perinatal period. While using effective therapeutic techniques is critical to therapeutic effectiveness, the relational aspect of the alliance is a key element in the process of change with bereaved parents (Cohen et al., 2019; Doley & Zilcha-Mano, 2019). Thus, the current study identifies therapeutic approaches utilized by mental health practitioners and illuminates the culturally influenced relational components impacting the therapy process with bereaved parents.

Purpose of the Study

The purpose of the study is to co-construct a therapeutic model addressing both grief and trauma symptoms presented in bereaved parents who have experienced perinatal loss. To conceptualize perinatal loss, research must not only consider the experience of the loss itself, but the cultural context in which the bereaved parent interacts as well. As Markin & Zilcha-Mano (2018) stated, “Rather, as therapists, we too are products of our culture and absorb the cultural denial around perinatal grief,” (p. 24). To gain insight into the therapeutic approaches applied to this population, the secondary aim of the study is to investigate three elements informing mental health practitioners’ therapeutic approaches: (a) cultural perceptions of perinatal loss; (b) how the cultural perceptions impact the therapeutic relationship regarding establishing goals, measuring client change, and determining effectiveness; and (c) identification of barriers within the therapeutic process.

Significance of the Study

By placing cultural norming processes at the center of psychological distress incurred by bereaved parents, the current study illuminates the influence of cultural perceptions on the therapeutic process when working with this unique population. Walker (2013) notes on this, stating, “...the therapy relationship is a microcosm of power and may, in fact, replicate the systems and arrangements we see in the larger world,” (p. 88). To lessen further perpetuation of

the disenfranchisement of perinatal loss within the therapeutic relationship, mental health practitioners must take extra precautions in being aware of biases and cultural norms surrounding the perinatal population. Lack of consistent, evidence-based research on how individuals are impacted by pregnancy and infant loss hinders practitioners' knowledge in how to respond appropriately, and the disparities between practice and evidence causes further ambiguity (Wright, 2011). This study is significant in responding to the call to research for the need of a therapeutic model designed specifically for the perinatal loss population (Güçlü et al, 2021; Kersting et al., 2009; Markin & Zilcha-Mano, 2018; Toller, 2005); a model that enfranchises these losses and decreases ambiguity within the therapeutic relationship.

Conceptual Framework

The conceptual framework for this study combines the theoretical underpinnings of symbolic interactionism (Blumer, 1969; Mead, 1962) and Relational-Cultural Theory (Jordan, 2010; Miller, 1976, 86; Miller & Stiver, 1997). Both frameworks challenge the idea of the individualistic “myth of the separate self” and emphasize the on-going, relational way in which individuals construct meaning and views of themselves (Crooks, 2001; Jordan, 2010; Oliver, 2011). Combining symbolic interactionism (SI) and Relational-Cultural Theory (RCT) allows the identification of cultural messages from which societal conceptualization of perinatal loss is derived. Jordan (2010) writes, “Understanding the culture and its distortions is essential to understanding the individual who lives within or on the periphery of that culture,” (p. 6). She further suggests the therapeutic process, and the effectiveness of interventions, are informed by issues of power imbalance and oppression. In the current study, the researcher further investigates the intricacies of the therapeutic alliance from a relational lens by understanding the meanings therapists attribute to the perinatal loss experience, subsequently influencing the

therapeutic process. The conceptual framework will be presented in greater detail at the beginning of Chapter 2, as it will lay the foundation for the review of the literature.

Problem Statement

Although research shows evidence of the unique grief reactions and trauma symptomology presented in perinatal loss parents (Hill et al., 2017; Kersting & Wagner, 2012; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020), there has yet to be a therapeutic model designed to work with the specific needs of this population. Due to the life-long impact of losing a child (Cacciatore et al., 2008), bereaved parents incur isolation for prolonged grief responses that fall outside the bounds of cultural grief norms (Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). Pathologizing expressions of grief, and the impact of social isolation, further perpetuates the disenfranchisement of the loss. While some therapeutic approaches have begun to address the relational impact of perinatal loss (Olivier & Monroe, 2021; Plagge et al., 2009), there has yet to be a therapeutic approach specifically designed to address grief and trauma symptomology unique to this population.

Methodological Approach

The qualitative study employs a constructivist grounded theory (CGT) methodology. The rationale for the methodological selection includes three influential factors. First, CGT is congruent with the researcher's epistemological view of the co-construction of knowledge, and ontological view of subjective truth and a socially-constructed reality (Charmaz, 2014; Charmaz et al., 2019). Second, the researcher's theoretical stance as a mental health practitioner, which emphasizes the relational components inextricably tied to the therapeutic outcome, parallels CGT's view of co-construction between the researcher and participants (Charmaz, 2014; Denzin & Lincoln, 2018; Fassinger, 2005). And lastly, CGT aligns with the study's conceptual

framework emphasizing the interpretivist paradigm through which meaning is assigned (Charmaz, 2014; Charmaz et al., 2019).

Research Question

The overarching research question informing the method of inquiry is: “How do mental health practitioners approach working with clients who have experienced perinatal loss?”

Framing the question through the lens of the conceptual framework warrants the following four sub-questions:

1. How do cultural perceptions of perinatal loss influence mental health practitioners’ work with perinatal loss clients?
2. How do mental health practitioners approach working with grief and trauma, separately and concurrently, when working with perinatal loss clients?
3. Which therapeutic approaches inform mental health practitioners’ use of clinical methods, treatment planning, and therapeutic interventions when working with perinatal loss clients?
4. What therapeutic barriers do mental health practitioners face when working with perinatal loss clients?

Methods

To ensure participants have experience working with the perinatal loss population, the sample in the study includes mental health practitioners who have obtained the Perinatal Mental Health Certification, indicating specialized knowledge and advanced training in the field of perinatal mental health. To address crystallization and establish trustworthiness, data is collected through intensive interviews, elicited documents, and extant documents (Charmaz, 2006; Stewart et al., 2017). In keeping with CGT methods, data analysis includes initial coding, focused

coding, and theoretical sampling. The iterative process of data collection and data analysis employs constant comparison, memo-writing, researcher reflexivity, and abductive reasoning (Guillemin & Gillam, 2004; Mruck & Mey, 2007; Pillow, 2003).

Limitations and Delimitations

Limitations

In keeping with CGT's view that the researcher cannot be removed from the data produced (Charmaz, 2014; Morrow, 2005), the researcher implemented gatekeeping tools to limit researcher bias to the extent possible. Not all biases are known, and the researcher utilizes gatekeeping tools to bring subconscious biases to the conscious to better conceptualize how those biases impact the lenses through which the data is interpreted. Although emotional investment in the research topic and aspects of the researcher-participant interaction may obstruct the collection of equitable data (Morrow, 2005), the grounded theory method is composed of various correctives to reduce the influence of researcher bias on the data collected (Charmaz, 2014).

Delimitations

The participants in the study are mental health practitioners with a specialized certification in perinatal mental health. Although the specialized certification increases the likelihood that participants will have worked with perinatal loss clients, the sample will not be representative of the general knowledge of mental health practitioners. Selection of participants based on the perinatal mental health certification provided by Postpartum Support International contributes consistency among participants' training and educational background. However, selecting one certification program does not take into account how other certification programs train mental health practitioners regarding perinatal loss.

Assumptions of the Study

It is assumed that obtaining a perinatal mental health certification increased participants' willingness to participate in the study. Further, that research into participants' specialized clinical area was of vested interest to the sample. The researcher assumed that participation in the study was done in a trustworthy and transparent manner on the part of the participants. Additionally, it is assumed that participants provided a truthful narrative of their experiences regarding cultural influences on the therapeutic process and the barriers that exist when working with the perinatal loss population.

Conclusion

The interpretivist lens through which constructivist grounded theory views the co-construction of subjective knowledge emphasizes the role of social interaction. Investigating mental health therapists' approach to grief and trauma in bereaved parents through a conceptual framework of symbolic interactionism and Relational-Cultural Theory, the current study aims to understand how cultural norms regarding grief rules influence therapeutic recognition and therapeutic response to perinatal loss. The purpose of the study is to bridge the gap in the literature between the reported psychological impacts of perinatal loss and the external context from which pathology is determined. The study is significant as it aims to decrease therapeutic perpetuation of culturally established normative grief rules, disenfranchisement of bereaved parents, and ambiguity surrounding the nature of the loss.

Organization of Manuscript

Chapter 2: The second chapter will provide a more thorough explanation of the conceptual framework, discuss the socialization of emotions, outline the psychosocial impacts of perinatal loss, and provide rationale for the study based on gaps within the literature.

Chapter 3: The third chapter will outline the methodological approach used.

Constructivist Grounded Theory methods are discussed, including participant selection, data collection, and data analysis.

Chapter 4: The fourth chapter outlines the validation procedure results and data analysis results of the study. Included in this chapter is the introduction of the Phase Model for Reproductive Loss developed from the study.

Chapter 5: The fifth chapter discusses the results of the study by situating them within the existing literature. The final chapter offers the implications of the study and recommendations for future research.

CHAPTER 2

Literature Review

The following chapter will present a review of the current literature relevant to the study. The deductive structure of the chapter is intended to situate the literature in the cultural context from which it is produced while distilling the content of the review down to the purpose of the study. To do so, the literature is organized in the following three sections: (a) the socialization of emotions, including an in-depth look at the study's conceptual framework, (b) the socialization of perinatal loss, and (c) therapeutically working with perinatal loss. The chapter will conclude with a summary of the literature, its relevance to the study, and a restatement of the purpose of the study.

Socialization of Emotions

Maintaining the structure of our monolithic society is done through what sociologists refer to as “socialization,” or learning how to act, react, and interact in ways that will solidify our membership within the societal context in which we reside (Charmaz et al., 2019). Primary socialization begins in childhood wherein the shaping of emotions occurs as children absorb cultural norms from their parents while simultaneously molding their senses of self to fit in with their peers. Secondary socialization is the continued process of emotional shaping when adults begin to learn their roles, expectations, and rules as they transition into a world outside of their families. This co-constructed, reciprocal process of evaluating self and others is crucial in the understanding of cultural norming processes that influence the language we use, the behaviors deemed “acceptable,” and how a sense of self is formed. This relational process will be explored through the conceptual framework.

Conceptual Framework

The conceptual framework for the study is comprised of symbolic interactionism (SI) and Relational-Cultural Theory (RCT). Combining SI and RCT is intended to illuminate the context in which social interaction occurs and how those interactions impact individuals. According to Aldiabat and Le Navenec (2011), studying human behavior warrants that researchers discover and generate an understanding of three components: “(a) the patterns and consequences of the interaction between individuals; (b) their self-definition and shared meaning about certain behaviour and the influence of the contextual factors on that behaviour; and (c) their interpretive process (i.e., how those individuals illustrate the shared meaning of their behaviour and the contextual factors that are held by themselves that may influence their decision to adopt that behaviour or not),” (p. 1077).

Symbolic Interactionism

Symbolic interactionism (SI) is an interpretivist approach to social psychology (Oliver, 2011) which posits that human beings are interpretive, reflective beings that construct and negotiate meanings through interactions with others (Blumer, 1969; Charmaz et al., 2019; Crooks, 2001; Mead, 1962). Founded by George Herbert Mead (1962), and popularized by Herbert Blumer (1969), the premise of SI is that human beings act and interpret situations based on meanings and symbols shaped by social interaction within the societal context. The concept of “self” is developed from social interaction and is reconceptualized over time, implicating the relational aspect of an individual’s construction of self (Crooks, 2001; Oliver, 2011). The ability to interact with themselves and interpret the consequences of interactions with others allows individuals to modify the meanings attributed to symbols, and subsequently choose alternate patterns of interactions (Crooks, 2001).

Mead (1962) proposed the construction of self being an interactive one between the subjective view of self (i.e., “I”) and the objective view of self (i.e., “me”). The dynamic relationship between the subjective and objective view of self is initiated by the “I” when taking the first action. The objective “me” is able to reflexively evaluate the subjective views of “I” within the social context. This conceptualization of self through the objective lens incorporates the relational aspect of self within society, subsequently forming one’s identity (Charmaz et al., 2019). The SI framework is vital in the proposed study as it seeks to reveal the socially constructed meanings that influence individuals’ perspectives and decision-making processes when interacting with others and themselves. It is appropriate for the proposed study as the shared meanings of reality that exist interactively in the mutual relationship between the researcher and participants are founded on the context of the phenomena being studied (Aldiabat & Le Navenec, 2011; Handberg et al., 2014).

Relational-Cultural Theory

Contrary to many other psychodynamic theories rooted in a Western industrialized emphasis of individualism, Relational-Cultural Theory (RCT) places human connection at the center of growth, positing that individuals construct meaning within relationships rather than as individualistic entities (Jordan, 2010; Miller & Stiver, 1997; Miller, 1976, 86). Conceived by Jean Baker Miller in *Toward a New Psychology of Women*, and further expounded upon by Judith Jordan, Irene Stiver, and Jan Surrey at The Stone Center, RCT posits that individuals grow and develop through participating in authentic and mutually empowering relationships (Jordan, 2010; 2013; Miller, 1976-86; Miller & Stiver, 1997; Walker, 2013); or, as RCT calls it, growth-fostering relationships. These relationships cultivate connection, resulting in “the five good things,” which include: (a) movement toward others, (b) increased energy and zest, (c) increased

self-worth and empowerment, (d) knowledge of self and others, and (e) desire for more connection (Jordan, 2010).

Oppositely, when individuals are not met with mutual empathy, they experience disconnection in the following ways: (a) movement away from others, (b) decreased energy and zest, (c) decreased self-worth and empowerment, (d) confusion and ambiguity, and (e) isolation and avoidance of others (Jordan, 2010). RCT theorists define isolation in the context of relational disconnection as it decreases one's self-worth, productivity, and confidence in authentic connections with others in the future. Chronic disconnection, resulting from repeatedly experiencing nonempathetic responsiveness, leads to condemned isolation at which point individuals believe they are unworthy of connection. To prevent future disconnections, individuals enact a phenomenon RCT terms the "central relational paradox," wherein they socially withdraw from others and protectively engage in inauthentic interactions. Utilizing these "strategies of disconnection" and achieving social isolation is the space from which Relational-Cultural theorists postulate most pathological issues are derived (Jordan, 2010; 2013; Kress et al., 2018; Lenz, 2016; Miller, 1976-86; Miller & Stiver, 1997; Walker, 2013).

The cyclical nature in which interactions occur reinforces either connection (i.e., experiencing mutual empathy and empowerment) or disconnection (i.e., not experiencing mutual empathy and empowerment). The internalization of connection or disconnection forms individuals' relational images; or the expectations they have for future relationships. Jordan (2010) challenges our individualistic society with the concept of the "myth of the separate self," arguing human beings develop a sense of self based on their own perceived impacts on other relationships. RCT's social constructivist foundation posits that relational images reflect the cultural norms that facilitate connection and disconnection. Furthermore, traditional psychology

pathologizes individuals' internalizations of disconnections rather than the cultural context from which the damaging misconceptions are derived (Jordan, 2013).

Synthesis of Conceptual Framework

As human beings, we act and interact based on culturally influenced symbolism woven into our understanding of self, others, and experiences. Both frameworks postulate the construct of “self” is formed by internalizations of being in relationships with others within the culture (Blumer, 1969; Charmaz et al., 2019; Jordan, 2010; Mead, 1962). The symbols, or relational images, held by mental health practitioners regarding perinatal loss inadvertently form the basis for the therapeutic process, as they inform what the practitioner believes to be dysfunctional, pathological, or in need of change.

Grief: A Social Emotion

Loftland's prolific 1985 article, *The Social Shaping of Emotion: The Case of Grief*, is notoriously cited across grief research and takes a symbolic interactionist approach to the socialization of grief. While the shaping of emotions vary between the cultural contexts in which they occur, Loftland argues the following four components are vital in conceptualizing the experiential aspect of grief: “(1) the level of significance of the other who dies; (2) the definition of the situation surrounding the death; (3) the character of the self experiencing a loss through death; and (4) the interactional setting/situation in which the three prior components occur,” (1985, p. 175). Although the varying degrees of symptoms are shown across the research to be unique to each individual experience, the common physiological symptoms shared among bereaved individuals are: sleeplessness, decreased appetite, decreased emotional and physiological regulation, heaviness, uncontrolled weeping, intense longing, and detachment from others (Hill et al, 2017; Kersting & Wagner, 2012; Jakoby, 2012; Loftland, 1985; Shear, 2012).

Jakoby (2012) adds a critical piece, stating, “Symptoms, duration, and intensity of grief are modified by social and cultural norms,” (p. 705).

Grief Terminology

Terminology regarding reactions to death are often used interchangeably; however, there are distinct differences between the terms (Jakoby, 2012; Loftland, 1985; Shear, 2012).

Approaching grief terminology from a neuroscientific perspective, Shear (2012) stresses the importance of differentiating between terms to conceptualize the client’s overall experience directly following loss. *Bereavement* is defined as being the experience or objective situation of loss; *grief* is the physiological response to the loss; and *mourning* includes the symbolic representation of loss through rituals and cultural practices (Jakoby, 2012; Loftland, 1985; Shear, 2012).

