Relational-Cultural Theory as a Therapeutic Approach to Perinatal Loss

Heather Olivier & Brittani Monroe

Abstract: Despite the likelihood of mental health therapists working with perinatal loss clients, there has yet to be a therapeutic approach directly applied to this population. As an ambiguous and disenfranchised loss, cultural responses to perinatal grief incur condemned isolation for perinatal loss parents. To decrease reenactment of cultural disconnections within the therapeutic process, the authors propose utilizing Relational-Cultural Theory as a therapeutic approach addressing both grief expressions and trauma symptomology resulting from perinatal loss. The model developed posits that through empowerment and self-empathy, clients can change relational images and increase relational resilience. Clinical implications and applications are discussed.

Keywords: perinatal loss, Relational-Cultural Theory, grief**,** trauma

Perinatal loss, which encompasses miscarriage, stillbirth, and neonatal death is an under-researched topic that is beginning to gain more traction in the research community (Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). Discrepancies among the prevalence of these losses may be attributed to them often being viewed as medical events as opposed to losses (Lang et al., 2011). In the United States, approximately 15% of pregnancies end in miscarriage (fetal death before 20 weeks' gestation), and 0.6% of pregnancies end in stillbirth (fetal death 20 or more weeks' gestation) or neonatal death (up to one month after birth) (Centers for Disease Control and Prevention, 2017; Kokou-Kpolou et al., 2018). Although perinatal loss is prevalent, cultural responses to this type of loss leaves bereaved parents feeling as though their experiences are minimized and unacknowledged (Cacciatore et al., 2009; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). The following discussion

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outlines perinatal loss as being an ambiguous loss resulting in disenfranchised grief and relational dysfunction.

Perinatal Loss & Grief

Ambiguous Loss

Ambiguous loss is a type of loss wherein a contradiction exists between the physical absence and psychological presence of the deceased, or vice versa (Boss, 2010). In a study by Lang et al. (2011) specifically regarding perinatal loss, the following four sources were identified as areas where bereaved parents might feel ambiguity: about the viability of the pregnancy, about the physical process of losing the pregnancy, around arrangements for the remains, and in sharing the news of the loss. Although studies suggest the positive impact of preserving the bereaved individual's memory of the deceased (Crawley et al., 2013; Lim & Cheng, 2011), bereaved parents who have experienced perinatal loss are often left without memories or mementos by which to remember their children. In fact, most physical representations of their babies (e.g., nursery furniture, car seats, baby clothes) are triggering for parents, as these items do not represent what the baby *had* experienced but what the baby *had not* experienced (Lang et al., 2011). In this sense, bereaved parents' losses are differentiated from other losses, as they represent a loss of a future (Lim & Cheng, 2011; Shannon & Wilkinson, 2020).

Disenfranchised Grief

Ambiguity surrounding perinatal loss is exacerbated by the lack of mourning rituals in the United States, such as funerals, ceremonies, and memorials. Perinatal loss is considered a disenfranchised loss, or unacknowledged by society as even having occurred (Doka, 2002; Lang et al., 2011). Bereaved parents subsequently experience disenfranchised grief—a grief parents feel they do not have the right to express (Doka, 2002). In addition to outlining sources of ambiguity in perinatal loss, Lang et al. (2011) differentiate between three aspects of disenfranchised grief experienced by perinatal loss parents: in the marriage relationship, when communicating to health professionals, and when interacting with extended family members and other individuals within the community.

Building on Doka's disenfranchisement of grief, Walter (2020) describes perinatal loss as a "hyper-enfranchised grief—a grief so terrible that others fear to come close to those enduring it" (p. 12). Walter posits that bereaved parents are often avoided by friends because the parents' experiences challenge a core falsehood about life processes—that they happen in a natural order. Parents burying their children is incomprehensible to most people. The unnatural occurrence threatens

emotional safety and the security of consistency (Walter, 2020). The incongruences between the ambiguity of perinatal loss and our culture's false sense of safety attributed to a natural order can and does cause individuals to avoid the topic at all costs. Bereaved parents are the ultimate reminder of this potential threat, and therefore can be distanced from others.

