Grieving Reproductive Loss in Art Therapy

by
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Abstract

Reproductive loss affects women of all ages and backgrounds, and at different stages of their lives. The specific and unique nature of reproductive loss implies disenfranchised grief and can lead to complicated grief and mourning, yet is often overlooked or minimized by health care professionals. The social stigma around abortion can discourage women from sharing or even speaking of their experience, which may have a profound impact on their lives. Miscarriages are a possible outcome of any pregnancy and occur in approximately 14% of all recorded pregnancies in the United States. This experience is often reduced to a normal occurrence and can present difficulties for women, their partners and their family and friends when coping with this loss. Art therapy is a flexible therapeutic outlet that can aid in managing grief and loss, and support healthy healing. By examining the research on reproductive loss within the context of art therapy, this document proposes an art therapy program aimed at healing and helping women and their families manage the complicated nature of reproductive loss.
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Introduction

The experience of reproductive loss is a difficult and stressful one physically and mentally. The circumstances around reproductive loss may result in disenfranchised or complicated grief and require specialized psychological care or counselling.

In the United States approximately half of all recorded pregnancies are unintended and four in 10 of these pregnancies will end in abortion (The Guttmacher Institute, 2011). The subject of abortion is often viewed as a controversial and stigmatized one; therefore the need for support and emotional care for women going through this process is necessary. The unique circumstances for a woman seeking this procedure may influence her emotional stability throughout the process, with some feeling more emotional distress than others. Mental health history, interpersonal relationships, belief systems, culture and therapeutic support all contribute to the well-being of an individual before and after the abortion (Brien & Fairbairn, 1996). There are limited resources for women experiencing emotional distress throughout the abortion process (Casey, 2010). Basic counselling is usually offered as a short-term service through abortion clinics, but there is little comprehensive literature outlining any abortion counselling interventions or programs.

Culture will determine the social climate and attitudes regarding abortion. In most cases abortion is a controversial subject and is stigmatized or simply not acknowledged. The grief experienced around abortion is therefore disenfranchised and discounted due to the nature of the loss (Doka, 1989).

The differing views on abortion present abortion clinics and their clients with individuals strongly opposing the procedure. These attitudes may create great difficulty for the individuals requesting the procedure. Additionally, individuals working in
academics and research with firm attitudes, either supporting or opposing abortion, are publishing biased research, confusing, undermining or exaggerating the experience of abortion and mental health (Ring-Cassidy & Gentles, 2002).

Miscarriages are another type of loss that can be psychologically challenging and complicated for a woman. For many, pregnancy is the culmination of a dream for a family; it is a significant stage in a woman's life and is generally a psychologically vulnerable time (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). Women going through this type of loss have experienced an immense closeness with their unborn, yet few have little, if not no immediate experiences to reflect upon or remember (Brier, 2008). Secrecy surrounding the early stages of pregnancy can also complicate and impede a woman's need to express her feelings and grieve (Brier, 2008). Immediate family and close friends may have never known of the pregnancy and will not be able to understand or provide the support necessary for bereaved women. Here, the relationship with the unborn is not recognized and the grief is disenfranchised (Doka, 1989).

In the United States approximately 10% to 25% of recognized pregnancies result in miscarriages, with an estimated 80% occurring within the first trimester of pregnancy (Kobler, Limbo, & Kanavaugh, 2007; Shreffler, Greil, & McQuillan, 2011). These statistics suggest pregnancy loss is a moderately common experience and this notion can be invalidating for the woman grieving this loss (DeFrain, Millsbaugh, & Xie, 1996). The research around miscarriage, grief and mental health is limited, but growing (Shreffler, Greil, & McQuillan, 2011). Wright (2011) highlights the need for interventions in perinatal grief and loss. Insufficient care and support from health care professionals is a problem and adds additional distress to the bereaved (Wright, 2011).
Qualitative studies explain how mothers felt their health care professionals and physicians minimized their loss, avoided their emotional needs, failed to educate and inform them about what had happened and what to expect, and failed to deliver information with sensitivity (Abboud & Liamputtong, 2005, as cited by Wright, 2011). These studies attempt to measure the emotional outcomes and experiences of women and their partners post reproductive loss. Exploring the full emotional impact miscarriage has on women and their partners and assessing how their needs can be met, will help develop therapy interventions necessary to encourage and aid in healing.

This research intends to establish the fundamental emotional needs regarding reproductive loss and identifies the counselling practices in place for women across North America. It outlines the circumstances regarding complicated and disenfranchised grief and identifies the way in which it relates to reproductive loss. By integrating this information with bereavement models within an art therapy framework, it provides counsellors and individuals seeking support with new resources, as well as with a potential art therapy program that may be implemented in abortion clinics, maternity wards and into general art therapy practices.

**Literature Review**

**Identity, Pregnancy and Maternity**

Erik Erikson's psychosocial stages of development model identifies eight stages of development, each with a specific crisis that must be resolved before the individual may move forward (Erikson, 1982). These crises present an opportunity for personal growth, personality development and maturation. He identifies the stage of 'adolescence' as the period for developing identity or resolving role confusion. According to Erikson,
developing identity involves an integration of childhood experiences and influences into a meaningful whole, providing the individual with a strong sense of self, and established ideas about political ideologies, religious perspectives and occupational interests. Following 'adolescence' is 'young adulthood' which is a period dealing with intimacy versus isolation. According to these stages one may not form intimate relationships without first forming a concrete identity of the self; only upon knowing the self can one be able to experience intimacy and romantic love. Erikson (1982) noted that women may experience identity development later than men, and more recent studies support this notion, finding that identity development may take place well throughout the 20s, particularly for women (Zucker, Stewart, & Ostrove, 2002). This information suggests that women in child-bearing years may still be developing an identity of the self.