Grief Misconceptions

The most well-known conceptualization of grief was conceived by Elisabeth Kübler-Ross in her 1969 publication, *On Death and Dying*, in which she delineates a linear model of grief. The five-stage model was developed from her observations of dying individuals’ experiences as they anticipatorily awaited death. The sequential stages Kübler-Ross identified were denial, anger, bargaining, depression, and acceptance. Despite stage theory being developed from overserving dying individuals – as opposed to their loved ones – it is widely known and viewed as the standard of grief for all bereaved individuals (Ober et al., 2012; Stroebe et al., 2017). In a review of the literature challenging the use of the stage theory of grief, Stroebe et al. assert the following five themes emerge regarding criticism of the model: (a) theoretical deficiency and inadequate explanation; (b) lack of conceptual clarity and misrepresentation of the experience; (c) paucity of empirical data; (d) existence of theoretically based alternative models congruent to

grieving; and (e) the consequential impact of ascribing to stage theory (2017). Challenging the simplistic notion of grieving as being a process through which there is a prescribed course, the writers also call attention to the stage model's typifying of an individualistic experience influenced by cultural norms and varying power dynamics.

Modernist View of Death and Dying

In keeping with the conceptual framework, the severity of grief individuals experience is determined by the presence, or lack thereof, of rituals surrounding the death event. Historically viewed as a spiritual experience within the religious realm of the cultural context, death is now conceptualized through human reason, rationalization, and medicalization (Walter, 2020). Capturing the zeitgeist of the Westernized culture, the modernist framework on which our understanding of grief is built asserts that efficacy is a product of rational reason and goal-oriented action (Stroebe et al., 1992). From this perspective, grief is something that should be let go of; a setback that inhibits productivity and efficiency. Our mastery-oriented society has created what Kastenbaum (2007) calls "the death system," wherein the process of dying becomes more like death management framed by the country's standards. Walter (2020) outlines the components of this system as being "medicalization, rationalization, professionalization, and institutionalization," (p. 32).

Conceptualizing modernity's intolerance of grief reveals the societal vulnerability felt when facing the existential threat of mortality (Stroebe et al., 1992; Walter, 2020). Ontological insecurity is revealed when the medicalized curtain is drawn, unveiling the harsh reality of death. As such, the focus is taken off death and put onto keeping individuals alive. The restorative, time-limited view of grief mimics machine-like functioning (Stroebe et al., 1992), or even a productive work ethic (Walter, 2020). Walter writes, "Bereavement is seen as a glitch, not a way

of being,” (2020, p. 54). Cultural perceptions of grief are distorted, seen as procedural, and taught as stages through which we should gracefully glide. Understanding the misconceptions regarding grief and the institutionalization of death is the crux of conceptualizing the socialization of emotions, and furthermore, the socialization of perinatal loss.

The Socialization of Perinatal Loss

The perinatal period encompasses pregnancy through an infant’s first year of life. For parents, it is a transitional stage wherein social roles, sense of self, and functions of a partnership are reexamined in preparation for child rearing (Blount et al., 2021). Successful attainment of this new role often fulfills familial, communal, and societal expectations. Adebayo et al. (2019) iterates this, writing, “There is a social and cultural expectation to be accepted into motherhood; though such an expectation might be universal, its manifestation may be different from culture to culture,” (p. 95). This portion of the literature review will discuss the implications of the perinatal period being severed by loss.

Perinatal Period

In a thematic review of literature pertaining to biopsychosocial factors influential during the perinatal period, Blount et al. (2021) presents numerous risk factors within the three realms of the biopsychosocial model. Biological risk factors include physical and hormonal changes, vitamin or nutritional deficiencies, neurological changes, and previous traumatic experiences. Psychological risk factors include peri-partum and post-partum shifts in mood, depression and anxiety, and decreased self-esteem. Psychological wellbeing is also impacted by stressors such as lack of support, neurobiological changes, and navigating the newness of parenthood. Sociological risk factors include income, racial disparities and discrimination, relational aspects, and reproductive care throughout the perinatal period.

Reproductive Stories

Although the bounds of the perinatal period are localized to the time preceding, or following, pregnancy, perinatal mental health specialists and researchers emphasize the impact of reproductive stories that begin at young ages (Diamond & Diamond, 2017; Jaffe, 2017; Wenzel, 2017). Reproductive stories represent the ideal perinatal experience based on the evidence garnered throughout the lifespan. As such, the perinatal experience is as equally a psychological one as it is physical. Hazen (2003) writes, “Psychologically and physically, the mother’s life, during the period surrounding birth, centers on the child. Perinatal loss interrupts this natural process of attachment,” (p. 150). When the reproductive story is interrupted by the pregnancy ending prematurely, the psychological ramifications must be considered in addition to those that are physical.

Perinatal Loss

Often viewed as a medical event (Markin, 2017; Neiterman, 2013; Wright, 2011) or “non-event” (Brierley-Jones et al., 2014-2015), perinatal loss includes pregnancy loss and neonatal death. Inconsistent and conflicting terminology within the literature causes discrepancies regarding the differentiation between losses (Diamond et al., 2021; Wright, 2011), subsequently limiting discussions and cultural implications surrounding the impact of such losses. Although the literature presents varied temporal parameters of what constitutes a perinatal death from a medical standpoint, distinctions are largely determined by the gestational age of the baby. For clarity purposes, the proposed study will divide perinatal loss into four categories: (a) miscarriage (i.e., the loss of a baby before the 20th week of pregnancy), (b) stillbirth (i.e., the loss of a baby at or before birth occurring the 20th week of pregnancy and beyond), (c) termination of

pregnancy, and (d) infant death (i.e., the death of a baby prior to one year of age) (Centers for Disease Control and Prevention, 2017; 2020; Lim & Cheng, 2011; March of Dimes, 2017).

Inconsistent terminology extends beyond the loss itself to the parents as well, as society has yet to establish a term specifically for parents who have experienced perinatal loss. Through the lens of the conceptual framework, the inconsistent terminology not only inhibits research efforts across disciplines, it also further invalidates the experience of perinatal loss. In our society, the labels “widow” and “widower” refer to those who have experienced the death of a spouse. The label “orphan” is given to those who have experienced parental loss. Parents who have experienced child loss in any form are essentially the nameless, and without a label our society has no way to communicate about those who have experienced such an excruciating loss.

Investigating the benefit of establishing a term, Diamond et al. (2021) found that parents who had experienced perinatal loss believed that a label would validate and legitimize the loss, improve communication with others about the loss, and create a sense of community among those who share the label. The participants included in the study were parents who had experienced perinatal loss and healthcare professionals who interacted with the parents. In determining a label most applicable to the population, “bereaved parent” was selected. Based on this finding, the proposed study will endorse “bereaved parent” to describe a parent who has experienced perinatal loss.

A Medicalized Loss

A contributing traumatic aspect of perinatal loss that repeatedly emerges in the literature is the medicalization of perinatal loss (Neiterman, 2013). Studies show grief and trauma are intensified as bereaved parents are met with insensitive reactions from medical staff while simultaneously reconciling the fact that their babies have died (Markin, 2017; Wright, 2011).

Contrary to the expectations placed on pregnant mothers to change every aspect of their lives upon learning of their pregnancies, the medicalization of their babies' deaths leaves bereaved parents confused as to how they should simply "turn off" the exact parental instincts they were expected to maintain. Medicalizing the experience of loss minimizes the grave impact bereaved parents incur by de-humanizing their experiences and often asserting blame to the gestational mother. The strong roots of the medical model permeate into the diagnostic criteria that mental health practitioners utilize to establish treatment plans for clients. Understanding how mental health practitioners perpetuate the medicalization of perinatal loss is critical in developing more effective therapeutic techniques to assist this population.

An Invisible Loss

Frequently appearing in the literature as a "silent" or "invisible" loss (Bennett et al., 2005; Cacciatore et al., 2008; Heifner, 2020; Lang et al., 2011), the socially sanctioned expectations placed on bereaved parents leaves them feeling as though they should expedite the grieving process (Martel, 2014; Toller, 2005). Martel (2014) ties modernity's intolerance for perinatal loss to the grief censorship reported to have been experienced by bereaved parents, stating "...this silence should not be isolated as an interpersonal issue to be shouldered by individual parents, but rather understood as a matter of reproductive justice," (p. 329). The silencing of this "cultural taboo" is also evident in the lack of mourning rituals, such as funerals and memorials (Diamond et al., 2021; Markin & Zilcha-Mano, 2018; Martel, 2014; Olivier & Monroe, 2021). Hazen (2006) articulates this loss as, "What is not said or written, the spaces between the lines, in the margins, off the pages—women's experiences of infertility, pregnancy loss, the death of their babies and the accompanying grief," (p. 237). Mental health practitioners have the role of being witnesses to bereaved parents' stories of loss; making the invisible feel

visible. To do so, however, it is vital to ascertain the way in which mental health practitioners currently work with bereaved parents to illuminate how visibility comes about within the therapeutic process.

A Relational Loss

Following perinatal loss, bereaved parents experience isolation and exclusion as others avoid them and their grief (Garrod & Pascal, 2019; Heifner, 2020; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). Feeling pressure to move on is ironically met with a lack of support from others. RCT highlights the negotiation process bereaved individuals encounter when attempting to avoid disconnections: discounting personal feelings to ease the discomfort of others, and chronic disconnection resulting in isolation and psychological distress. Most often described in the research as an ambiguous loss accompanied by disenfranchised grief, the lasting impact of perinatal loss is experienced most in a relational context (Boss, 2007; Doka, 2002; Lang et al., 2011; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020).

Ambiguous Loss. Conceived by Pauline Boss, the developing theory of ambiguous loss is structured upon two dialectical contradictions: (a) physical absence and psychological presence and (b) physical presence and psychological absence (2007). The first dialect, physical absence and psychological presence, represents losses such as divorce, kidnapping, a missing body after a natural disaster, etc. The second dialect, physical presence and psychological absence, represents losses such as addiction, Alzheimer's disease, preoccupation with work or mental illness, etc. She argues it is the most stressful kind of loss individuals can experience because there is no representation of the end of a life.

10 Core Assumptions. Boss (2016) lists the following core assumptions as the framework for the social constructivist theory of ambiguous loss:

1. Inability to measure a phenomenon does not negate its existence.
2. Living with the absence of truth is more critical than the epistemological view of truth.
3. The relational aspect of the theory shows the attachment to the absent individual.
4. Cultural perceptions of the loss influence how individuals tolerate the ambiguity.
5. Grief expressions are not pathological; rather, the type of loss is the root of pathology.
6. There is no such thing as closure.
7. Labeling the loss allows individuals to begin processing how to cope.
8. Dialectical thinking, as opposed to binary, provides a pathway to discovering meaning within the ambiguity.
9. Increasing one's tolerance of ambiguity leads to resilience.
10. Family structures consist of physical and psychological beings, which both contribute to one's ability to tolerate ambiguity.

The Myth of Closure. Grief therapy models historically push the client toward closure after loss. This is an impossibility for those who have experienced an ambiguous loss, which can be traumatizing for families and even result in pathology (Boss, 2007). Even when there is a “clear-cut death,” individuals never truly experience closure, as they continue to long for the deceased (p. 17). Death rituals in place within each culture act as a bookend to a life, providing a false sense of finality to the grieving loved ones and an expected sense of closure from the community. When those rituals are unable to be accomplished, the ambiguity of the loss is further exacerbated.

The Ambiguity of Perinatal Loss. Boss describes ambiguous loss as being a “relational disorder” wherein the dysfunction is not within the bereaved individual; rather, it is externally derived from cultural dysfunction (2006; 2007; 2010; 2016). The dialect bereaved parents experience is the physical absence and psychological presence of their babies. Although the loss of a baby could be viewed as an individual experience by a mother, or a shared experience between partners, the research repeatedly reveals one of the most damaging aspects of perinatal loss to be the isolation experienced by bereaved parents when being in relation with others (Lang et al., 2011; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). The ambiguity of perinatal loss places bereaved parents in a perpetual cycle of seeking connection with others and being met with disconnection instead. Furthermore, the ambiguous nature of the loss can be exacerbated when ambiguity exists surrounding the death itself (e.g., Sudden Infant Death Syndrome, spontaneous infections, etc.).

In a study conducted by Lang et al. (2011) investigating sources of ambiguity after perinatal loss, four forms of ambiguity were identified as being experienced by bereaved parents: (a) the pregnancy’s viability, (b) pregnancy loss as a physical process, (c) deciding what to do with the remains, and (d) delivering news of the loss to others. The complex dichotomy of this ambiguity is further depicted in Toller’s study of bereaved parents’ negotiation of dialectical contradictions (2005). The study indicated two contradictions: openness-closedness and presence-absence. The first dialectic, openness-closedness, depicts the contradiction of bereaved parents’ desire to talk about their children, but often not feeling comfortable enough with others to do so. The second dialectic, presence-absence, refers to the contradiction of the ongoing emotional bond bereaved parents maintain with their children while also being acutely aware of their child’s physical absence.

Disenfranchised Grief. The concept of disenfranchised grief explicates the role of cultural norms in governing the acceptability of grief expressions following loss. Grief rules dictate if we have the right to grieve, how we should grieve, where and with whom we should grieve, and the duration of time for which it is acceptable to grieve (Doka, 2002). Doka delineates five types of losses that result in disenfranchised grief: (1) the relationship is not recognized (e.g., non-kin relationship); (2) the loss is not acknowledged (e.g., perinatal death); (3) the griever is excluded (e.g., children); (4) circumstances of death (e.g., suicide); and (5) ways individuals grieve (e.g., level of affect). The paradox of disenfranchised grief is that grief expressions that are culturally dismissed are exacerbated, causing a decrease in social support and an increase in isolation.

Grieving a Perinatal Loss. Often unacknowledged by our society as even having occurred, perinatal loss is among losses that result in disenfranchised grief. Violating grief rules leaves bereaved parents vulnerable for decreased social support, further perpetuation of grief reactions, and possible pathology (Heifner, 2020; Shannon & Wilkinson, 2020). In his recent publication, Walter (2020) argues the cultural perception of perinatal loss as being severely more intense than disenfranchised losses, labeling the grief as a “hyper-enfranchised grief—a grief so terrible that others fear coming close to those enduring it,” (p. 12). Acknowledging perinatal loss means confronting the false sense of security in natural, orderly life processes and brings to awareness the fragility of human beings (Markin & Zilcha-Mano, 2018; Martel, 2014; Walter, 2020).

Pervasive Impact of Perinatal Loss.

Self. Not only does perinatal loss strip bereaved parents of their self-confidence and feelings of competence, but it also causes identity confusion (Côté-Arsenault & Dombeck, 2001;

Hazen, 2003; Wenzel, 2017). When the transition to parenthood comes to a screeching halt, bereaved parents incur narcissistic injury to their sense of self; a feeling of being flawed and ineffective in what others are able to accomplish (Diamond & Diamond, 2017). Adebayo et al. (2019) also notes the abrupt halt to identity construction mothers begin to form during pregnancy shoves them into a confusing space they call “the middle of nowhere,” (p. 96). Furthermore, disruption of their core beliefs (Krosch & Shakespeare-Finch, 2017), and often spiritual beliefs (Adebayo et al., 2019), leaves bereaved parents without a framework from which sense can be made of the loss.

Interpersonal Relationships. With identity confusion also comes role ambiguity within the social context of bereaved parents’ lives. Garrod & Pascal write, “There is no social role to play when a baby is born dead,” (2019, p. 10). The expressions of discomfort that silence bereaved parents leave them feeling excluded, avoided, and dismissed (Cohen et al., 2019; Garrod & Pascal, 2019; Hazen, 2003). In addition to marriages being impacted by differences in grieving (Diamond & Diamond, 2017), future pregnancies can ignite feelings of guilt, shame, and betrayal for feeling as though parents have moved on (Côté-Arsenault & Dombeck, 2001; Garrod & Pascal, 2019; Wood & Quenby, 2010). In fact, researchers suggest bereaved parents’ inability to integrate grief and reconstruct reproductive stories threatens the attachment with future children, as they might project their felt sense of inadequacy onto subsequent children (Hughes et al., 2001). Or, bereaved parents might become overbearing and overprotective to prevent an additional loss (Diamond & Diamond, 2017).

Societal Context. Becoming a parent can be a restorative process in which adults can integrate their own set of morals within a new family system as opposed to residing within a family system incongruent to who they have become as an adult. Relational-Cultural Theory

would refer to this as creating new relational images regarding the parent-child relationship (Wenzel, 2017). Perceived wrongdoing during their own childrearing stages can be reworked in a new, more functional way. From a developmental perspective, Wenzel (2017) discusses how producing offspring often fulfills an inherent desire to contribute to society as an adult; and when interrupted can cause questioning regarding one's worthiness, deservingness, and competence. Questioning one's efficacy also extends to work. Hazen (2006) discusses the deafening silence bereaved parents experience when returning to work, writing, "Silences and silencing are used to separate the unproductive reproductive experiences of women from productive interaction in the workplace," (p. 241).