Psychological Impacts of Perinatal Loss

Empirical research on the psychological impacts of perinatal loss on bereaved parents reports feelings of decreased self-esteem, guilt, and shame (Hill et al., 2017; Kersting & Wagner, 2012). Diagnoses such as depression, anxiety, and posttraumatic stress disorder (Bennett et al., 2008) are prevalent, often resulting in prolonged and complicated grief (Randolph et al., 2015). Recent research reveals that bereaved mothers who have experienced perinatal loss continue to report psychological symptomatology attributed to the loss and subsequent grief for many months and years afterwards. The largest epidemiologically based study to date measuring the psychological impact of perinatal loss showed that at nine months' post-loss, bereaved mothers presented with high levels of psychological distress without seeking treatment (Gold et al., 2016). Kokou-Kpolou et al. (2018) broadened that timeline by providing evidence that persistent depressive and grief symptoms following perinatal loss are present up to 10 years after the loss.

Diagnostic labels have the danger to incite further isolation and exacerbation of grief when applied to bereaved mothers. According to the *Diagnostic and Statistical Manual* (DSM-5), to fit the criteria for persistent complex bereavement disorder (PCBD), adults must report grief symptoms up to 12 months after the loss (American Psychiatric Association, 2013), although the previously mentioned studies report perinatal grief up to 10 years. The most troublesome qualifier for PCBD is, "the bereavement reaction is out of proportion to, or inconsistent with, cultural, religious, or age-appropriate norms" (Criterion E). Identifying "appropriate norms" as diagnostic criteria further perpetuates the disenfranchisement of perinatal loss. The most impairing part of perinatal grief is not what Markin and Zilcha-Mano (2018) refer to as "intrapsychic deficiencies or conflicts" experienced by bereaved parents; rather, it is the social isolation and lack of support from others.

Therapeutic Approaches to Grief and Loss

Newsom et al. (2017) studied grief and bereavement counseling's effectiveness and found a significant difference in symptom reduction among grieving clients who received counseling and those who did not. Therapeutic strategies and interventions are provided for the varied types

of losses; however, there is limited research on perinatal loss interventions. Various therapeutic techniques and interventions exist across theoretical orientations to assist clinicians working with clients experiencing grief and loss. Research describes psychotherapy as an effective instrument to facilitate a meaningful resolution of grief and loss, develop new coping styles, and minimize psychophysiological complications (Lamb, 1988). In this section, we will outline a few interventions used with clients experiencing grief.

Grief Interventions

Cognitive Behavioral Therapy (CBT) assists clients to reconcile with the death of their loved ones. A CBT approach to grief focuses on clients' thoughts, feelings, and behaviors related to clients' loved ones' death and creating a new life without the deceased (Morris, 2011). Wenzel (2017) describes three useful CBT strategies when working with clients experiencing grief: cognitive restructuring, behavioral activation, and mindfulness meditation. Cognitive restructuring, also known as cognitive reframing, is a process that helps clients learn to discover, challenge, and modify their cognitive distortions. Behavioral activation is:

> a structured, brief psychotherapeutic approach that aims to (a) increase engagement in adaptive activities (which often are those associated with the experience of pleasure or mastery), (b) decrease engagement in activities that maintain depression or increase risk for depression, and (c) solve problems that limit access to reward or that maintain or increase aversive control. (Dimidjian et al., 2011, pp. 3-4).

Mindfulness meditation is a technique that can be utilized with grieving clients as a tool to help them to be more present-focused, rather than ruminating over the past and being too consumed with the future.

