Chains of Grief: The Impact of Perinatal Loss on Subsequent Pregnancy

Author: Peterson, Gayle

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Full Text: Headnote ABSTRACT: This paper identifies women who are at greater potential for medical complications in their pregnancies due to post traumatic stress resulting from previous perinatal loss. The loss may have been suffered by the woman herself during a past pregnancy or she may have inherited heightened anxiety from perinatal loss experienced by her mother. In the latter case, the unresolved grief is transmitted from mother to daughter, affecting physiological, emotional and behavioral patterns in the next generation. Pregnancy presents an opportunity for healing. Given effective prenatal counseling by a trained clinician, perinatal loss issues can be addressed through body-centered hypnosis so that history does not repeat itself. Left untreated, post traumatic stress can produce crippling anxiety for the pregnant woman, contributing to complications of pregnancy, childbirth and even parenting. The family who loses a newborn infant (or fetus through miscarriage or stillbirth) endures a deep tragedy. When asked, many families who have experienced perinatal death have said that the death of a newborn hurts as much as the death of an older child, spouse or parent. The loss is different: one mourns unfulfilled life. However, the love and expectations that go into anticipating a life that will not be fulfilled are usually greatly underestimated by those who have not experienced such a loss. Richard Marshall Medical research has documented the impact of emotional stress on the outcome of pregnancy and childbirth (Lederman, et al., 1978; Levenson and Shnider, 1979; Gotsuch and Key, 1974, Peterson et al., 1988) as well as substantiating a critical period for bonding. (Klaus et al., 1972; Kennel, et al., 1975). The impact of emotional support on the length of labor and facilitation of maternal-infant interaction immediately following birth has also verified the importance of the emotional and psychological aspects of medical care during the perinatal period (Sosa, et al., 1980). However, little research has been done on the impact of perinatal loss on subsequent pregnancy and prenatal bonding, despite the fact that it is one of the most emotionally charged issues that a woman may have to deal with during the course of a subsequent pregnancy. Although some authors have attempted to identify the needs of bereft parents (Benreid and Nichols, 1981; Marshall, 1981) there has been little research done to explore the impact on a subsequent pregnancy, or information about what can be done to help women resolve grief prenatally. The purpose of this paper is to share the importance of addressing these needs during pregnancy, and the use of body-centered hypnosis in the context of a preventive prenatal counseling program as a method of choice to reduce anxiety and resolve loss, making way for the potential birth of another child. Women who have endured previous perinatal loss have greater emotional adjustments to a new pregnancy, including fear of another loss, which has impact not only on attachment to the unborn fetus but also may precipitate heightened fear and panic states throughout the pregnancy and into the labor process. Little had been done in standard prenatal care to help this special needs population. In my clinical experiences, it is evident that women who have endured loss in the perinatal period are at greater risk for future miscarriage, prematurity and complications of childbirth. As these women approach a subsequent pregnancy, attachment and loyalty to the previous child resurfaces, often making it difficult for the mother to form an attachment to the next pregnancy. When loss remains unresolved, disruption in bonding and attachment can affect not only the immediate maternal-infant relationship, but can have substantial impact on successive generations. Women who have absorbed the impact of their mother's unresolved prenatal loss during their own childhood are particularly vulnerable to high levels of anxiety and fear during pregnancy, childbirth and the ongoing maternal-child relationship. These women tend toward significant expectations of loss in their own pregnancies, childbirths and parenthood. IDENTIFYING AND TREATING SECOND