It is further suggested that to fully grieve, one must have a defined self-image separate from that of the child. The paradoxical necessity of redefining a separate sense of self apart from the parent-child attachment can inflict shame and ambiguity, further perpetuating feelings of loss (Côté-Arsenault & Dombek, 2001). Subsequently, all other interpersonal and societal relationships are compromised. Wenzel (2017) highlights the all-encompassing impact of perinatal loss writing:

"Women who seek treatment following a pregnancy loss are grieving not only the loss of an unborn child but also the loss (or threat of loss) of their personal reproductive story that they developed and solidified over the course of time and that give meaning to their pregnancy, childbirth, and transition to parenthood. These losses can challenge the very fabric of women's beliefs about themselves; their place in their family, partner relationship, and community; and their future," (p. 405).

Therapeutically Working with Perinatal Loss

Compounded by previously mentioned relational impact of perinatal loss, bereaved parents often experience feelings of inadequacy, and gestational mothers feel as though their bodies failed them (Hill et al, 2017; Kersting & Wagner, 2012). Therapeutically working with this population warrants mental health practitioners be aware of the complexity and pervasiveness of the loss (Bennett et al., 2005). Dispelling cultural norms regarding the severity of loss based on gestational age is vital in mental health practitioners developing a strong therapeutic alliance wherein the client feels their grief is acknowledged. Jaffe (2017) writes, “Irrespective of the type of reproductive trauma that clients experience, whether it is the inability to get pregnant or to carry a pregnancy to term, the underlying psychological constructs are the same,” (p. 380).

Challenges

In addition to experiencing the weight of the loss itself, bereaved mothers are grieving during an already turbulent time: the postpartum period (Lim & Cheng, 2011). As their bodies prepare to care for the baby, bereaved mothers experience the agony that ensues when they begin to produce breast milk for a baby that is physically absent. Their bodies become the most substantial trigger as the start of a menstrual cycle is often a reminder of the baby’s absence, and the visual of blood is also reported to be severely traumatic, causing flashbacks, panic, and tremendous grief. In order of events, if the pregnancy loss or baby’s death is the final event, the initiating event is sexual intercourse. Thus, many couples report experiencing a strain in physical intimacy. Some women report having the bodily response to pain while not actually experiencing pain. Essentially, their traumatized bodies are rejecting the very thing that initiated what for some is the most painful experience they have endured.

Entanglement of Grief and Trauma

The relational impacts, symptomatology, and psychological impacts reported by bereaved parents in the aftermath of their losses (Bennett et al., 2008; Hill et al., 2017; Krosch, 2017; Murphy et al, 2014) are congruent with RCT's strategies of disconnection. Disengagement perceived by societal standards as a dysfunctional response to perinatal loss is, in fact, what Jordan refers to as "strategies of survival," (2002, p. 108). Hypervigilance, sleeplessness, and flashbacks are but a few trauma symptoms bereaved parents experience (Christiansen, 2019). Therapeutic attempts at increasing social support may impose more triggering situations for bereaved parents (Cacciatore, et al., 2009; Cohen, 2019). The commonly used grief intervention of meaning-making (Alves et al., 2012) can reignite cognitive dissonance between personal beliefs and the loss of their child. To integrate the loss and reintegrate into society, trauma triggers must feel tolerable enough for the bereaved parent to grieve (Christiansen, 2019). If bereaved parents experience intolerance within the therapeutic alliance, intolerance for their own grief and trauma symptomology will be mirrored. Thus, for bereaved parents to integrate into society after experiencing perinatal loss, they must first feel accepted within the therapeutic relationship, asserting the necessity of a therapeutic model for this unique population.

Therapeutic Competence

The multifaceted nature of perinatal loss poses potential ethical issues for mental health practitioners working with bereaved parents (Lim & Cheng, 2011; Shannon & Wilkinson, 2020). As previously outlined, the complexity of grief and trauma symptomology warrants a range of competence on the part of the practitioner. Mental health practitioners in the counseling field are governed by the American Counseling Association's Code of Ethics (2014). The core professional values of the counseling profession are: "honoring diversity and embracing a

multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” and “promoting social justice,” (2014, p. 2). The code explicitly states a mental health practitioner must practice within her or his scope of practice. The boundaries of competence are in place to avoid harming clients. Beyond the governing ethical guidelines set forth by the ACA, the literature suggests mental health practitioners uphold a standard of death competence when working with bereaved individuals (Gamino & Ritter, 2012; Ober et al., 2012; Shannon & Wilkinson, 2020), which describes “specialized skill in tolerating and managing clients’ problems related to dying, death, and bereavement,” (Gamino & Ritter, 2012, p. 23).

Inadequate Therapeutic Interventions

As Moodley (2009) argues many traditional theoretical epistemologies approach clients from a deficit model as they are based on heterosexual masculine processes representative of the Eurocentric and individualistic centralized group. Unsurprisingly so, the majority of current literature on perinatal loss pertains to the birthing mother or the relational impact on the partnership. As such, the traditional theoretical frameworks foundational in practitioners’ work create a gap between theory and application of approaches to the appropriate population; in this case, bereaved parents. Historical and cultural narratives held by both the mental health practitioner and the client influence the therapeutic process. When dominant discourse, referred to by Watson as “conditioned messaging,” is reinforced by the mental health practitioner, the client is further marginalized (Watson, course handout, February 2018). In the context of perinatal loss, the disenfranchisement of the loss and grief is perpetuated.

While recent studies have applied existing therapy models to working with perinatal loss clients (Alves et al., 2012; Cohen, 2019; Johnson et al., 2016; Olivier & Monroe, 2021; Shannon

& Wilkinson, 2020; Wenzel, 2017), there has yet to be a therapeutic model specifically tailored to this population (Markin, 2017). Furthermore, despite our society's literal existence being fully dependent on the process of reproduction, master's level counseling programs do not require counseling students be educated on how to work with clients in the perinatal period. As such, therapeutic training regarding maternal mental health whatsoever must be sought out by mental health practitioners. Specialized training in this area is often not feasible for many practitioners, as it warrants a substantial investment of time and money. Boss and Carnes (2012) expose society's rejection of loss, writing,

“Until we as a society acknowledge our psychological roots, temper our need for certainty, and learn to manage our societal anxiety about loss, clear or ambiguous, we will continue to pathologize and isolate people who are necessarily and understandably still grieving. We deny death by denying the need to mourn. Our fear of death may ultimately be the fear of ambiguity. It frightens us. We are left to suffer without a clear ending to the story, thus we deny death as well as the need to keep the door open. This denial in concert with our historical legacy of ambiguous loss increases the stigmatization and isolation of the very people in need of compassion and human connection,” (p. 459).

Clinical Suggestions

In a review of the existing therapeutic interventions applied to this population, Markin (2017) enumerates clinical suggestions derived from synthesizing existing literature with her own clinical experience working with perinatal loss clients. She suggests clinicians acknowledge the multilayered experience of loss, and subsequent mourning, as the loss of a baby causes the loss of the reproductive story, concept of self, and social relationships. Conceptualizing the

client's subjective impact of the loss is crucial in not only facilitating movement toward client change on individual and social levels, it is also necessary in identifying trauma symptomology.

Relational Resilience

Despite the gap in the research regarding interventions for bereaved parents, the theme of relational resilience continues to emerge as researchers and clinicians agree that increasing resiliency is a key component in cultivating desired change among bereaved parents (Cohen et al., 2019; Heifner, 2020; Olivier & Monroe, 2021). Boss (2006) defines resiliency as, “the ability to regain one’s energy after adversity drains it,” (p. 27). From an ambiguous loss standpoint, resiliency is a product of one’s comfortability with the ambiguity surrounding the loss. From an RCT perspective, Jordan (2010) goes further by defining relational resilience as, “...movement to a mutually empowering, growth-fostering connection in the face of adverse conditions, traumatic experiences, and alienating sociocultural pressures; the ability to connect, reconnect, and/or resist disconnection,” (p. 107). Both models emphasize flexibility and movement being integral parts of resilience, which challenge feelings of being “stuck” or paralyzed.

Therapeutic Alliance

Regardless of the rationale for the efficacy of various existing therapeutic models, researchers agree the most vital factor when working with the ubiquitous effect of perinatal loss is the therapeutic relationship itself (Hiefner, 2020; Lim & Cheng, 2011; Markin, 2019; Wenzel, 2017). The pervasive impact of perinatal loss influences bereaved parents’ current and future relationships (Cohen et al., 2019). When bereaved parents feel supported in their mourning by employing psychoeducational and relational interventions intended to empower, validate, and normalize the clients’ experiences, their grief is enfranchised and the ambiguity surrounding the loss decreases (Markin, 2017). In fact, studies show these interventions can act as a corrective

experience for bereaved parents (Cohen et al., 2019; Doley & Zilcha-Mano, 2019). Markin emphasizes the climacteric role clinicians play in holding space for the bereaved parent writing, “they typically come to therapy feeling misunderstood, alone, unsupported, criticized, and often stigmatized,” (2017, p. 370). Bearing witness to the immeasurable devastation allows the client to feel seen, which in turn acknowledges the existence of the baby that is not present.

Chapter Summary

The incongruences between the ambiguity of perinatal loss and our culture’s false sense of safety attributed to a natural order cause individuals to avoid the topic at all costs. Bereaved parents not only grieve the loss of their children, they must also navigate the trauma of the death itself. Grief norms impose temporally localized and emotionally structured responses to perinatal loss. As products of the culture in which they reside, mental health practitioners bring known and unknown biases regarding perinatal loss that can pathologize bereaved parents’ experiences of an under-researched, medicalized, and silenced loss. As such, mental health therapists pose the risk of further isolating bereaved parents without proper understanding of socio-cultural influences on grieving a perinatal loss. Lack of training in perinatal mental health overall highlights a gap in counselor education, and furthermore illuminates the need for the proposed study’s aim of understanding how current perinatal mental health specialists work with bereaved parents.

Psychological distress and perpetuation of grief following perinatal loss are rooted in the relational dysfunction of bereaved parents’ interactions with others. When seeking mental health counseling, bereaved parents are seeking connection and tools on how to connect with others in the midst of their devastation. The interactive and socially contextualized nature of perinatal loss warrants a relational approach to therapy that empowers individuals to reintegrate into society while also integrating their grief simultaneously (Markin, 2017). Wright (2011) contends, “Given

that the phenomenon of perinatal bereavement cannot be understood in relation to current theories of maternal prenatal attachment, a new, comprehensive theory is needed to explicate the entire process of maternal perinatal bereavement, beginning with maternal attachment,” (p. 6).

The purpose of the study is to initiate the response to the call for research in developing a therapeutic model specifically tailored to the unique impacts of perinatal loss on bereaved parents. The current state of perinatal loss literature lacks intersectionality among disciplines and reveals gaps between existing theories and application to this population. As evidenced by the literature review, it is vital to gain understanding of how cultural perceptions of perinatal loss impact the therapeutic relationship and overall effectiveness of the therapeutic process. The perinatal loss population is in need of a model that sees the pain of what our culture has made invisible, a model that humanizes what is often medicalized, and a model that holds space for the parent who is unable to hold their baby. By uncovering the processes already in place by perinatal mental health specialists through the study, construction of a model appropriate for bereaved parents can begin.

CHAPTER 3

Methodology

The following chapter outlines the methodological details of the qualitative study. The ontological, epistemological, and axiological views informing the selection of constructivist grounded theory are expounded upon. The study's inquiry into mental health practitioners' approaches to perinatal loss clients is presented in the primary research question and four sub-questions. The research design will be elucidated through detailed explanation of participant selection, data collection procedures, and data analysis procedures. The role of the researcher and ethical considerations for the study are examined.

Purpose of the Study

Perinatal loss is ambiguous in nature as perinatal loss parents experience the contradiction of the psychological presence and physical absence of their babies (Boss, 2010; Lang et al., 2011; Shannon & Wilkinson, 2020). The ambiguity of the loss is compounded by disenfranchised grief, a grief that is unacknowledged by society (Doka, 2002; Lang et al., 2011; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). Studies reveal that perinatal loss parents often report experiencing depression, anxiety, and decreased sense of self-worth after the loss (Hill et al., 2017). One differentiating factor between perinatal loss and other losses, however, is the posttraumatic stress symptomology reported by these parents (Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). The combination of grief and trauma symptomology does not only complicate the healing process for the bereaved individual, it also poses a challenge for mental health practitioners who are unable to identify grief and trauma symptomology separately and concurrently.

While recent studies have applied existing therapeutic models to working with perinatal loss clients (Alves et al., 2012; Cohen, 2019; Johnson et al., 2016; Shannon & Wilkinson, 2020), much of the literature emphasizes making meaning of the loss (Alves et al., 2012) and the importance of social support (Cacciatore, et al., 2009; Cohen, 2019). Meaning-making is problematic for perinatal loss parents as the reasoning for the losses is commonly unknown or vague. Further, seeking social support may be inhibited by trauma symptoms such as isolation, self-blame, and fear of strengthening bonds only to have them break. While these approaches broach the topic of relational impacts related to grief, the vital component of trauma therapy is neglected.

Although research shows evidence of the unique grief reactions and trauma symptomology presented in perinatal loss parents (Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020), there has yet to be a therapeutic model designed to work with the specific needs of this population. Perinatal loss parents not only grieve the loss of their children, they must also navigate the trauma of the death itself. While other therapeutic approaches have begun to address the relational impact of perinatal loss, there has yet to be a therapeutic approach specifically designed to increase relational resilience by combining grief and trauma work. By neglecting the trauma symptomology, grief expressions may be perceived as prolonged or problematic when in reality it is the trauma that is resurfacing, not pathologized grief. Paradoxically, therapists can perpetuate trauma effects by ignoring the very aspect they are avoiding.

Therapeutic interventions are often implemented to encourage increased self-efficacy, or an individualized source of resiliency, to protect clients from damaging external views (Watson, 2018). Determining what constitutes therapeutic efficacy is subjective and shaped by the culture

in which the mental health practitioner interacts (Charmaz et al., 2019). The methods mental health practitioners use when working with the perinatal loss population is inextricably tied to the societally-constructed views of perinatal loss itself. Thus, the purpose of this study is to explore mental health practitioners' recognition and response to grief and trauma symptomology in perinatal loss clients utilizing a constructivist grounded theory approach.

Rationale for Use of a Qualitative Approach

The processes of many qualitative methodological approaches mirror that of mental health practitioners' clinical reasoning (Fassinger, 2005). The grounded theory method furthers this clinical parallel as it emphasizes researcher reflexivity and self-reflection, focuses on social processes, and investigates relationships between societal structures and individuals' behaviors (Tweed & Charmaz, 2017). A constructivist approach not only investigates how individuals view situations, it seeks to uncover how meaning is constructed (Charmaz, 2014). Approaching the qualitative study utilizing an interpretivist paradigm, the methodological approach is constructivist grounded theory.

Research Question

The primary research question guiding the study is: "How do mental health practitioners approach working with clients who have experienced perinatal loss?" To focus the inquiry, the primary research question will be further investigated using the following four sub-questions:

1. How do cultural perceptions of perinatal loss influence mental health practitioners' work with perinatal loss clients?
2. How do mental health practitioners approach working with grief and trauma, separately and concurrently, when working with perinatal loss clients?

3. Which therapeutic approaches inform mental health practitioners' use of clinical methods, treatment planning, and therapeutic interventions when working with perinatal loss clients?
4. What therapeutic barriers do mental health practitioners face when working with perinatal loss clients?

Methodological Approach

Grounded Theory

The leading scholars in the grounded theory approach are Barney Glaser and Anselm Strauss, the authors of *The Discovery of Grounded Theory* written in 1967. The cutting-edge approach to qualitative research proposed a new way in which to develop theories, by developing them from the research rather than using the process of deduction. The methodological approach emerged from the sociologists' studies of terminally ill patients and their coping with impending death. Building upon Glaser's background in quantitative research at Columbia University, and Strauss's subjectivist view of constructed meanings from the University of Chicago, an interpretive yet structured approach to qualitative research was born.

The divergence of Glaser and Strauss became more apparent over time as their views on the methodological approach varied. Glaser further informed the strategies of coding qualitative data based on his positivist approach and published *Theoretical Sensitivity* in 1978. Strauss's pragmatism and view of symbolic interactionism, however, led him to author *Qualitative Analysis for Social Scientists* in 1987, and to co-author *Basics of Qualitative Research* in 1990 with Juliet Corbin. The main differentiating variable between Glaser and Strauss's perspectives was the point in which personal knowledge influences the emergence of data in the research. Glaser's strict adherence to structurally and categorically organizing data is criticized for not

taking into consideration the personal experiences of the researcher that influence the data. The work of Strauss and Corbin is criticized as claiming abductive reasoning but lacking to show true abductive logic, as outlined by the founder of abduction, Charles Pierce, (Reichert, 2007; Charmaz, 2006).