Narrative therapy is based on the belief that individuals are continuously telling themselves stories about their lives (Peterson & Goldberg, 2016). Neimeyer (1999) identified several narrative strategies for grief, such as metaphoric images, linking objects, journals, and life imprints. "Re-storying" the loss through poetry or expressive writing can provide solace to grieving individuals; research shows that expressing emotions and truths through writing can offer healing (McClockin & Lengelle, 2018).

Vaterlaus (2014) combined psychoeducation and solution-focused therapy to create the new normal project based on the client's vision of what their desired future will look like following a loss. Vaterlaus asserts "psychoeducation is used to normalize the client's experience by providing a flexible framework through the presentation of the stages of grief" (p.

79). Solution-focused therapy recognizes the client as the expert on their experience and focuses on the client's strengths.

Relational-Cultural Theory

Relational-Cultural Theory Central Tenets

Relational-Cultural Theory (RCT) is a contemporary psychodynamic framework for understanding human development based on the assumption that an individual's happiness and well-being are a product of the degree to which they participate in growth-fostering relationships, as opposed to the separate self, which is common in traditional theories (Jordan, 2000; Kress et al., 2018; Lenz, 2016). The founder of RCT, Jean Baker Miller, characterizes growth-fostering relationships by "the five good things," which include an increased sense of zest, empowerment, clarity, self-worth, and connection (Duffey & Trepal, 2016).

The core tenets of RCT that promote growth and relational development are as follows: (a) people grow through and toward relationships during their lifespan; (b) movement toward mutuality rather than separation characterizes mature functioning; (c) the ability to participate in increasingly complex and diversified relational networks characterizes psychological growth; (d) mutual empathy and mutual empowerment are at the core of growth-fostering relationships; (e) authenticity is necessary for real engagement in growth-fostering relationships; (f) when people contribute to the development of growth-fostering relationships, they grow as a result of their participation in such relationships; and (g) the goal of development is the realization of increased relational competence over the life span (Jordan, 2000).

RCT, best understood in the context of a relational movement, outlines the process of moving through connections, through disconnections, and back into new and improved connections with others (Comstock et al., 2008; Kress et al., 2018). Disconnection often involves feelings of being misunderstood or shut down and may serve to manage a perceived sense of emotional safety within relationships (Duffey & Trepal, 2016). Chronic disconnection can result in the use of strategies of disconnection, which develop from a sense of shame and humiliation, seen in behaviors such as blaming, withdrawing, or minimizing (Duffey & Somody, 2011; Duffey & Trepal, 2016).

Chronic disconnection can also cause condemned isolation, a feeling that connection is not possible because one is not worthy (Duffey & Somody, 2011). "Isolation is viewed as the source of human suffering and precludes individuals' abilities to receive connection and support" (Kress et al., 2018, p. 108). Individuals use strategies of disconnection to manage their emotional safety, which then keeps them from experiencing gratifying connections. This what RCT refers to as the central relational

paradox: As a result of chronic and serious disconnections in relationships, individuals learn to keep feelings, experiences, and thoughts out of relationships, thus sacrificing authenticity and mutuality to experience some resemblance of acceptance and safety (Miller & Stiver, 1997).

To achieve connections with others, individuals paradoxically end up withholding aspects of themselves from others. Referred to as the central relational paradox, individuals preemptively isolate themselves through inauthentic connection and essentially end up in the exact situation they are avoiding (Miller, 1976/1986; Miller & Stiver, 1997; Jordan, 2010; Lenz, 2016; Kress et al., 2018). The subsequent isolation reported by bereaved parents is known in RCT as condemned isolation—the feeling of aloneness, being shut out of one's social community, and that this isolation is their own fault (Jordan, 2010; Miller & Stiver, 1997). In essence, the disenfranchisement of an ambiguous loss is a relational disorder. Boss (2010) goes as far as to describe ambiguous loss as externally derived as opposed to an individualistic experience. As such, viewing perinatal loss through a relational lens is intrinsically necessary in conceptualizing the experience.