GENERATIONAL LOSS I would like to focus first on the women who suffer second generational unresolved perinatal grief. This is the least recognized impact of perinatal loss and thus usually goes untreated during the course of a pregnancy. When grief over a lost child or pregnancy remains significantly unresolved, disruption of bonding may cascade through generations. Symptoms of survivor's guilt can be identified in women who experienced a sense of responsibility to "fill in for" or "make up" the loss for their own mother. The following cases will illustrate two examples of how second generational issues of unresolved maternal loss can have impact on a woman's pregnancy, childbirth and attachments to subsequent children. Dorothy was a 39 year old mother who came to me for preventive, prenatal counseling, described elsewhere, (Peterson, 1990; 1991; 1992) for help in preparing for a vaginal delivery after a cesarean delivery three years previously. During that pregnancy Dorothy had been two and one half weeks over due with her son. After the membranes were ruptured with no ensuing labor, pitocin was used to induce contractions. However, her cervix did not dilate beyond two centimeters during the subsequent 24 hours. Eventual signs of fetal decelerations prompted delivery by cesarean section. In her initial interview Dorothy revealed her mother's prenatal and childbirth history (a routine part of the preventive counseling program). Her mother, who had given birth vaginally to two stillborn babies, became the patient of a physician who agreed in advance to perform an elective cesarean. Eventually her mother became pregnant and gave birth to Dorothy and two years later to her younger sister, both by cesarean. Her younger sister had also had two live births by cesarean. Dorothy's statements in her initial interview reveal her feelings of survivor's guilt: Everytime I think about it, I want to die. Those two boys that died . . . must have been so horrifying for my mother. The upcoming birth is frightening me, Fd like to try to have a vaginal birth but I don't trust my body to do it. Cesarean looms as our saviour . . . not such a bad thing. My mother is totally against it {vaginal birth}. My baby . . . I'm so afraid she's going to die. Five previous cesareans were the history of childbirth in Dorothy's family. She was afraid for her child and for the pain her decision would cause her mother if she tried to deliver vaginally. Dorothy reported feeling her mother's unresolved grief throughout her childhood. She felt a need to make many of her own decisions about mothering her son based on her mother's fears. Anxiety and guilt kept Dorothy from a sense of being her own person and enjoying her motherhood, especially when making decisions regarding the safety of her own children. To some extent, Dorothy's bond with her son was laden with guilt that she had the boy her mother had lost. Her mother's loss of two infant sons affected her bonding with Dorothy, making normal separation and individuation difficult throughout their relationship. The body-centered hypnosis session (done in the second hour of the four hour preventive counseling program) presented an opportunity to release Dorothy from her mother's pain and to further her own development as a separate person. During the hypnosis, Dorothy had difficulty seeing anything but her two dead brothers in her womb. Before she was able to visualize the upcoming birth of her own baby, she needed to work through these losses, and to give these ghost children back to her mother. She wept as I helped her. This session gave Dorothy the opportunity to release her mother's grief from her pelvis and to imagine her own baby safe inside her womb. Once she was able to perceive and talk to her own baby, she could visualize the childbirth. It was noteworthy that Dorothy's mother reacted negatively to Dorothy's successful vaginal birth, - the first vaginal delivery in two generations since her mother's stillbirths. Her mother found it difficult to celebrate her daughter's success, and expressed some disapproval afterwards. This indicates the pressure Dorothy felt in her family system to validate her mother's unresolved loss through replication in her own life experience. Her statements at her postpartum visit illustrate the belated individuation that her vaginal birth engendered. I think my mother didn't want to be there {at the vaginal birth}. I understood that she had to distance . . . but I was not afraid, I just kept pushing and the baby came right out ... I made up my mind to do it ... and I felt so powerful... It was a great birth experience. Dorothy was able to begin to see her life's possibilities without the spectre of grief restricting her growth. The pregnancy presented a window of opportunity for resolving past generational grief and facilitating healthy development. The next case illustrates the anxiety which may be carried into a second pregnancy, interfering with the experience of both childbirth and ongoing