A student of Glaser and Strauss, and a trail-blazer in grounded theory research, Kathy Charmaz's constructivist approach to grounded theory informs the data analysis process outlined in this paper. In *Constructing Grounded Theory: A practical guide though qualitative analysis*, Charmaz outlines her proposition of building off Strauss's interpretive approach to grounded theory utilizing, more specifically, symbolic interactionism (2006). Charmaz's description of her approach to grounded theory parallels the researcher's view of the interpreted realities individuals construct. She wrote, "Unlike their position, I assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices," (2006). Charmaz emphasizes that there are no strict guidelines by which to approach grounded theory data analysis. Instead, however, she encourages the continual processing and refinement of data. She argues that we, as researchers, cannot remove our experiences from the way in which we interpret data. Thus, the theory developed is intrinsically bound to the researcher's view of the data and construction of meaning.

Rationale for Using Constructivist Grounded Theory

Constructivist Grounded Theory is the most appropriate approach to address the research questions as it asserts the cultural context of the phenomenon being studied is inherently informing the researcher's role in shaping the data (Charmaz et al., 2018). Aligning with the conceptual framework in the co-construction of self within the societal context, the constructivist

approach is useful in enfranchising marginalized groups by rejecting objectivity and generalizations. It emphasizes the relative positions of both the researcher and the participants while stressing the importance of researcher reflexivity throughout the entirety of the research process, so as not to further oppress or marginalize the population being studied. Furthermore, a constructivist approach to grounded theory parallels the co-construction of the therapeutic alliance, which is found in the literature as being an integral part of therapeutic effectiveness when working with the perinatal loss population.

Epistemological Position

Methodological selection was based on the researcher's subjectivist epistemological view in that the acquisition of knowledge is a co-constructed process that occurs through interaction between the researcher and the participant (Charmaz et al., 2019; Charmaz, 2014). The ontological view of grounded theory, in that reality is socially constructed and truth is subjective (Fassinger, 2005), supports the study's investigation of cultural perceptions of perinatal loss and how those perceptions influence the therapeutic relationship. The axiological position emphasizes the inextricable tie between the researcher's values and the lenses through which the data is interpreted. This epistemological stance is of particular relevance regarding the researcher's positionality as both a mental health practitioner and a bereaved parent. As such, it is vital for the researcher to acknowledge the existence of multiple realities (Charmaz, 2014; Denzin & Lincoln, 2018), specifically between the following four groups: (a) the clients with whom the participants work, (b) the participants, (c) the researcher, and (d) the research consumer.

Methods

The researcher's socially-constructed perception of truth through which the data is studied warrants the researcher's use of reflexivity by employing memo-writing and auditing throughout the duration of the study (Fassinger, 2005; Charmaz, 2014). Data collection methods include interviews, elicited documents, and extant documents. Data is analyzed with initial and focused coding, producing emergent categories. The iterative process of data collection and data analysis are reciprocal in nature as the researcher employs abductive reasoning, which Salvini (2019) discusses as, "the creation of new hypotheses and new concepts is possible based on the valorization of 'surprising' evidence – i.e. new and unexpected empirical experiences – in which there is no separation between the dimension of 'discovery' (through data collection) and that of 'justification' (the validation of hypotheses through that data)," (p. 23). Abductive reasoning is supported by procedures such as constant comparison of emerging themes, continually observing shifts in the emergent phenomena, and consistent evaluation of researcher interpretation by means of memo-writing (Kelle, 2005; Salvini, 2019).

Selection of Participants

Criteria Selection

The participants in this study are mental health practitioners who have obtained the Perinatal Mental Health Certification offered by Postpartum Support International. The remaining participant selection criteria are informed by the certification requirements, which include the following: (a) two years' experience as a mental health practitioner working with the perinatal population, (b) a graduate degree, and (c) completion of 20 hours of advanced training in perinatal mental health. Selection of participants specializing in perinatal mental health serves three purposes. First, a vested interest in the population being studied to increase participation in

the study and responsiveness in data collection. Second, specializing in perinatal mental health increases the likelihood that participants have clinical experience working with perinatal loss clients. Third, variations in participants' responses illuminate differences in therapeutic approaches as opposed to lack of training in perinatal mental health.

Participant Demographic Information

The researcher utilizes purposeful sampling to increase the diversity of the participant sample. The purposeful, criterion-based sampling also ensures that participants selected are able to answer the research questions and provide information-rich data (LeCompte & Goetz, 1982; Morrow, 2005). Demographic information collected during the interviews includes: (a) geographical location, (b) credentials, (c) work setting, (d) education level, and (e) years of experience working with the perinatal population. The sample size is comprised of 11 participants. Due to the ambiguity surrounding a specific number of participants necessary to reach data saturation in grounded theory studies, this range is determined on the findings of Guest et al.'s (2020) quantitative study revealing themes of homogenous samples reach 80% saturation with a minimum of six interviews, and 95% saturation with 11-12 interviews.

Data Collection Procedures

After the study was approved by the Institutional Review Board (IRB) at the University of New Orleans, the researcher recruited participants by emailing providers listed on the Postpartum Support International website, and by posting details of the study in online forums, such as perinatal mental health Facebook groups. The participants selected for the study received an informed consent document sent via email detailing the following: (a) purpose of the research, (b) benefits of participating in the study, (c) type of participant involvement, (d) potential risks of participating in the study, (e) researcher's ethical obligation to participants, and (f) participants'

ability to remove themselves from the study at any time (Creswell & Creswell, 2018). Visual recordings of the interviews were requested by the researcher in the informed consent document as implicit meanings are strengthened when comparisons are not only made between what participants say, but also between the behaviors they exhibit (Charmaz, 2014). The informed consent document also details the ethical responsibility of the researcher in storing, and properly disposing of, interview recordings.

Data Sources

Gathering rich data, and subsequent saturation of the data, are key components in establishing credibility of the research study. Qualitative literature suggests data saturation be achieved through adequate variety of multiple sources as opposed to redundancy of one data source (Charmaz, 2014; Morrow, 2005; Prior, 2003). As such, the researcher employs the use of three data sources outlined by Charmaz (2014) as methods of inquiry for CGT: (a) intensive interviews, (b) elicited documents, and (c) extant documents. What Charmaz (2014) describes as “focused attention and open-ended inquiry” (p. 85), intensive interviewing aligns with the interpretivist paradigm and CGT approach. Elicited documents include participants’ conceptualizations and treatment plans for a case study developed by the researcher, which was vetted by peer reviewers specialized in perinatal mental health who are not members of the participant pool. Intensive interviews and elicited documents are appropriate data-gathering tools as they inquire about the area of specialty in which the participants contribute to and have substantial experience. Extant documents consist of three training curriculums from perinatal loss trainings offered by specialists in the field.

Interviewing

In keeping with the CGT approach to interviewing, which views knowledge as co-constructed by the interviewer and interviewees (Charmaz, 2014; Fassinger, 2005; Morrow, 2005), the in-depth, semi-structured interviews utilize an interview protocol consisting of 29 open-ended questions and probes wherein the participants were the experts from which the researcher sought to learn. The researcher took a reflexive approach to the interview process, utilizing the interview protocol as a template inquiring about four main areas of interest: (a) cultural perceptions of perinatal loss, (b) addressing grief and trauma with perinatal loss clients, (c) therapeutic approaches to perinatal loss, and (d) therapeutic barriers to working with perinatal loss clients. (See Appendix D for interview protocol.)

The technological platform on which the interviews were conducted was Zoom. Due to the nature of the topic, and to protect participants' privacy, the researcher utilized a HIPAA compliant version of Zoom. In addition to recording the audio data, visual recordings were collected to further explicate the nuances of verbal discourse that may not be apparent in audio transcriptions. Charmaz (2014) writes, "Participants' unstated purposes in telling you what they 'think' may be more significant than their stated thoughts," (p. 159). By completing the informed consent provided to them prior to conducting the interviews, participants consented to audio and visual recordings of the interviews.

Elicited Documents

The researcher collected elicited documents as a second data source to gather information regarding the practical application of participants' therapeutic approaches to working with perinatal loss clients. A case study was disseminated to the participants, after which they composed a treatment plan by responding to prompts. Participants were prompted to formulate a

treatment plan based on the following content areas: (a) presenting problem; (b) diagnoses and rationale; (c) therapeutic goals, including how each goal will be measured and accomplished (e.g., therapeutic models, interventions, and how progress will be measured); (d) therapeutic knowledge necessary to effectively work with the client; and (e) how overall therapeutic effectiveness will be determined. (See Appendix E for the case study and treatment plan prompts.)

Extant Documents

In addition to gaining insight into mental health practitioners' approaches to perinatal loss clients, the researcher also aimed to uncover how mental health practitioners are being trained to work with this population. To do so, the researcher enrolled in three perinatal loss trainings for mental health practitioners offered by specialists in the perinatal loss field. Participation in the trainings provided the researcher with the training curriculums, which were analyzed for consistency and variability of themes.

Role of the Researcher

In accordance with constructivist grounded theory, Charmaz (2014) described the relationship between the researcher and data by stating, "Researchers are part of what they study, not separate from it," (p. 320). Recognizing the position of the researcher as a co-constructor of data, methodological self-consciousness, or continuous assessment of how the research process is impacted by the researcher, is warranted (Charmaz, 2016; Morrow, 2005). Taking the "researcher-as-tool" position, the researcher's role in being fully immersed in the data as a whole not only warrants methodological self-consciousness, it also calls for contextual grounding. Morrow (2005) explains this idea by stating, "Understanding participant constructions of meaning depends on a number of factors, including context, culture, and rapport," (p. 253).

Researcher Biases

Although the grounded theory method is composed of various correctives to reduce the influence of researcher bias on the data collected (Charmaz, 2014), emotional investment in the research topic and aspects of the researcher-participant interaction posed the potential of obstructing the collection of equitable data (Morrow, 2005). Consequently, the researcher practiced reflexivity, described by Pillow (2005) as the researcher being, “critically conscious through personal accounting of how the researcher’s self-location (across for example, gender, race, class, sexuality, ethnicity, nationality), position, and interests influence all stages of the research process,” (p. 5). The ongoing awareness of self using reflexivity specifically takes into account the researcher’s additional roles as a bereaved parent and a mental health practitioner. Because these roles cannot be removed from the interpretivist lenses through which the data is constructed, introspection was a critical aspect in providing role clarity.

Ethical Obligation

In keeping with constructivist grounded theory’s view that the researcher cannot be removed from the data produced (Charmaz, 2014; Morrow, 2005), the researcher implemented gatekeeping tools to limit researcher bias to the extent possible. Not all biases are known; however, gatekeeping tools are intended to bring subconscious biases to the conscious to better conceptualize how those biases impact the lenses through which the data is interpreted. Such tools include the practice of reflexivity, memo-writing, and maintaining a research journal. With these various interventions, the researcher was more apt to identify if the integrity of the data was reshaped based on personal and professional “privileges and preconceptions.” Although the population of mental health practitioners is not a vulnerable population itself, the profession of

which the research is exploring is built off an innately vulnerable population, as therapists are legally and ethically bound to maintaining client confidentiality.

Additionally, these areas of ethical credibility are strengthened by the researcher's extensive training and certifications in trauma therapy (Certified Clinical Trauma Professional) and in perinatal mental health (Perinatal Mental Health-Certified). To eliminate role confusion and professional misrepresentation, the informed consent differentiated between the researcher's roles from that of a mental health practitioner and bereaved parent. The informed consent also clarified research intentions (e.g., gathering knowledge about therapeutic interventions), emphasized anonymity of participants and participants' stories, and reinforced the bounds of confidentiality within the research and mental health therapy profession.

Data Analysis

Data analysis was an iterative process that included constant comparison and memo-writing throughout. Participant interviews were transcribed verbatim and coded. Utilizing what Charmaz (2014) lists as the two main phases of grounded theory coding, interview transcripts were analyzed through initial coding and focused coding. The "pivotal link" between data collection and emergence of theory, coding brings together two crucial components of grounded theory: "generalizable theoretical statements that transcend specific times and places and contextual analyses of actions and events," (Charmaz, 2014, p. 113). Elicited documents and extant documents were analyzed using initial coding and focused coding. As thematic categories began to emerge, theoretical sampling furthered the analysis through abductive reasoning and subsequent theoretical saturation (Fassinger, 2005).

Initial Coding

To preserve the experience of the participants and maintain the character of the data collected, interviews and case conceptualizations were coded using line-by-line coding. This initial form of coding with gerunds is a heuristic device that allows the researcher to interact with the data, define relationships between processes, and begin to construct thematic categories (Charmaz, 2014; Tweed & Charmaz, 2012). In addition to maintaining the fluidity of participants' experiences, coding for actions reduces researchers' tendencies to label the data as static and one-dimensional, and prematurely adopt existing theories. To illuminate patterns and contrasting themes, the researcher used incident-with-incident coding. Given the shared clinical specialty among participants, in vivo coding assisted the researcher in maintaining speech and meaning.

Focused Coding

Initial coding transitioned into focused coding after the most important codes were identified as being those that account for the majority of the data (Charmaz & Thornberg, 2020). Engaging in reflexivity is of particular importance when developing focused codes as these codes shape further data analysis (Charmaz, 2014). Focused coding was used to expedite data collection by providing the researcher with fewer data from which subsequent targeted questions were formulated. This process of sorting and synthesizing the data brought about emerging categories for the researcher to pursue further.

Theoretical Sampling

As opposed to Strauss and Corbin's formal procedure of axial coding, the constructivist approach makes sense of the data through the emergence of categories (Charmaz, 2014; Charmaz & Thornberg, 2020; Fassinger, 2005). Charmaz suggests axial coding may limit the researcher's

ability to construct codes as it encourages application of an analytic frame through which the data is viewed. Spurred by memo-writing and constant comparative methods, theoretical sampling illuminated gaps between and among the emergent categories, prompting further investigation of underdeveloped concepts. Taking the inductive process a step further, theoretical sampling involved abduction, wherein the researcher made inferences to explicate the relationships between and among data. The process of theoretical sampling, which occurred concurrently with data analysis, is described by Charmaz as “strategic, specific, and systematic,” (p. 199). Upon discovering no new categorical properties from theoretical sampling, theoretical saturation was achieved within the bounds of the study.

Establishing Trustworthiness

To establish trustworthiness in this study, the researcher utilized reflexivity and crystallization. Although reflexivity is prevalent among research literature, Guillemin (2010) posits it is a resource and should be seen as an ethical practice in qualitative research requiring the researcher’s intentional and continual reflection of self and scrutiny of the data. Critically examining existing uses of reflexivity within qualitative research, Pillow (2003) recommends the following four interdependent strategies in which qualitative researchers utilize reflexivity to assert validity: (a) reflexivity as recognition of self (i.e., observation of self and awareness of self with others), (b) reflexivity as recognition of other (i.e., sound research is predicated upon understanding the subject of the research), (c) reflexivity as truth (i.e., prioritizing truth and capturing the participants’ experiences), and (d) reflexivity as transcendence (i.e., moving past personal and cultural misrepresentations of participants).

Rejecting dichotomous thinking and suggesting a continuum of ways to produce knowledge in qualitative research, crystallization is described by Elligson (2009) as “productive

blending” of commonly partitioned methods of research (p. 6). Elligson further lists the five principles of crystallization as: (a) providing thick description of the investigated phenomenon is achieved through employing various genres of data and incorporating the researcher’s epistemological stance, (b) utilizing multiple points of the qualitative continuum to represent knowledge in more than one way, (c) drawing on more than one form of data, (d) utilizing reflexivity throughout the entirety of the research process, and (e) opposing positivist objectivity and instead celebrating knowledge as a construction of multiple sources.

Specific to constructivist grounded theory, trustworthiness was also evaluated with four criteria developed by Charmaz: (a) credibility, (b) originality, (c) resonance, and (d) usefulness. (Charmaz, 2014; Charmaz & Thornberg, 2020). Credibility is demonstrated by providing evidence of systematic comparisons between categories and linking of data to the argument. Additionally, it is founded on the researcher’s reflexivity throughout the study. Originality involves establishing the social and theoretical significance of the study, offering fresh insight, and providing a new conceptualization to existing concepts. Portraying the breadth of the participants’ experiences and presenting the categorical data in a way that is understood by the participants and individuals with similar experiences demonstrates resonance. Finally, implications of the data that spark further research, and provide implications for how the analysis can be used in everyday life, speaks to the usefulness of the study.

Chapter Summary

The interpretivist lens through which constructivist grounded theory views the co-construction of subjective knowledge emphasizes the role of social interaction. Investigating mental health practitioners’ approaches to grief and trauma in perinatal loss clients through a conceptual framework of relational cultural theory and symbolic interactionism, the study sought

to understand how cultural norms regarding grief rules influence therapeutic recognition and therapeutic response to perinatal loss. The purpose of the study is to bridge the gap in literature between the reported psychological impacts of perinatal loss as a disenfranchised loss, and mental health therapists' awareness of cultural biases within the therapeutic relationship, to decrease therapeutic perpetuation of culturally established normative grief rules.