Relational-Cultural Theory and Trauma

Perinatal loss is recognized as a traumatic life event, making it relevant to highlight how the RCT framework can be used when working with trauma. Regarding interpersonal trauma, disconnection from others can help individuals sustain a false sense of control and safety from revictimization (Banks, 2006). The focus on connection and isolation make RCT suitable for treating survivors of trauma. Traumatic experiences can significantly impact an individual's well-being and be detrimental in maintaining interpersonal relationships and their view of self (Kress et al., 2018). The therapeutic relationship in relational therapy is essential in the framework as the counselor provides a safe space for clients to develop self-empathy, where they began to see themselves as being worthy of connection. The therapeutic alliance can also help clients reconstruct the problematic relational images formed because of the traumatic experience by creating new images that facilitate new connections.

Banks (2006) conceptualized RCT for trauma using Herman's three therapy stages for trauma survivors: safety, recovery and mourning, and reconnection. In the first stage, Banks asserts the therapist acts more as a teacher providing psychoeducation on the neuroscience of trauma and its impact on the brain, body, and relationships. In the second stage, the therapist works with the client on the relational images associated with the relational violation; at this stage, the therapeutic relationship is essential as a depiction of a positive connection. In the third stage, the client demonstrates reconnection with self and no longer generalizes

negative relational images to all relationships. The client is more open to building new connections with others.

Perinatal Loss through an RCT Lens

When bereaved parents violate grief rules through expressions of grief following the ambiguous loss of a child, they face what RCT researchers identify as being the most damaging aspect of grief: isolation (Doka, 2002; Kress et al., 2018; Lang et al., 2011; Lenz, 2016; Markin & Zilcha-Mano, 2018; Shannon & Wilkinson, 2020). RCT theorists define isolation in the context of relational disconnections as it decreases one's self-worth, productivity, and confidence in authentic connections with others in the future (Jordan, 2010; Miller, 1976-86; Miller & Stiver, 1997). Existing therapeutic models assess dysfunction and establish goals for change based on the client's ability – or lack thereof – to reintegrate into normative societal bounds. As previously stated, however, perinatal loss parents also face the challenge of negotiating between connections to their babies and connections to other individuals within society (Toller, 2005). Clients are perceived as withdrawing from others when they are actually withdrawing from the trauma. Thus, what is perceived as dysfunction based on societal grief rules is rather dysfunction within the interactional paradigm. Grieving a perinatal loss is intrinsically relational.

Increasing Relational Resilience

Grief and loss literature emphasizes the value of social support following a loss. Because of the ambiguous nature of perinatal loss, however, individuals within the client's support network express difficulty understanding how to provide support (Lang et al., 2011; Shannon & Wilkinson, 2020). As a result, perinatal loss parents report heightened feelings of isolation and subsequent chronic disconnection. Therapeutic recommendation of increased socialization without consideration of trauma attribution to interactions poses an impossible task for perinatal loss clients; a task that when left unaccomplished reinforces a client's core belief that he or she is incapable, or unworthy, of connection.

Therefore, the goal of the therapeutic process from an RCT perspective is to increase what Jordan (2010) refers to as relational resilience, "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). This is done by creating a new relational image wherein the client has the ability to identify trauma triggers within relational interactions. In doing so, the distress a client experiences in response to a trauma trigger is differentiated from the individual with whom the client interacted when experiencing the trigger.

Approaching perinatal loss clients from an RCT framework, the authors posit increasing relational resilience with the following three components: (a) empowerment, (b) self-empathy, and (c) changing relational images. From a processual perspective, empowerment allows the client to foster self-empathy in order to change relational images. To further explicate this process, the three components will be discussed utilizing a case example and how an RCT therapist would facilitate relational movement within the therapeutic process. The case example is as follows:

A female client who experienced a stillbirth two months prior is seeking therapy. She reports feeling immense guilt for her reaction to her best friend's pregnancy. Although she is happy for her friend, the client reports having difficulty interacting with her due to feelings of anxiety, anger, and jealousy. The client expressed that when she is around her friend, she thinks, "that should be me." The subsequent guilt she experiences is distressing and confusing as the client feels she and her friend have a healthy relationship. As a result, the client reports self-isolating and withdrawing from the relationship.