maternal-child relationship. Jill was a 38 year old mother who came to me for preventive prenatal counseling following her son's birth three and a half years previously. She was pregnant with her second child, and reported feeling anxious about the childbirth. Her first birth had been a forceps delivery which she described as "horrifying." She reported that her mother had miscarried her first pregnancy and had a stillbirth with her fourth. Jill's statements from her initial interview described the anxiety she suffered and the ongoing impact of her mother's perinatal loss: I was the third living child . . . I'm afraid that if I have another child I'll lose one like my mother. I have the fear of that happening to me . . . I don't sleep nights because I'm so afraid . . . I had a really severe postpartum depression last time . . . and problems with bonding and realizing I was a mother . . . both my husband and I have a terror of {the depression) happening again. The flavor of unresolved grief was evident in Jill's childhood as she described the manner in which her younger brother's ghost was kept alive: "We always kept the memory of him alive . . . we'd say that it was Michael's birthday, and he'd be so many years old today . . ." In addition, Jill suffered extreme anxiety about her son's readiness for a sibling. I believed that she was projecting her own experience of her brother's birth and death onto her son's anticipated experience of his future sibling. She expected her son to feel abandonment and want to hurt or kill the baby - perhaps emotions she had felt in her own childhood following the death of her brother, Michael, and the ensuing experience of her own mother's grief and depression Jill's body-centered hypnosis session focused on normalizing her fears regarding her son's adjustment to a new baby. I focused on hypnotic messages and metaphors for seeing her two healthy children in the future. She responded positively to these suggestions. She was able to see that she was giving her son a "gift of brotherhood." This helped to release the unresolved grief that was held in her family and in her own body. No postpartum depression was reported at her six months follow up visit. Her statements at the postpartum visit reflected a generalized "lift" in her spirits as she described her childbirth experience and referred to the hypnosis session which we had taped and to which she had listened throughout the last months of her pregnancy: When I went into labor there was no fear at all ... I already felt bonded to the baby because you gave me the feeling she would live and grow up. I had such a good time . . . listening to your tape. I felt it was really O.K. to let go. It was such a positive experience ... It was so much fun. I really wanted to do it again. Jill also reported sleeping better, and enjoying her two children interacting with each other. She related that her son was adjusting well to the new baby and that she was enjoying motherhood "so much more than the first time." It seemed clear that her unresolved grief issues about her own brother and her family's continued and unresolved grief over their loss had impeded Jill's ability to enjoy and bond to her own children. Again, the pregnancy presented an opportunity for lifting the anxiety and depression stimulated by unresolved grief in the previous generation, allowing Jill to be more present and emotionally available to her children. DEALING WITH PRESENT PERINATAL LOSS IN A SUBSEQUENT PREGNANCY The following case illustrates the benefit of adequate grief resolution before the next birth. Nancy was 31 and had recently experienced an early miscarriage when she came to see me for help conceiving and maintaining her next pregnancy. Eighteen months previous to her miscarriage she had given birth to a son prematurely, at five and a half months gestation. He had lived seven hours before he died in her arms. During our short term work she was also concurrently in individual therapy. She was frightened of trying to get pregnant again because she felt she could not bear another loss. She also expressed feelings of disloyalty if she were to love another child. I saw Nancy for three sessions prior to conception, and two sessions during her next pregnancy. In our second meeting, body-centered hypnosis for releasing her grief took the form of a regression back to her son's birth. We also spent time with her images of a "ragged" womb, which needed healing. During this process she was able to experience her son as having lived for seven hours. This helped to reframe her sense of loss, as she came to appreciate the hours spent with him. She spoke to him of her guilt at not being able to protect him, expressing love to him and wondering if he had felt pain. Near the end of the session, her statements indicated a sense of peace, and the beginning of being able to make way for another child: I never thought of him as having lived before . . . but he did and he was so strong. The doctors were surprised he hung on so long . . . maybe so I

