Adultspan Journal

Volume 14 | Issue 1 Article 1

4-1-2015

Counseling Women Who Have Experienced Pregnancy Loss: A Review of the Literature

Amber L. Randolph

Brittany T. Hruby

Shaakira Sharif

Received 01/01/13
Revised —
Accepted 04/08/14
DOI: 10.1002/j.2161-0029.2015.00032.x

ARTICLES

Counseling Women Who Have Experienced Pregnancy Loss: A Review of the Literature

Amber L. Randolph, Brittaney T. Hruby, and Shaakira Sharif

The authors review pregnancy loss scholarly literature and discuss themes of silence, grief, psychological distress, role of social support, satisfaction with health care, and coping strategies from a counseling standpoint. Counseling needs of women who have experienced pregnancy loss are delineated, and recommendations for future research in this area are made.

Keywords: pregnancy loss, miscarriage, counseling

Approximately 17% of pregnancies in the United States in 2008 ended in spontaneous fetal death before birth (Centers for Disease Control and Prevention, 2012). This rate includes reported early losses, often referred to as miscarriage (Lim & Cheng, 2011), and losses later in the pregnancy, often referred to as stillbirths. For the purposes of this article, losses at all gestational periods are recognized and referred to as *pregnancy loss*.

With the occurrence rate around 17%, it is likely counselors working with women will encounter a client who has experienced pregnancy loss. However, scholarly literature on this topic in the counseling field is rather limited. Literature in counseling and other medical and helping fields was reviewed, and several common themes emerged: silence, grief, psychological distress, the role of social support, satisfaction with health care, and coping strategies. We discuss these themes briefly from a counseling standpoint, delineate the counseling needs of women who have experienced pregnancy loss, and provide a few recommendations for future research in this area.

SILENCE

Women who experience pregnancy loss often find themselves surrounded by silence, which can transcend all areas of their life. These women may experi-

Amber L. Randolph, Brittaney T. Hruby, and Shaakira Sharif, Graduate Counseling Program, Saint Xavier University. Correspondence concerning this article should be addressed to Amber L. Randolph, Graduate Counseling Program, Saint Xavier University, 3700 West 103rd Street, Chicago, IL 60655 (e-mail: arandolph@sxu.edu).

ence isolation as a result of the silence surrounding their loss, a silence that is perpetuated by friends, family, coworkers, medical professionals, and society in general (Bansen & Stevens, 1992). When loss is publicly recognized, grieving parties tend to receive more community support (Betz & Thorngren, 2006). Grief after miscarriage is often avoided by friends and family members of the grieving parents (Van, 2001). Even death itself is somewhat of a taboo topic in American society (Reif, Patton, & Gold, 1995). Added to this, miscarriage is not a disease or a medical condition. It is often not expected. Pregnancy loss is ambiguous; combined with the lack of publicity and discussion on the topic, it can add to the isolation and loneliness many women experience (Cohen, 2005).

Bansen and Stevens (1992) found that women were generally dissatisfied with the responses they received from others following their pregnancy loss. These women felt their friends and family diminished their loss, if they acknowledged the loss at all. Women reported feeling that others avoided them after their loss, and Bansen and Stevens attributed this avoidance to a general discomfort with the subject of miscarriage.

Consistent with these findings, Rowlands and Lee (2010) found that women's interactions with others were instrumental in how they experienced their pregnancy loss and that most women were distressed by a lack of support from significant people in their lives. Additionally, these women reported that they were shocked by the insensitivity of the comments made by others, including encouragements to "try again" and assurances that the loss was "for the best." In both studies (Bansen & Stevens, 1992; Rowlands & Lee, 2010), women emphasized the significance of their loss. Women who experienced pregnancy loss viewed the loss as a major life event (Bansen & Stevens, 1992) and felt that the meaning they had attributed to their loss was not understood by their partners or family members (Rowlands & Lee, 2010). Layne (1997) suggested that the cultural denial of pregnancy loss stems from the lack of a shared meaning between the women who experience the loss and their significant others, which she attributed to a lack of firsthand knowledge regarding pregnancy loss by those significant others.