CHAPTER 4

Results

The purpose of the study is to co-construct a therapeutic model addressing both grief and trauma symptoms presented in clients who have experienced perinatal loss. To conceptualize perinatal loss, research must not only consider the experience of the loss itself, but the cultural context in which the bereaved parent interacts as well. The research question framing the inquiry of this qualitative study is, “How do mental health practitioners approach working with perinatal loss clients?” Further divided into four sub-questions, the secondary aim of the study is to illuminate the following: (a) cultural perceptions of perinatal loss, (b) how practitioners approach working with grief and trauma subsequent to perinatal loss, (c) therapeutic approaches that inform practitioners’ clinical methods when working with perinatal loss clients, and (d) therapeutic barriers to working with perinatal loss clients.

Methods

The constructivist grounded theory study utilizes the following three forms of data: (a) intensive interviews, (b) elicited documents in the form of a case study for which participants outline a therapeutic approach, and (c) extant documents in the form of curricula for perinatal loss clinical trainings. Prior to seeking IRB approval, the case study was vetted by a focus group made of clinicians certified in perinatal mental health who did not participate in the study. Subsequent to obtaining IRB approval, I began recruiting participants via email utilizing the participant recruitment email shown in Appendix C. I utilized criterion sampling to recruit mental health practitioners with the perinatal mental health certification (PMH-C) in a systematic way of rotating through each region of the United States so as not to saturate the sample in one localized area. Additionally, I posted details of the study in a private Facebook group for mental

health practitioners who have the PMH-C credential, which led to including the first individual to obtain the PMH-C credential outside of North America. Having obtained the PMH-C credential through Postpartum Support International indicates participants have met the following criteria: (a) at least two years of experience working with the perinatal population, (b) at least 20 hours of advanced training in perinatal mental health, and (c) a graduate degree.

Upon receiving the signed consent form from each participant, interviews were scheduled and participants were given a participant study number (e.g., ODS01), which they used as an identifier for completing the case study to maintain confidentiality. As discussed below, pseudonyms were later selected by the participants. Participation in the study included a virtual recorded interview via HIPAA Zoom lasting 45 to 60 minutes and completion of a case study response warranting approximately 15 minutes. In total, the study called for no more than an hour and a half of participants' time. The informed consent signed by all participants outlines the details of the study and emphasizes the voluntary nature of participation in that participants could choose to remove themselves from the study at any point without penalty or question. See Appendix B for the informed consent document.

The remainder of the chapter will present the results of the study in three sections. First, the validation procedure results will be presented by introducing the participants and outlining data gathered from the following three data sources: (a) intensive interviews, (b) elicited documents, and (c) extant documents. Second, data analysis results will be presented by introducing the phase model developed from the focused codes and conceptual categories. Third, the findings of the study will be presented through the lens of each research question. Finally, the chapter will conclude with a summary of the results.

Validation Procedure Results

Participants

The proposed study sought to include 8-12 participants, and the participant count was met with a total of 11 participants. To increase participant variability and to diversify the participant sample, four regions of the United States and Portugal are represented among the 11 participants. The pseudonyms were chosen by each participant as I felt it was important each participant be authentically represented in the study even as far as how they would be referenced throughout the manuscript and in the presentation of the results. Unsurprisingly, many of the pseudonyms chosen held personal meaning for participants, which further empowers the aim of the study. Participant demographics are provided in Table 1 including an explanation of credentials represented in the participant sample.

Table 1*Participant Demographics*

Participant	Credentials	Geographical Location	Setting	Years Working w/Perinatal Clients
Angelica	LMFT, PMH-C	California, USA	Private practice	4
Elina	LPC, NCC, PMH-C	Connecticut, USA	Private practice	13
Double Rainbow	LPC, PMH-C, MAC, BC-TMH	Georgia, USA	Private practice	15
Tina	LPC, PMH-C, Retain-PLC	Pennsylvania, USA	Private practice; outpatient setting	2
Serena	LMFT-S, PMH-C	Texas, USA	Private practice	8
Daphne	LCSW, PMH-C	Connecticut, USA	Private practice	3
Amelia	LCSW, PMH-C	Tennessee, USA	Private practice	10
Marie	LPC, PMH-C	Georgia, USA	Private practice	20+
Lilith	Clinical Psychology, Ph.D., PMH-C	Washington, USA	Private practice	16
Jessie	LPC, PMH-C	Georgia, USA	Private practice	4
Isabel	Licensed Counsellor and Psychotherapist, SAC-R, PMH-C	Portugal	Private practice	10

Note. The credentials are listed in the format provided by the participants. PMH-C = perinatal mental health certified; LMFT = Licensed Marriage and Family Therapist; LMFT-S = Licensed

Marriage and Family Therapist Supervisor; LPC = Licensed Professional Counselor; NCC = National Certified Counselor; MAC = Master Addiction Counselor; BC-TMH = board certified tele-mental health; Retain-PLC = Retain Parental Leave Coach; LCSW = Licensed Clinical Social Worker; SAC-R = Singapore Association for Counseling Registered Counselor.

Intensive Interviews

The first data type collected for the study was intensive participant interviews lasting 45 to 60 minutes via HIPAA Zoom. The interview protocol used in each interview facilitated participant dialogue on the following four main areas derived from the four research sub-questions: (a) cultural perceptions of perinatal loss, (b) therapeutic approaches to perinatal loss, (c) grief and trauma in perinatal loss, and (d) therapeutic barriers. The four areas of inquiry included 14 open-ended questions and prompts in addition to 36 sub-questions and sub-prompts. The results of the interviews will be presented by providing participant responses to the four areas of inquiry.

Cultural Perceptions of Perinatal Loss

The main theme identified by participants centers on the disenfranchised nature of how reproductive loss is culturally perceived as, “It doesn’t really merit that emotional investment and it’s not that big of a deal,” (Lilith). Serena points out the relational distress experienced by clients when other women in the childbearing years act as if they are wondering, “Is it contagious? If it happens to them, can it happen to me?” Perpetuating the relational distress is the lack of knowledge surrounding reproductive loss. “People don’t understand how you can have grief about someone you may have not actually met or that you only knew for a short time. It doesn’t make rational sense to them and so they’ll say really insensitive things,” (Double Rainbow).

Participants reported how clients feel the push to have another baby as a way to move past the loss. Daphne articulates this by stating:

There's this sense of, like, "Just get up and keep going. Yeah, you're sad and I get it, but you gotta snap out of it and go for baby number two. You just gotta keep going." And you're weak if you don't.

Double Rainbow further expounds upon this societal pressure to quickly continue the reproductive process saying, "They want it to look a certain way and they want it to have an endpoint. People assume that the endpoint is having another baby and they sigh relief when another pregnancy happens." Daphne emphasizes the cultural discomfort with reproductive loss, describing it as "definitely invisible; silent."

Therapeutic Approaches to Perinatal Loss

It is implored by all participants that therapeutic approaches to working with clients who have experienced reproductive loss must be co-constructed by the client and practitioner, as the subjective experience of the client is what will determine therapeutic effectiveness. Lilith describes this process as, "meeting the client where they're at instead of jumping to goals," and further describing the therapeutic timeline as, "It's going to take as long as it takes." Serena differentiates between therapeutically working with clients who have experienced reproductive loss and those who have not by saying, "It's a very different type of therapy because it's, it's that companioning versus 'we're gonna get you from A to B.' Right? Like, 'B' is not necessarily that they're okay, it's more of that they're managing their grief or their trauma or what have you."

Grief and Trauma in Perinatal Loss

Reactions to grief and trauma resulting from reproductive loss leave clients feeling "shame" and "separation from their peers, families, and partners," (Lilith). Serena points out

“pain, grief, trauma, and [the] impact it has on people” are minimized. She further discusses the challenges parents face when having a child subsequent to experiencing reproductive loss as, “Holding duality of hope, and excitement, and joy for the baby that is here but that’s in addition to the loss. It doesn’t replace the loss. Which with other losses we don’t do that.” Double Rainbow captures the relational aspect of the loss by saying:

So, just as a whole we’re not good with it. We want it to be, “Well, we had a funeral, and it’s been a few weeks, so you’re good now! Right?!” Like, with the internal experiences that they’re forever changed. Nothing is the same, and even if it looks the same from the outside, that’s not their lived experience. So, it makes them feel disconnected. It makes them feel misunderstood. It makes them feel invisible. And they so desperately want to not lose everything... like, so they’ve lost their child, their pregnancy, their whatever it is; their ability to have a child like they thought they would. Um, and then their friends treat them differently. Or, their work is weird. Or, ya know, or they can’t enter a room without people going, “How are you?” [said with pity].

Therapeutic Barriers

Therapeutic barriers identified by participants include lack of clinical knowledge regarding the reproductive stage and by default, lack of clinical knowledge regarding reproductive loss. Examples of gaps in knowledge include practitioners not knowing “the language of what is occurring,” not fully understanding “the processes of what occurs,” and being unable to fully conceptualize the client’s trauma by “not understanding what happens in the hospital and the medical trauma,” (Elina). The lack of therapeutic knowledge is derived from the cultural perceptions of reproductive loss; that it is something that should not be discussed.

Elicited Documents

Elicited documents were the second form of data collected wherein all participants were prompted to respond to a case study example by identifying the following: (a) client symptoms, (b) client diagnoses, (c) three therapeutic processes to utilize when working with the client, (d) therapeutic knowledge necessary to effectively work with the client, (e) how therapeutic effectiveness would be determined, and (f) challenges a practitioner might face when working with the client. Following the case study example will be participant responses to each of the six areas of inquiry prompted by the client case. The case study example is as follows:

The client is a 32-year-old, African American female reporting what she believes to be symptoms of anxiety. The symptoms she describes are chest tightening, shortness of breath, feeling “panicked,” and inability to focus. She reports having no history of anxiety; however, the symptoms began approximately one month ago after she attended a baby shower where she experienced “what felt like a panic attack.” The client describes the baby shower event as “confusing” because the joy she felt for her friend quickly shifted into “anger, jealousy, and resentment.” She also mentions that while watching her friend open gifts, she felt like she was numb and disconnected from her body.

The client discloses that in September of 2020, at 22 weeks’ gestation, her first pregnancy ended in the baby being stillborn. It was determined at the 20-week anatomy scan that the baby had a fatal diagnosis with no chance of survival. Because of the COVID restrictions in place, the client was alone when she received the news. She was also alone at the subsequent birth and death of her

child, which occurred two weeks after the anatomy scan. In addition to the anxiety symptoms, the client also reports recurring nightmares wherein she can see her baby but is unable to get to him or her. Since the onset of symptoms, the client reports isolating herself from others and avoiding social situations. She is fearful of having another panic attack, and reports feeling that interacting with other people increases her anxiety. The client lives with her partner and does not have any living children. In addition to the relational anxiety experienced with others, she also reports experiencing the feeling of isolation when she is with her partner, as her partner was unable to witness the events of the anatomy scan and subsequent birth.

Client Symptoms

The client symptoms identified by participants, and the frequency with which each symptom was identified, are listed in Table 2. The table lists symptoms in order of frequency beginning with the most frequently identified symptoms and ending with those identified with the lowest frequency. The symptoms identified most frequently are: (a) panic attacks and/or panic, (b) anxiety, (c) somatic symptoms, and (d) social isolation, withdrawal, or avoidance.

Table 2*Symptoms Identified by Participants Responses in Case Study*

Symptoms Identified	Frequency in Responses
Panic attacks and/or panic	8
Anxiety	7
Somatic Symptoms	7
Social isolation, withdrawal, or avoidance	7
Nightmares	6
Difficulty focusing	4
Trauma	3
Dissociation	3
Anger	3
Intrusive thoughts	2
Labile mood	2
Overwhelm	2
Jealousy	2
Resentment	2
Numbness	1
Dysregulation	1
Grief	1
Anhedonia	1

Determining to Diagnose

When determining to diagnose, participants responded to the question, “What, if any, diagnosis would you give the client?” The diagnoses given are listed in Table 3. The diagnosis appearing most frequently is Post-Traumatic Stress Disorder (PTSD), which was identified by nine of the 11 participants. It is important to note six of the 11 participants include verbiage indicating hesitancy in providing a diagnosis. Isabel and Daphne preface their diagnoses with “potentially.” Marie stated, “I would need more time working with her, but maybe post-traumatic stress disorder, anxiety disorder, maybe panic disorders, etc,” while Serena stated they would need to “rule out” certain diagnoses. Jessie framed their potential diagnoses with, “if using

insurance...” Finally, Double Rainbow responded by writing, “There is not an existing diagnosis that accurately fits this client’s situation so I would not provide a diagnosis. If I had to give one for reimbursement reasons, I would give F43.22 [adjustment disorder] but it does not fit the client accurately.”

Table 3

Diagnoses Identified by Participants Responses in Case Study

Diagnosis Listed	Frequency in Responses
Post-Traumatic Stress Disorder	9
Post-Traumatic Stress Disorder with dissociative symptoms and delayed onset	1
Depression	1
Generalized Anxiety Disorder	3
Adjustment Disorder with anxiety and/or depressed mood	1
Adjustment Disorder	1
Panic Disorder	1
Postpartum Mood Disturbance	1
Prolonged Grief Disorder	1
Acute Grief	1
No existing diagnosis that accurately fits	1

Therapeutic Processes

The therapeutic processes outlined by the participants uncovered how they work with clients by approaching specific areas of reported impairment rather than ascribing to one theoretical orientation. The most common processes include assessing client activation, holding space for the client, and integrating psychoeducation throughout the therapeutic process. Each participant identified the use of a psychosomatic approach as being necessary in decreasing trauma symptoms. Meeting the client where they are, fully conceptualizing the severity of the loss, and understanding the client’s cultural norms are reported by participants as being integral aspects of creating safety and establishing trust.

Therapeutic Knowledge Necessary

The primary source of knowledge found to be necessary by participants when working with the client portrayed in the case study was knowledge of the perinatal period. Further, participants highlighted the importance of being informed of empirical data regarding perinatal health related to African American women. Understanding the pervasive impact of reproductive loss is critical to utilize psychoeducation as a way to normalize and validate client experiences. Finally, clinical knowledge of the physical reproductive processes and the medical reproductive processes are essential in capturing the client's full experience.

Measuring Therapeutic Effectiveness

Participant responses revealed therapeutic effectiveness would be determined primarily by the client's self-reported perception of change. Although therapists' observations of change are mentioned, it is unclear what the participants constitute as observed changes. Much of the verbiage points back to client self-report as being the primary source of determination regarding therapeutic effectiveness. Observational change, for example, was described by some participants by using the language "client's ability to," which is inherently client self-report. Only one participant, Jessie, lists specific assessments to be utilized when measuring effectiveness, which include the Edinburgh Postnatal Depression Scale (EPDS) and the Subjective Units of Distress Scale (SUDs).

A notable theme among all participant responses to the case study is the verbiage being used to describe desired client change, such as "manage," "reduce," and "cope." Therapeutic effectiveness is not equated with eradication of symptoms; rather, it is connoted with increased tolerance and management of symptoms. Marie describes therapeutic effectiveness as, "That the client and I see relief and reduction of her symptoms, that she is building community and she

feels equipped to cope with her feelings and experiences.” Serena responds similarly in adding the relational component within measuring therapeutic effectiveness, “By client’s ability to manage triggers, anxiety and trauma symptoms, engage and communicate with partner and participate in daily and general activities in life.” Isabel expostulated the idea of “fixing” grief by stating, “Grief is not something to ‘get over,’ so I would be looking primarily at reduced trauma symptoms (reduced hyperarousal and nightmares for example) and increased ability to function.”

Therapeutic Challenges

The potential therapeutic challenges reported by the participants fell within two main areas, including cultural biases and severity of trauma. Regarding cultural biases, Serena responded to the inquiry of possible challenges they might face when working with this client by stating, “Have to be aware of the impacts of systemic racism and how this impacted client’s care and experience. Whether client has a support system, impacts of covid protocol and being alone.” Double Rainbow lists a potential challenge as, “ensuring culturally competent care that the client feels is meeting her needs,” which coincides with Isabel’s point that “cultural expectations could also hinder client’s ability to heal.” Highlighting the aim of the study, Lilith lists a possible therapeutic challenge as, “Therapist’s unconscious biases and culturally inappropriate or untested interventions that are mainstream but never tested, possibly inappropriate, for BIPOC women.”

Therapeutic challenges attributed to trauma severity are listed by Angelica as, “avoidance of the topic, not being present in her body due to the trauma,” which can be compounded by the “intensity, frequency, and duration of symptoms,” as reported by Tina. Isabel challenges the linear processes of change practitioners are often taught, responding, “‘Recovery’ from losing a baby is not a linear process so I would expect the client to have a few setbacks which include due

date, anniversary, triggers from pregnant friends, potentially issues in conceiving and increased anxiety in a subsequent pregnancy could all have an adverse impact.” Lilith and Jessie broaden the challenging picture of trauma severity by pointing out the potential of past trauma resurfacing as a result of the current trauma. Jessie writes, “Previous traumas tend to come up mixed into the current trauma.” Lilith builds on this point by responding, “A complex diagnostic picture including complex relational trauma from childhood or other mental health issues (including other perinatal mood disorders) and/or substance use and poverty etc. complicating the picture.”