could say 'goodbye' . . . He brought my whole life into a different relief . . . I've changed so much . . . but I can hear him saying to me, now . . . go ahead, Mom it's O.K. {referring to having another child}. The next week Nancy reported that her womb "no longer looked ragged." The second hypnosis session focused on healing and Nancy was able to see her womb as smoother and pinker than before. She responded positively to hypnotic suggestions for implantation and metaphors for preparing the womb, readying it for a new baby. Visualization of her family with the new baby was also suggested. Nancy returned nine months later, at 22 weeks of pregnancy. She reported minor anxiety about fear that came up when she went to the bathroom in the night. This was the time in her first pregnancy when she had discovered she was in premature labor with her son more than two years earlier. Her anxiety was also no doubt correlated with the fact that this was the exact time in the pregnancy that she had given premature birth. She responded positively to hypnotic metaphor and images of "a garden with adequate drainage, which assured that the roots remained securely implanted and nourished." Nancy gave birth at home to a healthy, full-term baby girl. She reported having had a wonderful childbirth and no postpartum depression at her six months follow up. She expressed feeling very bonded as a family which consisted of her baby, step-daughter, and partner. Nancy had sensed that her miscarriage was related to her inability to let go emotionally of her first baby. Feelings of disloyalty at the imagined bond to another child were painful, and might have remained so had she not taken the opportunity to resolve some of this grief before conception . . . . It is noteworthy to observe the difference in Nancy's level of anxiety in her next pregnancy (relatively low), following pre-conception work, compared to the ongoing anxiety, still present in the two previous clients, Dorothy and Jill, when our initial contact was during rather than before pregnancy. These cases suggest that perinatal grief, when not treated, continues to have impact on future pregnancies and maternal-infant relationships. It is important for prenatal care-givers to recognize anxiety related to past perinatal loss in a woman's personal obstetrical history, and to be aware of the possibility of previous generational loss on a present pregnancy. Body-centered hypnosis in the context of preventive prenatal counseling, as described elsewhere (Peterson, 1990, 1991, 1992), is a primary method of choice in dealing with the resolution of perinatal loss. GUIDELINES FOR DEALING WITH PERINATAL LOSS IN PRENATAL COUNSELING USING BODY CENTERED HYPNOSIS AS A METHOD OF CHOICE 1. Incorporate anxiety rather than attempting to minimize or lessen it. 2. Don't avoid using the previous child's name. Make a place for the previous bond and "seed" possibilities of moving on, making room for the next child. 3. Recognize/acknowledge the fear related to previous loss, and the desire related to future experience. Hold the space for both. 4. Be aware that the time of loss, when it occurred in the previous pregnancy will be charged in a subsequent pregnancy. Ongoing contact with a caregiver (prenatal counselor) is important during this period. 5. Acknowledge client attachment to the last child. Address disloyalty issues related to the next child. Be aware that "survivor's guilt" could be projected onto the second child, making bonding difficult. 6. Be aware that facing the possibility/reality of a healthy, normal child can take a great deal of courage. Validate that it takes courage to attach/bond again. 7. Look for ways to help the client leave the loss behind. But pace the therapy appropriately to the woman and her specific situation and needs. 8. Support commitment, but do not insist on prenatal bonding, during the birth visualization: settle for facing/meeting the baby, but not necessarily greeting it! 9. Emphasize the resiliency of hie in the context of a non-blaming approach and reframe the loss experiences to make way for the future possibilities of a live birth. 10. Be aware that the client may feel guilt over the failure to protect her child - undermining her confidence as a mother. Seek to accept her, and offer appropriate ways to reframe any sense of failure. CONCLUSIONS AND RECOMMENDATIONS As previously discussed, research has documented the effects of emotional and psychological issues on pregnancy and childbirth. However little has been done clinically to create opportunities in standard prenatal care to recognize and address emotional and psychological factors in a short term and effective manner. Perhaps this is due to a lack of appropriate training programs and knowledge of how to design and implement these programs in the context of prenatal care. It is my hope that more prenatal practitioners will become aware of women's needs and seek to refer and/or expand their practices appropriately to address the