Silence surrounding pregnancy loss is especially prevalent in the workplace and is evidenced by the lack of inclusion of any aspect of pregnancy loss in women's career development research and literature (Hazen, 2006). Hazen (2006) suggested that the silence is rooted in the idea that conversations about birth and death are considered taboo in the workplace and that research on women's career development fails to acknowledge any aspect of pregnancy loss. Additional research is needed to explore the obstacles women and men face in seeking bereavement leave from their employers following pregnancy loss and how this may contribute to the invalidation of pregnancy loss as a significant loss.

The often unsupportive, invalidating, and insensitive, albeit well-intentioned, responses of partners, family, friends, and coworkers to women who have experienced pregnancy loss may be attributed to a lack of cultural scripts and a public language that is dominated by medical jargon (Hazen, 2006; Layne

1997). Jonas-Simpson and McMahon (2005) compared medical terms and the possible meaning women may make from these terms and emphasized the role health care professionals may play in inadvertently minimizing the importance of the loss by using language that objectifies a woman's experience. Layne (1997) suggested that the terminology associated with pregnancy loss frames the loss as a medically unimportant event. Society and those attempting to support women who have experienced pregnancy loss have no cultural references from which to draw information, and the topic is not typically discussed in childbirth classes or literature (Layne, 1997). The silence and ambiguity that surround pregnancy loss do little to ease the associated grief.

GRIEF

Brier (2008) defined grief as the affective, physiological, and psychological reactions to the loss of an emotionally important figure, and it can include severe and prolonged distress. Women who experience pregnancy loss typically experience grief accompanied by feelings of guilt, emptiness, abandonment, and emotional detachment. Adolffson, Larsson, Wijma, and Bertö (2004) conducted a qualitative study in which participants shared their experiences and feelings associated with pregnancy loss. It was noted that after pregnancy loss, some women detached themselves from their families and were unable to stabilize their emotions (Adolffson et al., 2004).

Lim and Cheng (2011) acknowledged that the grief associated with pregnancy loss differs in many ways from the grief experienced after the death of another loved one. With a pregnancy loss, there is no shared history or memories of the loved one on which to reflect and remember; there is only the anticipated future that is no more. Grief after a pregnancy loss is healthy and even normal, but it can become prolonged and lead to psychological distress in some women.

PSYCHOLOGICAL DISTRESS

Some form of psychological distress often accompanies pregnancy loss (Brier, 2004; Broen, Moum, Bodtker, & Ekeberg, 2005; Carrera et al., 1998; Kong, Chung, Lai, & Lok, 2010; Lok & Neugebauer, 2007). Up to 50% of women who experience pregnancy loss also experience psychological symptoms following the loss (Lok & Neugebauer, 2007). The most common psychological issues resulting from pregnancy loss are depression and anxiety disorders, particularly obsessive-compulsive disorder and posttraumatic stress disorder (Brier, 2004; Broen et al., 2005; Lok & Neugebauer, 2007).

Experiencing pregnancy loss places women at high risk for depression (Mann, McKeown, Bacon, Vesselnov, & Bush, 2008). Carrera et al. (1998) found that women who have experienced pregnancy loss had higher levels of depression than women who had live births. Women experiencing pregnancy loss who received

12 months of psychological intervention fared better than those who did not receive the intervention with regard to depressive symptoms and, by the end of 1 year, had depressive levels more similar to women who experienced live births. Women who did not receive psychological intervention had also improved after 1 year with regard to depressive symptoms, but not to the extent of the other women who received psychological intervention or who had live births (Carrera et al., 1998). Kong, Chung, et al. (2010) echoed the idea that mental health implications following pregnancy loss can last up to a year following the loss.

Counselors should carefully consider the psychological implications of pregnancy loss, including both the risk of distress and protective factors. Some protective factors against the development of depression following pregnancy loss are absence of baseline depression, lack of mental illness history, and increased age (Mann et al., 2008). Social support is another potential protective factor for women who have experienced pregnancy loss.