Extant Documents

The final data type in the study includes extant documents in the form of training curricula for perinatal loss trainings. The three trainings analyzed were fully completed by the researcher as opposed to simply obtaining the training agendas. To maintain confidentiality of training materials, the results presented will provide the length of the training and the core areas discussed.

The first training is five hours in length and covered the following three areas: (a) companioning, (b) strengthening support systems, and (c) the healing power of ritual. The second training is six hours in length and consists of the following four modules: (a) different types of losses, (b) understanding the grief and loss, (c) interventions, and (d) healthcare professionals. The third training is six hours in length and consists of the following six modules: (a) perinatal loss, (b) the nature of grief, (c) integrated and complicated grief, (d) loss and the biopsychosocial model of perinatal mental health, (e) pregnancy, birth, and parenting after loss, and (f) therapy and the therapist.

Data Analysis Results

The following section will outline the data analysis results. Because the focus of the study at its core is based on the interactive therapeutic process, all data sources were coded using gerunds. Coding with gerunds is a heuristic device emphasizing the movement and sequence of the process rather than shifting the actions of participants into topics (e.g., “describing” versus “description”) (Charmaz, 2014; Tweed & Charmaz, 2012). “By defining processes early in the research, the grounded theorist avoids limiting the analyses of interviews to typing people into simplistic categories,” (Charmaz, 2006, p. 685). To maintain the integrity of the processual nature of the data collected, in-vivo codes can be seen throughout each phase of data analysis (Charmaz, 2006, p. 58).

Examples of the coding process are provided to show how the data constructed the final model entitled the “Phase Model for Reproductive Loss.” Presented in Figure 1 is an excerpt of initial codes from all three data sources. Figure 2 shows the 24 focused codes and six conceptual categories that emerged from the initial codes. Following Figure 2 is an explanation of how the model is designed for therapeutic use by moving through the phase model, which incorporates each conceptual category and focused code.

Figure 1

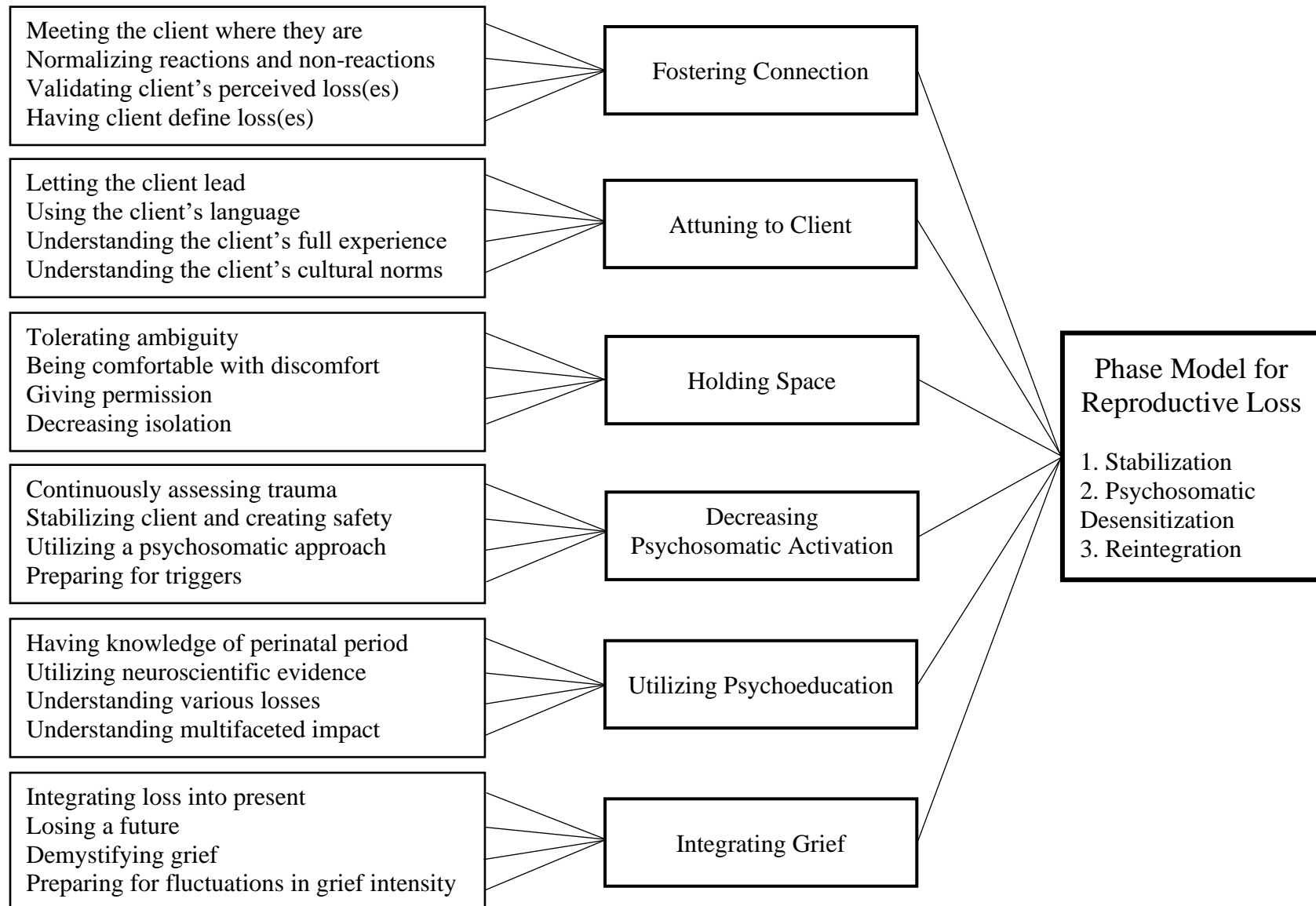
Excerpt of Initial Codes

Having the language	Showing up
Integrating the grief	Utilizing a trauma-informed approach
Finding rituals	Understanding the various losses
Acknowledging the ongoing, life-long process	Tolerating ambiguity
Validating the loss	Acknowledging other's inability to hold space
Letting the client lead	Acknowledging social impact
Holding space	Understanding impact on client's identity
Stabilizing the client	Decreasing shame
Utilizing psychoeducation	Companioning
Giving permission	Employing a psychosomatic approach
Emphasizing therapeutic alliance	Normalizing reactions and non-reactions to loss
Building strong therapeutic rapport	Understanding various losses
Creating safety	Bring knowledgeable about the medical processes
Viewing experience through trauma lens	Letting the client define the loss
Being comfortable with discomfort	Asking about baby
Focusing on client's full experience	Preparing for trauma triggers
Understanding client's cultural norms	Preparing for anniversaries, due dates, etc.
Meeting the client where they are	Preparing for physical triggers
Understanding the perinatal period	Placing client in the perinatal context
Understanding the physical impact	Acknowledging normal postpartum reactions
Understanding the emotional impact	Being knowledgeable about local resources
Understanding the psychological impact	Asking permission
Decreasing isolation	Finding rituals
Preparing for intense grieving days	
Letting the client choose a term	
Assessing for trauma	

Note. The list provided is an excerpt of initial codes and does not show the list of initial codes in its entirety.

Figure 2

Focused Codes and Conceptual Categories



Phase Model for Reproductive Loss

Figure 2 provides a visual representation of the analytical process resulting in the conception of the Phase Model for Reproductive Loss. As mentioned in previous chapters, perinatal loss is often defined in existing literature as being the loss of a pregnancy through miscarriage, stillbirth, and infant death. Participant responses, however, included the discussion of other, less frequently identified reproductive losses, such as infertility, adoptive loss, termination, and more. Although there has yet to be consistency with what forms of loss are encompassed within perinatal loss, each reproductive loss is unified by one consistent description: the loss of a future. With the aim of being inclusive of all losses within the reproductive period, the Phase Model for Reproductive Loss is intended for mental health practitioners to utilize when working with any reproductive loss, however it might be defined by the client. The phase model consists of the following six conceptual categories: (a) fostering connection, (b) attuning to client, (c) holding space, (d) decreasing psychosomatic activation, (e) utilizing psychoeducation, and (f) integrating grief. Each conceptual category is comprised of four focused codes explicating how each category is implemented within the therapeutic process when utilizing this model. Although the conceptual categories appear to be built from the same framework consisting of four focused codes, the way in which the conceptual categories are implemented throughout the model varies.

The most prominent codes to emerge from the data were holding space, utilizing psychoeducation, letting the client lead, and understanding the full context of the loss (e.g., within the client's culture, how the loss impacted the client, the client's reported experience of trauma, etc.). Participants reported utilizing psychoeducation and holding space for clients throughout the entirety of the therapeutic relationship. Furthermore, the consensus to let the

client lead was explicated as only being possible through therapeutic attunement. Therefore, the conceptual categories of attuning to client, holding space, and utilizing psychoeducation are used throughout each phase of the model but are employed intentionally to facilitate client change within each respective phase. To preface the design of the phase model, the conceptual categories are presented along with the focused codes from which they are derived.

Conceptual Categories

Fostering Connection. To foster connection, the data revealed the following four focused codes as being necessary components: (a) meeting the client where they are, (b) normalizing reactions and non-reactions, (c) validating client's perceived loss(es), and (d) having client define loss(es).

Attuning to Client. In attuning to the client, the data revealed the following four focused codes as being necessary components: (a) letting the client lead, (b) using the client's language, (c) understanding the client's full experience, and (d) understanding the client's cultural norms.

Holding Space. To hold space for the client, the data revealed the following four focused codes as being necessary components: (a) tolerating ambiguity, (b) being comfortable with discomfort, (c) giving permission, and (d) decreasing isolation.

Decreasing Psychosomatic Activation. The data revealed the following four focused codes as being necessary components to decreasing psychosomatic activation: (a) continuously assessing trauma, (b) stabilizing client and creating safety, (c) utilizing a psychosomatic approach, and (d) preparing for triggers.

Utilizing Psychoeducation. Utilizing psychoeducation throughout the therapeutic process was revealed in the data as necessitating the following four components: (a) having

knowledge of perinatal period, (b) utilizing neuroscientific evidence, (c) understanding various losses, and (d) understanding multifaceted impact.

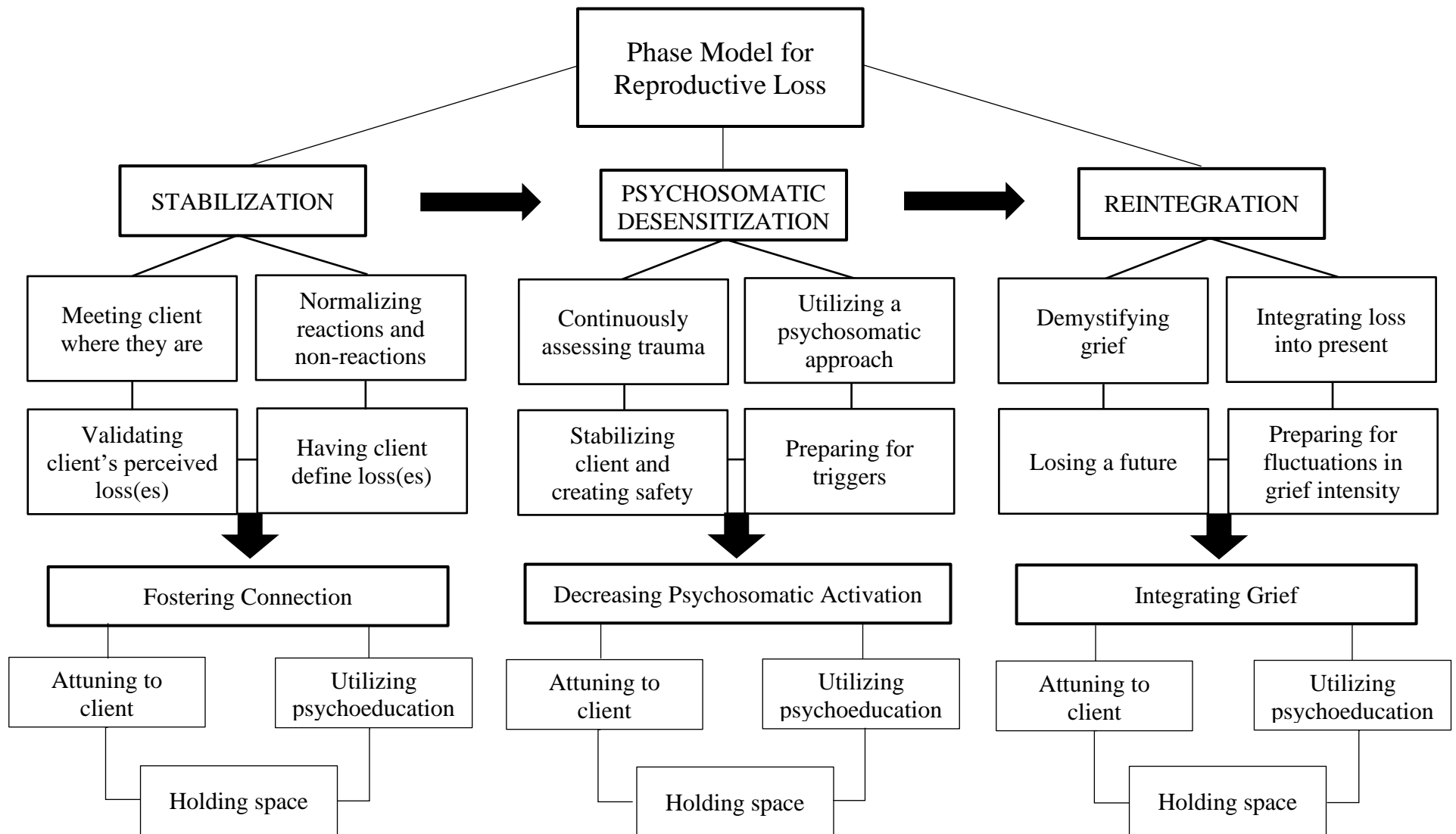
Integrating Grief. The data revealed the following four focused codes as being necessary components to integrating grief: (a) integrating loss into present, (b) losing a future, (c) demystifying grief, and (d) preparing for fluctuations in grief intensity.

Using the Phase Model for Reproductive Loss

Therapeutic approaches vary based on several variables, such as the practitioner's frame of reference based on training and experience, the practitioner's conceptualization of the client's reproductive loss experience, and the co-construction of therapeutic movement toward change. The model developed in this study is intended to have structured flexibility, meaning practitioners from every training backgrounded, educational experience, cultural context, and theoretical framework can move through the phases without abandoning the integrity of their therapeutic foundation. Implementing all six conceptual categories within the model, the Model for Reproductive Loss consists of three phases: (a) stabilization, (b) psychosomatic desensitization, and (c) reintegration. (See Figure 3.)

Figure 3

Phase Model for Reproductive Loss



Phase 1: Stabilization

Client stabilization is only attained by fostering connection within the therapeutic alliance. In this phase, the conceptual category of attuning to the client is essential in cultivating therapeutic rapport. Elina offered, “Rapport is *a lot* of it; to feel like they’re not alone, someone’s hearing them.” Holding space for the client starts in the first interaction and continues throughout the therapeutic process. In the stabilization phase, holding space shows the client that the therapist is “someone to walk beside you,” (Lilith) and someone who is “companioning” the client (Serena). Utilizing psychoeducation in the stabilization phase is supported by Lilith’s statement, “Psychoeducation – one of the very first things I’m doing so they don’t feel like they’re going crazy.”

Meeting the Client Where They Are. The first part of stage one is “showing up” for the client (Lilith) and “not assuming things” (Tina). Tina describes acknowledging the client’s personhood by “not just seeing them as a client but seeing them as a human.” Double Rainbow builds on this sentiment by discussing the energy practitioners exude while holding space in the stabilization phase of the therapeutic process. They suggest, “‘I’m really glad you’re here’—I don’t think we stop enough to do that. And what that transmits is it transmits ‘You haven’t scared me off. I can handle this with you. I care about you, and you matter.’”

Validating Client’s Perceived Loss(es). Validating the client’s perceived loss(es), as opposed to medical definitions of what constitutes a loss, is a critical aspect of fostering connection in the stabilization phase. Tina supports the validation of clients’ subjective experiences by stating, “All losses are equal and equally as painful; but all losses aren’t the same.” Validating the loss also communicates the clinician’s knowledge and sense of safety in discussing the loss as the client experienced it.

Normalizing Reactions and Non-reactions. Psychoeducation is a core component in normalizing reactions and non-reactions in clients. Daphne describes client expressions as “reported feelings of emptiness” and “all-consuming.” She provides the example many clients experience as, “I can get up, I can go to work, but like, I’m just sort of here. I’m not...I’m not really thinking through things. I can’t...I can’t sort of integrate things, articulate things, I can’t comprehend things.” Pointing out that it would, in fact, be abnormal if clients were able to resume with usual activities subsequent to the loss is normalizing and increasing client’s sense of control and stability.