emotional nature of pregnancy utilizing the appropriate short term preventive, prenatal counseling models described in this paper. Prenatal counseling using the methods described benefit the medical as well as psychological outcomes of pregnancy. Addressing emotional issues during this crucial family transition can offer significant positive impact on the psychological health of family relationships for years to come. In addition, there has been little exploration into the effects of perinatal loss on subsequent birth and developing human relationships. Clearly women who have experienced pre or perinatal loss are a particularly high risk population, given the increased emotional trauma to be resolved. As is true in the ordinary situation but even more important with this specific group of women, pregnancy offers a window of opportunity for healing and resolution that has been too long ignored. Pregnancy is a period of natural growth and development, fueled by hormonal changes and a normal psychological developmental crisis. It is suggested from the clinical work described, that perinatal loss is an area that warrants further investigation due to the impact not only on physical health and reproduction, but on the disruption to the bonding and attachment processes that usually follow. Further research is needed to determine the impact of perinatal loss on subsequent pregnancy and ongoing human development. References REFERENCES Benfield, Gray and Nichols, J. (1981) Living With Newborn Death. In P. E., Ahmed, (Ed.) Pregnancy, Birth and Parenthood: Coping with Medical Issues, North Holland 359-376. Gorsuch, R. L. and Key, M. K. (1974). Abnormality of Pregnancy as a Function of Anxiety and Life Stress. Psychosomatic Medicine. 36: 352-362. Kennell, J. H., Trause, M. A., and Klaus, M. H. (1975). Evidence for a Sensitive Period in the Human Mother. In Parent, Infant Interaction, CIBA: Symposium on Attachment, Amsterdam: ASP. Klaus, M. H., Jetauld, T., Kreger, N., Alpine, N., Steffa, M. and Kennell, J. H. (1972). Maternal Attachment: The importance of the First Postpartum Days. New England Journal of Medicine. 286, 460-463. Lederman, E., Lederman, B. A and Work, J. (1978). The Relationship of Maternal Anxiety, Plasma Catacholomines, and Plasma Cortisol to Progress in Labor. American Journal of Obstetrics and Gynecology 132, 495. Levenson, G. and Shnider, S. (1979). Catacholimines: The Effects of Maternal Fear and Its Treatment on Uterine Dysfunction and Circulation. Birth and Family Journal 6(3), 167-174. Marshall, R. (1981). Perinatal Death in Pregnancy. In P. Ahmed (Ed.), Birth and Parenthood: Coping with Medical Issues. North Holland: Elsivier. Peterson, G., (1992). A Preventive Prenatal Counseling Model. In R. Klimek (Ed.). Pre and Perinatal Psycho-Medicine, Cracow, Poland: DWN DREAM. Peterson, G., (1991). An Easier Childbirth: An Easier Childbirth: A Mother's Workbook for Health and Well-Being during Pregnancy and Delivery. Los Angeles: J.P. Tarcher. Peterson, G., (1984). Birthing Normally. Berkeley, CA: Shadow and Light. Peterson, G. (1990). Body-Centered Hypnosis for Childbirth: A Training Videotape in the Technique of Gayle Peterson. Berkeley, CA: Shadow and Light. Peterson, G. (1991). Pregnancy, Birth and Bonding, A Body centered Hypnosis Audiotape for Pregnant Women. Berkeley, CA: Shadow and Light. Peterson, G. (1987). Prenatal Bonding, Prenatal Communication, and the Prevention of Prematurity. Pre- and Perinatal Psychology Journal 2(2). Peterson, G., Mehl, L., and McRae, J. (1988). The Relationship of Psychiatric Diagnosis, Defenses, Anxiety and Stress to Birth Complications. In Freyburg and Vogel (Eds.), Prenatal and Perinatal Psychology and Medicine. Sosa, R., Kennell, J. H, Klaus, M. H., Robertson, S. and Urrutia, J. (1980), The Effects of a Supportive Companion in Perinatal Problems, Length of Labor and Maternal-Infant Interaction. New England Journal of Medicine, 303(11). AuthorAffiliation Gayle Peterson, Ph.D., MSW AuthorAffiliation Gayle Peterson, Ph.D., MSW has done pioneering research into preventing complications in pregnancy and childbirth since 1973. She is the author of Birthing Normally and An Easier Childbirth. Dr Peterson is in private practice in Berkeley, California specializing in perinatal psychology and early family development. She currently trains psychotherapists and childbirth educators in a year-long certification program for prenatal counseling. She can be reached for correspondence, communication and information on her preventive prenatal counseling training program at 1749 Vine St., Berkeley, CA 94703.

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