SOCIAL SUPPORT

The role of social support is imperative to the healing process for women and their partners after a pregnancy loss. Abboud and Liamputtong (2005) found that family and friends were viewed as positive support systems for couples who have experienced pregnancy loss, and mothers and sisters specifically were named as key figures in the healing process. Participants stated that friends provided significant support through active listening and encouragement (Abboud & Liamputtong, 2005). Additionally, friends would help with household chores such as cooking and cleaning.

In contrast, participants felt older family members often blamed women for their pregnancy loss, which drew these women closer to their partners (Abboud & Liamputtong, 2005). Aside from close family and friends, community members were felt to provide an overwhelming amount of support and appeared understanding of the emotions the couples felt toward the pregnancy loss (Abboud & Liamputtong, 2005). It is clear that social support can be an important component in the healing process after pregnancy loss. Often the first nonfamily social interactions a woman will have after a pregnancy loss are with health care workers. The relationships with health care providers are a crucial part of a woman's adjustment to the news of pregnancy loss.

SATISFACTION WITH HEALTH CARE

Satisfaction with health care by women who have experienced pregnancy loss varies across the literature. Rowlands and Lee (2010) found that the majority of women interviewed were dissatisfied with the care they received, whereas Lasker and Toedter (1994) found only 11% of women interviewed reporting feeling dissatisfied. Several themes emerged from the literature regarding women who

were dissatisfied with the care they received following pregnancy loss, including insensitivity and a lack of empathy on the part of the health care providers, invalidation of the loss, and a lack of information provided (Lasker & Toedter, 1994; Rowlands & Lee, 2010).

Lasker and Toedter (1994) found that satisfaction was dependent on the quality of interactions between the couple and their health care providers and that one of the most common complaints of the women interviewed was a lack of sensitivity on the part of the health care worker. Twenty-one percent of the women in Lasker and Toedter's study reported feeling that the medical staff should have been more attentive to their needs. Geller (2012) found that 79% of women reported not being asked by their health care providers how they were doing during their experience, which is consistent with previous studies' findings that women who are dissatisfied with the health care they received report insensitivity on the part of their health care providers.

Additional complaints with regard to dissatisfaction with health care focused on the lack of information provided by health care professionals to women who have experienced pregnancy loss. Abboud and Liamputtong (2005) found that the information women received from their health care providers following pregnancy loss was minimal and inadequate. Kong, Lok, Lam, Yip, and Chung (2010) discovered that one out of 10 health care workers was unaware that pregnancy loss could have psychological implications for women. It is possible that health care professionals are unaware of the emotional trauma women can experience following nonmedically dangerous pregnancy loss and therefore act insensitively.

However, not all experiences with health care workers after a pregnancy loss are negative. Several factors contribute to women's positive experiences with health care during and after pregnancy loss. Geller, Psaros, and Kornfield (2010) concluded that women who were satisfied with the care they received felt that their health care providers had acknowledged the magnitude of their loss. Additionally, Abboud and Liamputtong (2005) identified understanding, caring, and listening as aspects that related to women's positive experiences with health care following pregnancy loss. Lasker and Toedter (1994) found that women who had experienced interventions following their loss were significantly more satisfied with their health care than those who had not.

COPING STRATEGIES

Following pregnancy loss, women are faced with processing the physical and emotional aftermath. After being discharged from the hospital or leaving the doctor's office, women are often not fully aware of the physical and emotional aftermath, what to expect, and the available resources. With this lack of preparation and support, many women often suffer in silence and are unsure how to process the emotions they experience. Having therapeutic coping strategies is the first step for the healing process after pregnancy loss.

Van (2012) led a study to gain insight on ways in which women cope after pregnancy loss and the level of need for more effective coping methods. Women who participated in the study felt that having time to be introspective and reflect on their miscarriage helped them cope. Positive conversations with others were also a way for women to begin the healing process. Through these conversations, women were able to have someone listen to their feelings and sometimes find someone who had also experienced pregnancy loss. Some women, however, internalize their grief by masking their feelings and not engaging in any conversations about their pregnancy loss. Counselors can facilitate this introspection on the part of women who have experienced pregnancy loss, as well as to help women make sense and meaning of their loss.