Having Client Define Loss(es). The perception of reproductive loss held by the client within their culture is the core component in conceptualizing the current and future impact of the loss. Medical terms used to define losses often incite blame (e.g., “miscarriage” implying one “carried incorrectly”). To avoid subconscious and conscious biases, allowing the client to define their loss is crucial. It is also the first step in clients regaining a sense of control over their reproductive narratives.

Phase 2: Psychosomatic Desensitization

The second phase of the model, psychosomatic desensitization, consists of decreasing the client’s psychosomatic activation. In this phase, attuning to the client is critical to avoid retraumatizing the client. Holding space for the client’s trauma allows the client to feel as though they are able to hold space for their own trauma. Utilizing psychoeducation in this phase of the model includes normalizing clients’ reported activation by providing neuroscientific evidence of ego-syntonic and ego-dystonic thoughts. For example, clients who previously experienced reproductive loss often report feelings of distress attributed to the inability to bathe their subsequent living baby from fear of the infant drowning. The client’s felt sense of being an ill-

equipped parent warrants the clinician be knowledgeable about trauma responses often being protective measures. In this example, differentiating between ego-syntonic thoughts (e.g., “that sounds like a good idea to me”) versus ego-dystonic thoughts (e.g., “that sounds horrible to me”) would shift the client’s concept of self as a parent from being ill-equipped to instead being protective.

Continuously Assessing Trauma. In assessing trauma in clients, the clinician must be knowledgeable about the physiological presentation of trauma, the client’s baseline activation when beginning therapy, and how the activation fluctuates. Consistent use of assessments such as the Subjective Units of Distress Scale (SUDs) would reveal shifts in trauma activation. When assessing trauma, participants point out the importance of the clinician acknowledging the physical processes clients might dismiss. Daphne highlights the physical aspect of reproductive loss by stating,

Miscarriage—any pregnancy loss—it’s not a one and done. It’s not like you go to the bathroom, you’re bleeding, and that’s it. Like, it’s a process; the actual *physical* process is a process. But then that emotional process, it is not...yeah, it’s not, “Okay. My next cycle I’m ready to try again.”

Stabilizing Client and Creating Safety. Unfortunately, many participants described how clients’ previous experiences of being minimized or silenced shows up in the establishment of safety and trust within the therapeutic relationship. Elina provides the following example from their work with clients:

Because a lot of times, in some of the stuff I work with, I hear a lot of “nobody was listening to me. No one heard what I wanted. No one was answering my questions. No one believed me when I said I was in pain and they *still* did the c-section anyway.” Ah!

[expressing frustration] “No one heard me when I said, ‘please don’t put me under general anesthesia’ but they did it anyway.”

Elina furthers the emphasis of creating safety as a lack of felt safety could inhibit any and all therapeutic interventions. “EMDR is an intervention, but if they don’t feel safe enough in the relationship then they won’t go there,” (Elina).

Utilizing a Psychosomatic Approach. As evidenced by the case study and interview responses regarding therapeutic processes, decreasing somatic activation is suggested to be done by using psychosomatic approaches such as Brainspotting and EMDR. Serena describes the intention of utilizing EMDR in her approach to decreasing client activation as, “Turning the volume down on the memory; not changing it or decreasing the value of it.” Emphasizing the necessary component of decreasing psychosomatic activation to process the grief following loss, Double Rainbow states, “Some people aren’t able to tap into the grief because they’re so traumatized.”

Preparing for Triggers. Utilizing psychoeducation in the second phase is critical in preparing clients for upcoming triggers. Tina describes the use of psychoeducation normalize client activation by saying, “You’re never going to forget a loss or a traumatic event. You can learn how to live with it; how to cope through it when you are triggered.” Tina reports client change in this area is measured “by the client integrating the trauma into a life narrative in a way that yields a more fair, compassionate, coherent and continuous sense of self and relatedness to others.”

Phase 3: Reintegration

The final phase of the model, reintegration, warrants the use of the components found within the conceptual category of integrating grief. In this phase, attuning to the client is

important in understanding how cultural norms impact the rituals clients choose to integrate. Holding space in this phase would act as a model for which the client can recognize that other individuals have the capacity to hold space for the client's grief as well. The reintegration phase is also an appropriate time to incorporate social support within the therapeutic process in the form of therapeutic groups or appropriate support groups.

Demystifying Grief. Daphne articulates the question most clients ask after experiencing reproductive loss: "How do I grieve something—someone—I never knew?" The disenfranchised grief resulting from the ambiguous loss leaves clients "feeling stuck," (Elina). Utilizing psychoeducation in the reintegration phase seeks to normalize integrating the loss despite clients feeling like they have broken an understood societal grief rule. "A loss will inspire grief; it's just a question of when and how," (Double Rainbow).

Losing a Future. Holding space for clients as they express losing a future along with the reproductive loss is described by Jessie as, "Developing a clear understanding that this loss is carried the rest of the client's life and how to manage those moments - holidays, would-be graduation dates, etc." further suggesting clients "make a way to carry that child and our grief forward in life in non-intrusive ways."

Integrating Loss into Present. Angelica articulates integrating the loss into the present in her third therapeutic process as, "After processing through Brainspotting, I would then work with the client on the narrative surrounding her life." The narrative approach Angelica suggests is intended to "help the client to understand what her previous narrative of her life was, what it is now, and what it can be after this type of loss." Tina measures client change in reintegration as the "ability to reconcile with oneself and reconnect with others."

Preparing for Fluctuations in Grief Intensity. Psychoeducation is a key component in the ongoing process of grief, as waves of grief await each milestone that was not met as a result of the loss. Providing insight into the life-long allows clients to give themselves permission to grieve rather than feeling as though they have regressed.

Findings by Research Questions

The following section presents the study's findings through the lens of each research sub-question. For the purpose of this chapter in presenting the results of the data, findings for the research questions are presented primarily as participant responses. Existing literature and empirical evidence to support the responses will be discussed in the following chapter.

Sub-question 1: Cultural Perceptions

Seeking to illuminate cultural perceptions impacting how practitioners work with this population, the first sub-question asks, "How do cultural perceptions of perinatal loss influence mental health practitioners' work with perinatal loss clients?" When asking this research question, I had done so to further understand how the therapists themselves were influenced by cultural perceptions regarding perinatal loss. The participants provided a wealth of insight, however, into how practitioners' work is not only influenced by their own biases, but also by each client's perception, the perceptions held by the client's support system, the way in which the client's culture views reproductive loss, and how the client's partner perceives the loss. Double Rainbow describes how cultural perceptions shape the way in which we handle loss as a society by saying, "We're terrible with loss. We're terrible with death. We're terrible, as a whole, at even discussing it even when it's not tragic." Serena builds off this notion by expressing the impact cultural perceptions have on the therapeutic process:

When it comes to cultural perceptions, that includes clinicians so it's not in our body of knowledge where even if you haven't had training, you still have some basic information, right? Like, as clinicians, I'm not an addiction specialist by any means, but I have a basic knowledge to be able to not do harm, get somebody on the right path. Whereas with perinatal loss, I think people don't even have that unless they themselves have invested in training, or they've had their own experience – and I'm definitely not implying that their own experience is equal to training – but unless they've kind of been immersed in it for whatever reason, there's not a minimum body of knowledge that could help a clinician provide the basic support whenever more expertise isn't available. And so what happens is not only are they unable to do that, unfortunately—and not all the time—it can then lead to doing things that are harmful.

Sub-question 2: Grief and Trauma

To further understand how practitioners work with grief and trauma in this population, the second sub-question asks, “How do mental health practitioners approach working with grief and trauma, separately and concurrently, when working with perinatal loss clients?” Lilith describes the pervasive impact of reproductive loss as, “It's a biological, psychological, social event.” As such, participant responses aligned in how trauma symptoms are recognized first in order to create a sense of safety and stability to process the loss. Daphne speaks to the physical part of reproductive loss highlighting the “physical trauma of delivering a dead baby” which can cause the gestational carrier to experience their own body as a trigger. For example, “trying to have intercourse for the first time” and “seeing blood at following cycles” can bring clients back to the traumatic experience of the loss (Daphne). Elina concisely stated, “I see it as trauma every time.”

The physical impact of reproductive loss is also present in recognizing the presentation of grief when clients report increased sadness from physical results of their loss, such as their breastmilk coming in and being home-bound as they recover from procedures or birth. The emotional impacts of reproductive loss are compounded by hormonal and psychological shifts intended to prepare for pregnancy and childbirth, which can further intensify grief. When working with both grief and trauma, the phase model reflects the results of the data revealing the therapeutic alliance itself is the most identified integral aspect of the therapeutic process when working with grief and trauma. Despite participants' shared views on utilizing a trauma-informed approach of some kind, and integrating the client's grief, all participants ultimately identified the therapeutic relationship as the foundation from which all other therapeutic processes are built.

Sub-question 3: Clinical Methods

Investigating clinical methods used to work with this population, sub-question three asks, "Which therapeutic approaches inform mental health practitioners' use of clinical methods, treatment planning, and therapeutic interventions when working with perinatal loss clients?" Throughout all data, the primary source of measuring therapeutic effectiveness points to the subjective perspective of the client and what the client perceives as impairing function the most. Also highlighted throughout the data sources is the importance of addressing the traumatic nature of reproductive loss. As depicted in the first phase of the model, fostering connection to promote therapeutic attunement is shown in the case study responses as being the pivotal first step in recognizing the client's perceived traumatic response and resulting impairment. Holding space for the client and continuous therapeutic attunement is necessary to effectively utilize trauma interventions without causing harm. The common factor among all data sources and participant

responses is shown is Lilith's response to the case study: "Clinical acumen and assessments are helpful, but the client will ultimately determine if therapy has been effective."

Sub-question 4: Clinical Barriers

The final sub-question aims to identify therapeutic barriers by asking, "What therapeutic barriers do mental health practitioners face when working with perinatal loss clients?" The primary therapeutic barrier identified by participants includes inaccessibility to care, which can ultimately impact continuity of care within the therapeutic process as well as with other healthcare providers. Amelia points out the impact of community support by writing, "Client retention and lack of available community resources to fully support her psychiatric and physical health needs." Echoing the importance of receiving equitable care, Lilith points out the therapist's role in supporting the client's accessibility to therapy by listing challenges as, "Getting client sufficient resources that are culturally appropriate, affordable, and realistic for and/or preferred by client. Getting client to keep coming back. Barriers to treatment including i.e., insufficient transportation, babysitting etc." Even with community support and accessibility to resources, the therapeutic process is still impacted by the care, or lack of care, clients receive from other healthcare providers. This therapeutic challenge is outlined in Double Rainbow's response:

Managing [the client's] expectations of other providers (OB, primary care, psychiatrist) of what are the next best steps for this individual balancing her desires with her physical and emotional needs, it can be an artful dance to continue centering the client.

Summary

This chapter discusses the results of the iterative process of data collection and data analysis that began in the initial interview and continued throughout the process until completion

of the manuscript. Memos and constant comparison of data were tools used to maintain the integrity of the data by eliciting further investigation of emerging themes and gaps between categories (Charmaz, 2014; Charmaz & Thornberg, 2020; Fassinger, 2005). The recursive function of researcher reflexivity was an integral part of the process to illuminate emergent themes, focused codes, and conceptual categories throughout the entirety of the study while also asserting validity of the study (Pillow, 2003) and crystallizing the data (Ellingson, 2009). Crystallization adds to the trustworthiness of the study as it incorporates three genres of data sources, approaches the research with an interpretivist epistemological stance, and an ontological emphasis on celebrating subjective knowledge as part of the co-construction of multiple realities (Ellingson, 2009).

CHAPTER 5

Discussion

The following chapter provides a discussion of the results presented in the previous chapter. First, the philosophic foundations of the study are discussed by drawing parallels between constructivist grounded theory (CGT) and the therapeutic process, further emphasizing the appropriateness of the study's chosen methodological approach. Next, the findings of the study are discussed within the four main areas of inquiry (i.e., cultural perceptions, therapeutic approaches, clinical methods, and clinical barriers) as they relate to existing literature. Implications are provided specific to the research community, mental health practitioners, and clinical training. Prior to concluding the chapter, limitations and delimitations are presented, followed by recommendations for future research and my reflection of the research.

Philosophic Foundations

The results of this study further validate the appropriateness of employing a CGT approach to investigate the study's frame of inquiry. The way in which the participants co-construct the therapeutic process when working with clients who have experienced reproductive loss parallels the epistemological view of CGT in that knowledge is acquired through co-constructed interaction (Charmaz, 2014). Framing the study with the theoretical perspectives of symbolic interactionism and Relational-Cultural Theory is affirmed by participants' perspectives on therapeutically working with clients by fostering connection and using the clients' language. Emphasizing the acknowledgment of the subjective experiences of both the client and counselor, the therapeutic process further aligns with the study's methodological approach, which values the subjective views of the participants and researcher.

The axiological perspective held by CGT posits the researcher's values cannot be removed and are intrinsically related to the study's results (Charmaz, 2014). Furthermore, the paradigm's ontological stance highlights the interpretivist lens through which individuals subjectively perceive the existence of multiple realities. As such, the ontology and axiology warrant the use of researcher reflexivity to establish trustworthiness of the study. As mentioned in Chapter 3, utilizing reflexivity as a contributing factor to posit validity was done following what Pillow (2003) outlines as the four aspects of researcher reflexivity: (a) reflexivity as recognition of self (i.e., observation of self and awareness of self with others); (b) reflexivity as recognition of others (i.e., sound research is predicated upon understanding the subject of the research); (c) reflexivity as truth (i.e., prioritizing truth and capturing the participants' experiences); and (d) reflexivity as transcendence (i.e., moving past personal and cultural misrepresentations of participants). The results of this study, emphasizing the importance of acknowledging cultural biases to establish trust within the therapeutic process, also warrant therapeutic reflexivity.

Research Findings Related to Literature

To contextualize the Reproductive Phase Model within the broader context of empirical data, it is essential to uncover how the findings relate to clinicians, education and trainings, and the research community as a whole. The silencing and medicalizing of reproductive loss begins at the systemic level as societal messaging of reproductive loss labels the experience as "taboo" (Markin, 2017; Neiterman, 2013), representing an "unproductive reproductive process" (Hazen, 2003), and challenging the false sense of security found in our mastery-oriented society (Boss 2006; 2010; Boss & Carnes, 2012; Walter, 2020). As a result, mental health practitioners pose the risk of reenacting cultural misperceptions regarding reproductive loss, maintaining the loss as

being medicalized (Markin, 2017; Neiterman, 2013; Wright, 2011), silent, or invisible (Bennett et al., 2005; Cacciatore et al., 2008; Heifner, 2020; Lang et al., 2011). Markin emphasizes the climacteric role clinicians play in holding space for the bereaved parent writing, “they typically come to therapy feeling misunderstood, alone, unsupported, criticized, and often stigmatized,” (2017, p. 370). Thus, therapeutic effectiveness, as determined by the client’s subjective experience, is grounded in the relational processes of fostering connection, attuning to the client, and holding space for the client’s experience.

Existing research provides evidence for the relational distress individuals experience after reproductive loss, reporting increased isolation, social withdrawal, and being excluded from social groups (Garrod & Pascal, 2019; Heifner, 2020; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). The current study, however, sheds light on the level of impairment clients attribute to relational distress as evidenced by intensive interviews and being the second highest identified symptom in the case study. These results reiterate the critical aspects of fostering connection in the stabilization phase while continuing to hold space and attune to the client throughout the therapeutic process. Hiefner (2020) highlights the importance of normalizing and validating clients’ experiences by stating, “Normalization of miscarriage can reduce stigma and isolation, but paired with validation of the meaning of the loss, can help to prevent the loss from feeling minimized as trivial and commonplace,” (p. 60).

Markin (2017) suggests clinical guidelines are lacking despite the mounting data gathered regarding the biopsychosocial impacts “perhaps partly because as a society we tend to see pregnancy and pregnancy loss from the neck down,” (p. 368). Reinforcing the invisibility of reproductive loss and thickening the barrier to clinical knowledge, current diagnoses do not accurately describe the experience of reproductive loss as these losses are uniquely interwoven

with grief and trauma (Bennett et al., 2005; Markin & Zilcha-Mano, 2018; Randolph et al., 2015; Shannon & Wilkinson, 2020). Broadening the scope to the reproductive period in general, lack of accurate diagnoses can result in causing harm to clients by pathologizing adaptive behaviors as maladaptive instead. As evidenced by the current study, participants struggled to identify specific diagnoses by using language that implied they would select a diagnosis only if required to do so.

From the perspective of the study's conceptual framework, symbolic interactionism and Relational-Cultural Theory further reinforce the crucial aspect of practitioners being knowledgeable about the impact of reproductive loss. Inability to effectively communicate with clients about their deepest traumas creates disconnection and inhibits therapeutic effectiveness (Cohen et al., 2019; Doley & Zilcha-Mano, 2019; Jordan, 2010; 2013; Kress et al., 2018; Lenz, 2016; Miller, 1976-86; Miller & Stiver, 1997). Furthermore, evidence for the socialization of emotions sheds light on how therapeutic disconnection interferes with the client's co-construction of self after reproductive loss (Blumer, 1969; Charmaz et al., 2019; Crooks, 2001; Mead, 1962; Oliver, 2011). Based on the existing research and the current study, the therapeutic alliance is the most crucial component in facilitating client change. Without meeting the client where they are by providing psychoeducational tools founded in research and knowledge, clinicians threaten the trust and stability of the therapeutic alliance.