Empowerment

Client empowerment begins with the initial session as the therapeutic alliance strengthens. Empowerment is elicited through (a) client validation, (b) increasing client's sense of control, and (c) identifying client feelings and the presence of cognitive dissonance. An RCT therapist addresses these components with the following response: "You're happy for your friend, but being around her reminds you of your loss, which is also triggering your trauma responses. I bet that's really confusing when you react to your friend as though you're reacting to your trauma." In this type of response, identification of the client's polarizing emotions is both validating and increases her sense of control as she is now able to attribute her emotional reactions to specific sources. By identifying the dissonance between the emotions, the therapist is able to decrease the anxiety attributed to ambiguity.

Self-Empathy

Empowerment allows the client to foster self-empathy, defined by Jordan (2010) as "the ability to bring an empathic attitude to bear on one's own experience. Sometimes achieving self-empathy involves invoking an image of the client at an earlier age to reduce the self-blame and self-rejection that the individual carries," (p. 108). Self-empathy becomes a product of the RCT therapeutic relationship when the therapist (a) normalizes the client's reactions, (b) provides psychoeducation to support

the normalization, and (c) utilizes neuroscientific empirical evidence to discuss neuroplasticity and hope for change.

In response to the case example, an RCT therapist assisting the client in fostering self-empathy might say, "I hear that you feel guilty about experiencing the pull to withdraw from your friend. The desire to withdraw is actually your brain's attempt at protecting you from the trauma triggers, so it makes sense that you want to withdraw. Because the wires between interacting with your friend and interacting with trauma triggers are entangled, however, the protective measures are displaced." In gaining clarity about the intersectionality between trauma and relational interactions, the client's guilt attributed to the relationship decreases. A key component in fostering self-empathy is bridging the gap between the client's distressing emotions and neuroscientific rationale for the emotional reactions by using the phrase "that makes sense." For example, "I hear you feel _____ and that's distressing, but it makes sense because your brain is _____."

Changing Relational Images

By empowering the client, and subsequently fostering self-empathy, relational images are changed. The change is experienced when trauma responses are differentiated from present interactions. Decreasing anxiety attributed to cognitive dissonance, and guilt attributed to relational withdrawal, also decreases distress displacement. In reference to the case example, a client experiencing change in a relational image would internalize that her own loss is separate from her friend's pregnancy. The client's perception of dysfunction that was previously placed on the relationship is appropriately placed on the trauma reaction, of which can be changed through therapeutic processing while maintaining the relationship.

Conclusion

Relational-Cultural Theory is an approach appropriate for working with those impacted by perinatal loss, acknowledging their need to find meaning in relationships and foster authentic and mutual connection while also recognizing the risk of disconnection due to societal stigma around perinatal loss. When a potential client experiences the loss of a child, he or she may silence themselves due to family and friends following societal and cultural norms, not addressing the loss, subsequently creating negative relational images, and causing the client to isolate for fear of rejection.

When the individual presents to therapy, the clinician must create a safe space and not ignore the client's perinatal loss, as this would cause re-traumatization and further perpetuation of the disenfranchisement of

the loss experienced. The client and clinician's therapeutic alliance is essential because it acts as a model of a growth-fostering relationship from which the client can build other connections. The relationship between the two will create a new relational image for the client, which will help them not categorize all relationships as damaging. The result of a perinatal loss client participating in an RCT approach to the therapeutic process is the desire to re-engage in their environment and build growth-fostering connections while simultaneously increasing congruence of grief expressions and decreasing trauma symptomology.

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