COUNSELING NEEDS

With the relatively high prevalence rate of pregnancy loss, it is likely that a counselor will work with a client who has had this type of loss at some point. In addition, based on the level of psychological distress associated with pregnancy loss, it would appear that the counseling implications are great for working with these women. However, pregnancy loss has not yet been explored much in the counseling-specific literature. Although the nursing and medical fields, as well as other helping fields such as psychology and social work, have explored the topic of counseling needs after pregnancy loss (Gerber-Epstein, Leichtentritt, & Benyamini, 2009), the counseling field has yet to do so in an in-depth manner.

Bennet, Ehrenreich-May, Litz, Boisseau, and Barlow (2012) completed a pilot study during which they used cognitive-behavioral counseling strategies to work with five women who had suffered pregnancy loss. The goals of their study were to teach emotional regulation and encourage social support for these women, as well as to improve self-efficacy while dealing with the grief associated with pregnancy loss. Bennet et al. explained that the results of these interventions did lead to decreased grief symptomatology for most of the women, though not to a significant level.

The women in Bennet et al.'s (2012) study indicated through qualitative questioning that the most helpful aspects of the counseling sessions were the psychoeducation regarding emotions and emotional regulation, the normalization of intense emotions, and simply having a supportive and nonjudgmental clinician with whom to discuss their pregnancy loss. Brier (2004) and Trepal, Semivan, and Caley-Bruce (2005) echoed these same counseling needs by emphasizing how important it is for counselors to listen to clients as they discuss their pregnancy loss, validate the experience of loss, and normalize the associated feelings.

Counseling needs with regard to pregnancy loss can be complex and different for every person. However, an important therapeutic concept is for clients to feel heard and have their loss and their story acknowledged by another person (Trepal et al., 2005). In Gold, Boggs, Mugisha, and Palladino's (2012) study regarding the use of Internet support groups after a pregnancy loss, the majority

of participants explained that the support groups helped them feel heard and feel less isolated in their experience. In fact, a suggestion from participants in the individual counseling provided by Bennet et al. (2012) was for a group counseling component to be present within the treatment. This is a counseling delivery method that could be further explored.

Although the complex needs and situations of each client make it challenging to be prescriptive in how a counselor should conduct therapy with a client who has experienced pregnancy loss, a few common threads have emerged from the albeit limited counseling literature on this topic. It is important, first and foremost, for counselors to actively and empathically listen as a client tells her story, acknowledge the loss that occurred, and normalize the associated feelings (Bennet et al., 2012; Trepal et al., 2005). Psychoeducation concerning emotions and emotional regulation can also play a role in helping to decrease grief symptomatology (Bennet et al., 2012). Further research on this topic from a counseling perspective is clearly needed.

RESEARCH NEEDS

Research on the experience of pregnancy loss is somewhat represented in the professional literature across the medical and helping professions, although it is still in its infancy, especially in the United States. This is particularly true in the counseling field, because much of the available research comes from the medical, nursing, and psychology professions. Those who have researched pregnancy loss have recommended the continued exploration of this important topic.

There is a call for increased sample sizes in pregnancy loss research (Abboud & Liamputtong, 2005; Bennett et al., 2012) to increase the generalizability of the information gained through research. More representative samples are also warranted, as opposed to the sometimes homogeneous convenience samples often cited in literature (Brier, 2008; Geller et al., 2010). Large, diverse samples in future research is ideal; however, Bennett et al. (2012) cautioned that without an established presence in an environment frequented by individuals who have experienced pregnancy, recruitment for participation in pregnancy loss research can be challenging.

Because pregnancy loss is often an ambiguous and sensitive topic, researchers usually conduct qualitative studies to provide an open area for women and couples to discuss their experiences and emotions. There is a call for more qualitative (Abboud & Liamputtong, 2005; Chan & Arthur, 2009) as well as quantitative (Brier, 2008) research on the topic of pregnancy loss, with calls for qualitative interviews and focus groups for the former and a standardized measure specifically for grief in pregnancy loss for the latter. Brier (2008) also advocated for consistency in language regarding pregnancy loss and miscarriage and an operational definition of grief grounded in scholarly literature. Geller et al. (2010) advocated for specificity in the operational definitions of therapeutic responses to pregnancy loss, such as compassion. It is clear that there are many appropriate ways to approach research on pregnancy loss.