Implications

Clinicians

The clinical barriers reported by the participants and supported by the literature reveal clinical barriers are inextricably tied to cultural misperceptions of reproductive loss (Adebayo et al., 2019). Silencing discussions around reproductive loss inhibits practitioners' access to

knowledge on how to effectively work with clients who have experienced reproductive loss. Most participants in the current study reported mental health practitioners' lack of knowledge regarding reproductive loss as a massive therapeutic barrier which can ultimately lead to misdiagnosing clients and "pathologizing their experience," (Serena). Tina highlights this gap in knowledge for some practitioners that "may not understand everything this mother is carrying – guilt, shame, body isn't working how it's supposed to, how society says her body isn't working how it's supposed to." Double Rainbow describes a pitfall clinicians may encounter when they lack the knowledge necessary to effectively work with clients in the perinatal period as, "Normalizing things that aren't normal. Not knowing the difference between the baby blues and actual PMADs [perinatal mood and anxiety disorders]. Not knowing the difference between, like, acute distress and regular stress."

Education and Training

Mental health practitioners have the responsibility to not only hold space for clients in distress but should also possess the knowledge necessary in working with specific populations, such as reproductive loss. For clinicians to access this knowledge, increased feasibility, and accessibility to clinical trainings specific to reproductive loss are necessary. As shown in the data results, all participants responded with a resounding "no" when asked if they felt that their graduate programs in mental health prepared them to effectively work with reproductive loss clients. Many participants questioned why the impact of reproduction is shied away from completely, stating that they had not even discussed reproduction as it relates to the family system. Teaching conceptual models, such as the Reproductive Phase Model, would empower counseling students in feeling more competent and confident in working with traumatic loss in

any realm as it provides a flexible framework with which they can apply various techniques, utilize various theoretical orientations, and conceptualize clients from all cultural backgrounds.

Research

As researchers, we are charged with the task of making the unknown known; and, furthermore, illuminating the seemingly invisible aspects of what is perceived to be known. This begins with acknowledging that an occurrence exists, revealing the pervasive nature of the occurrence, and seeking to understand how change can be cultivated. Although diagnosing clients is not the goal of therapy, many clients require a diagnosis acknowledged by health insurance companies to afford mental health services. Without a diagnosis provided by mental health practitioners, health insurance companies will not acknowledge the need for therapeutic interventions following reproductive loss, thus making it unaffordable for most clients and seemingly unnecessary. Furthermore, without empirical evidence from which diagnostic criteria can accurately be formulated, mental health practitioners pose the risk of further perpetuating the disenfranchisement of reproductive loss by not acknowledging the existence of the experience and its pervasive impact. In essence, sound clinical effectiveness through graduate education and specialty trainings warrants further research into reproductive loss from the perspectives of the client, practitioner, and the health care system.

Limitations and Delimitations

Limitations of the study include the timeline established for the study for partial fulfillment of the doctoral requirements. With the research timeline, the number of participants could not be expanded as it would not be feasible. Delimitations of the study include the decision to select participants with the perinatal mental health certification obtained through Postpartum Support International as opposed to any perinatal certification. This certification was chosen as it

also establishes criteria for the participants that are inherently part of obtaining the certification. This distinction was also made based on accessibility to clinicians with this certification as it is obtained internationally.

Recommendations for Future Research

The results of this study beg to ask the question, “If we as a society are unable to define the experience of reproductive loss, how much more weight, then, are our clients carrying in trying to express the gravity of their losses?” Our system’s framework uncovers the unsettling inaccessibility, infeasibility, and lack of affordability to receiving care for reproductive loss. This dilapidated model of healthcare sends the ultimate message from which cultural perceptions of reproductive loss are conceived: Your loss does not matter; *you* do not matter. Thus, the recommendations for future research target four perspectives of the societal system in need of further research: (a) the societal perspective, (b) the clinical perspective, (c) the relational perspective, and (d) the client’s perspective.

From a societal perspective, future research regarding the effectiveness of establishing the terminology “reproductive loss” would be beneficial in exploring how this phrasing would, or would not, support practitioners, clients, and other healthcare professionals. Echoing the existing reproductive loss literature, the findings of this study reveal the impact cultural silencing has on reproductive losses even at the most fundamental level: not having a term to refer to individuals who experience the traumatic losses (Diamond et al., 2021; Wright, 2011; Jakoby, 2012; Loftland, 1985; Shear, 2012). Without a term there is no intersectionality among disciplines and research produced within each discipline; thus, reinforcing the existing gap in empirical evidence supporting the biopsychosocial impact of reproductive loss. A mixed-

methods study investigating the use of “reproductive loss” would begin the journey to establishing a universal term.

From a clinical perspective, reproductive loss research would benefit from conducting quantitative studies investigating the effectiveness of psychosomatic approaches, such as Brainspotting and EMDR, with perinatal mental health clients overall, and more specifically, when working with clients experiencing reproductive loss. Utilizing a standardized assessment (e.g., SUDs) would produce statistical data regarding decreased psychosomatic activation as it relates to number of sessions, duration of symptoms, etc. Furthermore, a quantitative study investigating psychosomatic approaches would support the results of the current study (i.e., effectiveness is based on client's perception) and would allow for therapeutic effectiveness to be measurable while also being subjective based on client's experience.

From a relational perspective, reproductive loss literature would be strengthened from qualitative studies illuminating the relational distress felt by loved ones closest to those who experience reproductive loss. Based on the results of the study, relational distress was among the top three areas of distress reported by clients to their clinicians. Uncovering the impact of reproductive loss on the client's closest network of support would strengthen connection between the client and those individuals, and would ideally decrease clients' experiences of feeling silenced.

Finally, further qualitative studies exploring what techniques are most instrumental in integrating grief from the client's perspective would provide insight for not only perinatal mental health practitioners, but for grief specialists as well. Qualitative studies would also further clinical understanding of how to work with reproductive loss clients by investigating what clients have found helpful, and hurtful, when integrating rituals, acts of memorializing, and

acknowledging painful milestones. We need intersectionality among disciplines to create holistic change within our overarching societal system as a whole and how it views reproductive loss. Change can only occur when those that have been silenced are heard from their own voices rather than spoken for by healthcare providers, social support, and the system overall.

Conclusion

Discussing the results of the qualitative study, this chapter provided support for the research findings with existing literature. The philosophic perspective of the constructivist grounded theory study is grounded in an interpretivist foundation and highlights the power of the subjective experience held by clients and practitioners, and how those ontological views impact the therapeutic process. Implications of the study are discussed followed by limitations and delimitations. The chapter concludes by outlining recommendations for future research in hopes the enfranchisement of reproductive loss has only just begun.

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Appendix A

IRB Approval Letter



Memorandum

Principal Investigator: Christopher Belser
Co-Principal Investigator: Heather Olivier
Date: November 8, 2022
Protocol Title: Therapeutic Approaches to Working with Perinatal Loss Clients:
A Grounded Theory Study
IRB Number: 01Nov22

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has deemed that the research and procedures of the above-named protocol are compliant with the University of New Orleans and federal guidelines and meet the standard for expedited IRB review according to:

A. Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. [...]

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Review of the submitted protocol indicated that all procedures are in compliance with 45 CFR 46. Any changes to the procedures must be reviewed and approved by the IRB prior to implementation. All approvals are valid for one year and can be renewed upon request.

I wish you much success with your research project. If you have any questions, please do not hesitate to contact me at 280-7481.

Sincerely,

A handwritten signature in blue ink that reads "Roberto Refinetti".

Roberto Refinetti, PhD
IRB Chair

Appendix B

Informed Consent



[Date]

Dear [Name of Prospective Participant],

I am a Ph.D. candidate in the Counselor Education and Supervision program at the University of New Orleans in Louisiana. For my dissertation research, I am conducting a qualitative study exploring how perinatal mental health certified clinicians (PMH-Cs) therapeutically approach working with clients who have experienced perinatal loss. The study will be conducted under the guidance of Dr. Christopher Belser and is entitled *Therapeutic Approaches to Working with Perinatal Loss Clients: A Grounded Theory Study*. The purpose of the study is to co-construct a therapeutic model addressing both grief and trauma symptoms presented in clients who have experienced perinatal loss by investigating three elements informing therapeutic approaches: (a) cultural perceptions of perinatal loss; (b) how the cultural perceptions impact the therapeutic relationship regarding establishing goals, measuring client change, and determining effectiveness; and (c) identification of barriers within the therapeutic process.

Your participation in the study is being requested based on your specialty work as a perinatal mental health certified clinician (PMH-C). Participation in the study would involve a virtual recorded interview via HIPPA Zoom lasting 45 to 60 minutes, a possible 15-minute follow-up interview for any additional questions I might have, and approximately 15 minutes for your conceptualization of a case study. In total, your participation would include no more than an hour and a half of your time. Participation is voluntary, and if at any point you should choose to remove yourself from the study, you have the freedom to do so without penalty or question.

The results of the study will be published in my dissertation manuscript with the possibility of future publications in academic research and/or presented at professional conferences. Your name and participation will be kept confidential throughout the duration of the study and for all time thereafter, and you will at no point be asked to discuss any client cases. Data collected throughout the study will be securely stored on a password-protected device to which I will be the only person having access. There are no foreseeable risks to you in

participating in the study; however, your participation would benefit other practitioners working with clients who have experienced perinatal loss by providing insight into your area of specialty regarding perinatal mental health. Your contribution to the mental health field will not only impact other practitioners, it will impact how perinatal loss clients experience the therapeutic relationship.

Should you choose to graciously accept my invitation to participate in the study, please sign your name in the space provided below and return the informed consent letter to me via email at hholivie@my.uno.edu to inform me of your decision to do so along with your preferred name and email address.

Thank you for your time and dedication to this field.

Sincerely,

Heather Olivier, M.S., LPC, PMH-C, CCTP, NCC
Ph.D. Candidate, Counselor Education and Supervision
School of Education
University of New Orleans
2000 Lakeshore Drive
New Orleans, LA 70148

By signing below, you are giving consent to participate in the above study, including your consent to be recorded during the virtual interview conducted using HIPPA Zoom.

_____	_____	_____
Signature	Printed Name	Date

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, please contact Dr. Roberto Refinetti at the University of New Orleans (504) 280-7481.

Appendix C

Recruitment Email

Dear [Name of Prospective Participant],

I hope this email finds you well. My name is Heather Olivier and I am a fellow perinatal mental health practitioner (PMH-C) as well as a Ph.D. candidate in the Counselor Education and Supervision program at the University of New Orleans in Louisiana. For my dissertation research, I am conducting a qualitative study exploring how perinatal mental health certified clinicians (PMH-Cs) therapeutically approach working with clients who have experienced perinatal loss. With your specialty training as a perinatal mental health certified clinician (PMH-C) and your specific knowledge of the perinatal period, I am reaching out to invite you to participate in the study.

As you know, there has yet to be a model specifically designed to work with clients who have experienced perinatal loss, which poses many challenges to working with this unique form of loss. My study, entitled *Therapeutic Approaches to Working with Perinatal Loss Clients: A Grounded Theory Study*, will be conducted under the guidance of Dr. Christopher Belser and aims to fill the gap in the literature regarding therapeutic approaches to perinatal loss. The purpose of the study is to investigate how perinatal mental health certified clinicians therapeutically approach working with perinatal loss clients, and to co-construct a therapeutic model addressing both grief and trauma symptoms presented in clients who have experienced this unique loss.

In total, your participation would include no more than an hour and a half of your time, which would involve a virtual interview via HIPPA Zoom lasting 45 to 60 minutes, a possible 15-minute follow-up interview for any additional questions I might have, and your conceptualization of a case study. Interviews will be conducted and case conceptualizations will be collected during the months of November and December 2022. Your name and participation will be kept confidential, and you will at no point be asked to discuss any client cases. Participation is voluntary, and if at any point you should choose to remove yourself from the study, you have the freedom to do so without penalty or question. There are no foreseeable risks to you in participating in the study; however, your participation would benefit other practitioners working with clients who have experienced perinatal loss by providing insight into your area of specialty regarding perinatal mental health.

Should you choose to accept my invitation to participate in the study, please email me at hholivie@my.uno.edu to inform me of your decision to do so along with your preferred name and email address. Additionally, please sign the attached informed consent letter outlining the details of the study and graciously return it via email. I will respond promptly so that we can schedule an interview at your convenience. Should you have any additional questions, do not hesitate to contact me at the previously listed email address.

Thank you for your time and dedication to this field.

Sincerely,

Heather Olivier, M.S., LPC, PMH-C, CCTP, NCC
Ph.D. Candidate, Counselor Education and Supervision
School of Education
University of New Orleans
2000 Lakeshore Drive
New Orleans, LA 70148

Appendix D

Interview Protocol

Cultural Perceptions of Perinatal Loss

Describe what you believe to be the cultural perceptions of perinatal loss.

- What experiences do you recall that informed these perceptions?
- How do you see others react and respond to perinatal loss?
- When you think of “perinatal loss” what words or images come to mind?

Describe how you believe cultural perceptions of perinatal loss impact how mental health practitioners approach working with perinatal loss clients.

- What roadblocks do you think practitioners face when working with this population?
- How do you think personal biases impact the interventions practitioners choose to use?

How, if at all, have your perceptions of perinatal loss changed through your training in perinatal mental health?

- How has your training impacted your own perception of this loss?

How, if at all, has your therapeutic approach to working with perinatal loss clients changed through your training in perinatal mental health?

- How is perinatal loss discussed among perinatal mental health specialists?
- Do perinatal mental health specialists use any variations in their work with this population that is different than other perinatal mental health clients?

Therapeutic Approach to Perinatal Loss

Describe your therapeutic approach when working with perinatal loss clients.

- Do you use a general approach, or does it change based on each perinatal loss client?
- How do you decide what the therapeutic goals are?

- What informs the direction you choose to take in the therapeutic process?

Describe how your theoretical framework influences your work with perinatal loss clients.

Describe your role in the therapeutic relationship when working with perinatal loss clients.

Grief and Trauma in Perinatal Loss

Describe how you recognize the presentation of grief when working with perinatal loss clients.

- What grief symptomology is present with this population?
- What interventions do you utilize to address grief symptoms?

Describe how you recognize the presentation of trauma when working with perinatal loss clients.

- What trauma symptomology is present with this population?
- What do you notice is different between trauma symptoms with this population versus other populations?
- What interventions do you utilize to address trauma symptoms?

Describe how you recognize the concurrent presentation of grief and trauma symptomology in perinatal loss clients.

- What interventions do you utilize to address the concurrent presentation of grief and trauma?

Therapeutic Barriers

Discuss the possible therapeutic barriers that exist between mental health practitioners and perinatal loss clients.

Discuss any therapeutic barriers that you have experienced, or could potentially experience, in your work with perinatal loss clients.

Appendix E

Case Study

The client is a 32-year-old, African-American female reporting what she believes to be symptoms of anxiety. The symptoms she describes are chest tightening, shortness of breath, feeling “panicked,” and inability to focus. She reports having no history of anxiety; however, the symptoms began approximately one month ago after she attended a baby shower where she experienced “what felt like a panic attack.” The client describes the baby shower event as “confusing” because the joy she felt for her friend quickly shifted into “anger, jealousy, and resentment.” She also mentions that while watching her friend open gifts, she felt like she was numb and disconnected from her body.

The client discloses that in September of 2020, at 21 weeks’ gestation, her first pregnancy ended in the baby being stillborn. It was determined at the 20-week anatomy scan that the baby had a fatal diagnosis with no chance of survival. Because of the COVID restrictions in place, the client was alone when she received the news. She was also alone at the subsequent birth and death of her child, which occurred two weeks after the anatomy scan. In addition to the anxiety symptoms, the client also reports recurring nightmares wherein she can see her baby, but is unable to get to him or her. Since the onset of symptoms, the client reports isolating herself from others and avoiding social situations. She is fearful of having another panic attack, and reports feeling that interacting with other people increases her anxiety.

Treatment Plan

What are the client’s presenting problems?

What, if any, diagnosis would you give the client?

Outline three therapeutic goals for working with this client.

Goal 1:

Therapeutic model to be used:

Interventions to be used:

How progress will be measured:

Goal 2:

Therapeutic model to be used:

Interventions to be used:

How progress will be measured:

Goal 3:

Therapeutic model to be used:

Interventions to be used:

How progress will be measured:

What therapeutic knowledge is necessary to be effective with this client?

How will overall therapeutic effectiveness be determined?

Vita

The author was born in New Orleans, Louisiana. She obtained her Bachelor's degree in psychology from Louisiana State University in 2015, her Master's degree in counselor education from Southeastern Louisiana University in 2017, and embarked on her Ph.D. in counselor education at the University of New Orleans in 2018.