The range of topics that have not yet been fully explored in pregnancy loss research is broad and encompasses many factors. Further research includes the woman's grief reactions after pregnancy loss (Brier, 2008), psychological distress, and the role of the passage of time and the satisfaction with care after a pregnancy loss (Geller et al., 2010). Additionally, Abboud and Liamputtong (2005) and Chan and Arthur (2009) suggested a need for further research regarding the reactions of the father, family member(s), and health care providers to pregnancy loss in an attempt to further understand the context in which the women are functioning.

FUTURE IMPLICATIONS AND CONCLUSIONS

This article reviewed scholarly literature regarding pregnancy loss in many fields, both medical and nonmedical, and several common themes emerged. There is a silence as well as ambiguity that surrounds pregnancy loss, leaving those affected unsure of how to respond to this tragedy. The grief associated with pregnancy loss is often profound and can lead to psychological distress. This psychological distress often presents in the form of depression or anxiety disorders and can remain well after the loss. Social support and positive interactions with health care workers can help women to cope with pregnancy loss, although at times these interactions are not helpful or positive.

Although interactions with primary health care professionals are important following pregnancy loss, Kong, Lok, et al. (2010) found that most participants preferred the care of a specialist when dealing with the aftermath of a pregnancy loss. Counselors can be effective in this regard, helping clients to share their story, acknowledging the loss, normalizing associated feelings, and providing resources. According to Brier (2004), it is important to screen for symptoms of anxiety, grief, and depression after a pregnancy loss, a task for which counselors in particular are qualified.

Additional research is needed so counselors can become better at identifying and advocating for women in need of mental health care after a pregnancy loss (Bennett et al., 2012; Geller et al., 2010). Gerber-Epstein et al. (2009) and Kong, Lok, et al. (2010) emphasized that pregnancy loss and its prevalence must be pushed into public awareness and answers be provided to families in need. Counselors are in a prime position to provide advocacy and education regarding the needs of families following pregnancy loss.

REFERENCES

Abboud, L., & Liamputtong, P. (2005). When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners. *Journal of Reproductive and Infant Psychology, 23,* 3–18. doi:10.1080/02646830512331330974

Adolffson, A., Larsson, P., Wijma, B., & Bertö, C. (2004). Guilt and emptiness: Women's experiences of miscarriage. *Health Care for Women International, 25,* 543–560.

Bansen, S., & Stevens, H. (1992). Women's experiences of miscarriage in early pregnancy. *Journal of Nurse-Midwifery, 37,* 84–90.

Bennet, S. M., Ehrenreich-May, J., Litz, B. T., Boisseau, C. L., & Barlow, D. H. (2012). Development and preliminary evaluation of a cognitive-behavioral intervention for perinatal grief. *Cognitive and Behavioral Practice, 19,* 161–173.

Betz, G., & Thorngren, J. M. (2006). Ambiguous loss and the family grieving process. *The Family Journal: Counseling and Therapy for Couples and Families, 14,* 359–365.

Brier, N. (2004). Anxiety after miscarriage: A review of the empirical literature and implications for clinical practice. *Birth, 31,* 138–142.

Brier, N. (2008). Grief following miscarriage: A comprehensive review of the literature. *Journal of Women's Health, 17,* 451–464.

Broen, A., Moum, T., Bodtker, A., & Ekeberg, O. (2005). The course of mental health after miscarriage and induced abortion: A longitudinal, five-year follow-up study. *BMC Medicine, 3,* 18. doi:10.1186/1741-7015-3-18

Carrera, L., Diez-Domingo, J., Montanana, V., Monleon Sancho, J., Minguez, J., & Monleon, J. (1998). Depression in women suffering perinatal loss. *International Journal of Gynecology & Obstetrics, 62,* 149–153.

Centers for Disease Control and Prevention. (2012). *Estimated pregnancy rates and rates of pregnancy outcomes for the United States 1990–2008.* Retrieved from https://www.cdc.gov/nchs/datalnvst/nvsr60/nvsr60_07.pdf

Chan, M. F., & Arthur, D. G. (2009). Nurses' attitudes towards perinatal bereavement care. *Journal of Advanced Nursing, 65,* 2532–2541.

Cohen, J. (2005). *Coming to term: Uncovering the truth about miscarriage.* New York, NY: Houghton Mifflin.

Geller, P. A. (2012). The role of emerging technology in women's response to pregnancy loss. *Expert Review of Obstetrics and Gynecology, 7,* 19–23.

Geller, P. A., Psaros, C., & Kornfield, S. L. (2010). Satisfaction with pregnancy loss aftercare: Are women getting what they want? *Archives of Women's Mental Health, 13,* 111–124. doi:10.1007/s00737-010-0147-5

Gerber-Epstein, P., Leichtentritt, R., & Benyamini, Y. (2009). The experience of miscarriage in first pregnancy: The women's voices. *Death Studies, 33,* 1–29.

Gold, K. J., Boggs, M. E., Mugisha, E., & Palladino, C. L. (2012). Internet message boards for pregnancy loss: Who's on-line and why? *Women's Health Issues, 22,* 67–72.

Hazen, M. A. (2006). Silences, perinatal loss, and polyphony: A post-modern perspective. *Journal of Organizational Change Management, 19,* 237–249.

Jonas-Simpson, C., & McMahon, E. (2005). The language of loss when a baby dies prior to birth: Cocreating human experience. *Nursing Science Quarterly, 18,* 124–130.

Kong, G. W., Chung, T. K., Lai, B. P., & Lok, I. H. (2010). Gender comparison of psychological reaction after miscarriage: A 1-year longitudinal study. *BJOG: An International Journal of Obstetrics and Gynaecology, 117,* 1211–1219. doi:10.1111/j.1471-0528.2010.02653.x.

Kong, G. W., Lok, I. H., Lam, P. M., Yip, A. S., & Chung, T. K. (2010). Conflicting perceptions between healthcare professionals and patients on the psychological morbidity following miscarriage. *Australian & New Zealand Journal of Obstetrics & Gynaecology, 50,* 526–567. doi:10.1111/j.1479-828X.2010.01229.x.

Lasker, J. N., & Toedter, L. J. (1994). Satisfaction with hospital care and interventions after pregnancy loss. *Death Studies, 18,* 41–64.

Layne, L. L. (1997). Breaking the silence: An agenda for a feminist discourse of pregnancy loss. *Feminist Studies, 23,* 289–315.

Lim, C., & Cheng, N. (2011). Clinician's role of psychological support in helping parents and families with pregnancy loss. *Journal of the Australian Traditional Medicine Society, 17,* 215–217.

Lok, I. H., & Neugebauer, R. (2007). Psychological morbidity following miscarriage. *Best Practice & Research Clinical Obstetrics & Gynaecology, 21,* 229–247.

Mann, J. R., McKeown, R. E., Bacon, J., Vesselnov, R., & Bush, F. (2008). Predicting depressive symptoms and grief after pregnancy loss. *Journal of Psychosomatic Obstetrics and Gynaecology, 29,* 274–279.

Reif, L. V., Patton, M. J., & Gold, P. B. (1995). Bereavement, stress, and social support in members of a self-help group. *Journal of Community Psychology, 23*, 292–306.

Rowlands, I. J., & Lee, C. (2010). "The silence was deafening": Social and health service support after miscarriage. *Journal of Reproductive and Infant Psychology, 28,* 274–286. doi:10.1080/02646831003587346

Trepal, H. C., Semivan, S. G., & Caley-Bruce, M. (2005). Miscarriage: A dream interrupted. *Journal of Creativity in Mental Health, 1,* 155–171.

Van, P. R. (2001). Breaking the silence of African American women: Healing after pregnancy loss. *Healthcare for Women International, 22,* 229–243.

Van, P. R. (2012). Conversations, coping, and connectedness: A qualitative study of women who have experienced involuntary pregnancy loss. *Omega (Westport), 65,* 71–85.