In the early 1950s, Rubin, a pioneer in maternal behaviour and maternal identity research, was the first to develop and present research on maternal role attainment from women’s subjective experiences (Mercer, 1995). Her work has resulted in significant theoretical concepts that have informed and made considerable contributions to research across disciplines (Mercer, 1995). Rubin (1984) describes the maternal identity as a growing extension or new part of the self, an identity that is distinct from a social role. Incorporating this new dimension of the self is motivated by the ideals a woman wishes to achieve in her new role as mother. Through consistent and intimate engagement with imagery, and thoughts of the bodily experiences involved in childbearing and the woman’s self-image, she may begin to incorporate this new facet of her personality into her identity (Rubin, 1984).
When exploring the notion of identity and the roles one may choose to identify with, motherhood may be a role that some women are drawn to, and may commit to before they have experimented with other roles, or resolved their integrated sense of self (Dalla & Gamble, 2000). It is possible that taking on the maternal role in a time of identity configuration is tied to the unconscious motivations for pregnancy, and the desire to resolve a complete and fulfilled identity.

For some women, becoming pregnant can be part of a developing identity or represent desired ideals about the self (Brien & Fairbairn, 1996). Pregnancy can highlight feelings of fertility and sexuality, self-worth and fulfillment (Baley, 1999), it can also give reassurance to one's femininity or feelings of attractiveness (Brien & Fairbairn, 1996).

In the context of a feminine identity, Zoja (1997) suggests an unconscious desire for an affirmation of one's fertility initiated through pregnancy. Another unconscious desire she identifies is the experience of motherhood and the changes women expect it to bring to our identities. Motherhood embodies an initiation or rite of passage into an ideal of womanhood. Some women may find identity in the pregnancy itself, fulfilling a need to care, mother and create. Pregnancy is also associated with themes of power and importance, and the unconscious motivation for pregnancy may stem from a desire for power, as a pregnant woman will have her needs met without question, privately and publicly (Zoja, 1997).

Other motivations identified in wanted pregnancies but unwanted babies, are when a baby is viewed as a means to resolving feelings of being unloved or uncared for (Brien & Fairbairn, 1996). In the cases of adolescents and younger women, the baby may be seen as a part of herself; by caring for and nourishing the unborn child she may be
confusing her loving and nourishing expressions with her own needs, or rather the needs of her inner child (Brien & Fairbairn, 1996). Understanding the biology and psychology of pregnancy, identity and maternity is vital for clinicians offering support and care to women grieving a reproductive loss.

**Prenatal Attachment**

Mother-infant attachment begins long before birth (Peppers & Knapp, 1980). Bonding and attachment can start as early as the fantasy of having children and a family develops, which can be as early as childhood. When young women imagine their roles as mothers they are subconsciously preparing themselves for their desired future role as mothers. Becoming pregnant becomes a goal when women begin taking steps to conceive; at this time the process of bonding has begun (Peppers & Knapp, 1980).

Planning does not need to be necessary for prenatal attachment to transpire. Women initially become attached to the idea of pregnancy and gradually cultivate an attachment for the foetus and her future (Muller, 1993). Once confirmed and accepted, women experiencing unplanned pregnancies will commence bonding with their unborn (Peppers & Knapp, 1980).

Research tools to measure prenatal attachment have been developed to measure the extent to which women practise and demonstrate behaviours that imply a relationship with their unborn child, such as Cranely’s (1981) Maternal Foetal Attachment Scale and Muller’s (1993) Prenatal Attachment Inventory. Reports using these tools suggest body image, self image and quality of relationship with the woman’s partner can influence the way a woman attaches to her foetus (Muller, 1993). Additionally, gestational age and
quickening have been found to be consistent in correlating with the development of prenatal attachment (Muller, 1993).

**Abortion**

**A brief history**

Until 1988 abortions in Canada were illegal. Dr. Henry Morgentaler, an activist for abortion rights, led a 20-year struggle to make abortions available to Canadian women in safe, professional clinics. Since 1969, Dr. Morgentaler has worked towards opening clinics in several provinces across Canada. Between 1970 and 1975, Dr. Morgentaler’s endeavours suffered extreme clinic violence including arson attacks and raids. In 1975, Dr. Morgentaler was also sentenced to 10 months in jail for breaching the abortion law. Clinic violence and aggression towards abortion practitioners range from vandalism to targeted shootings. In the 1990s at least four abortion practitioners were shot at while in their homes and laws surrounding anti-abortion protesting were put in place to protect the staff and women attending the clinics. In the early 2000’s, Dr. Morgentaler was integral in the movement towards obtaining provincial funding for abortions in Quebec, New Brunswick, Nova Scotia, Manitoba and P.E.I. He made plans to sue the Manitoba, New Brunswick and Nova Scotia governments for the refusal to provide funding for abortions, and followed through with this plan in New Brunswick. In 2008, Dr. Morgentaler was appointed to the Order of Canada for his work and dedication to women's health care and rights (National Abortion Federation, 2010).

According to the Guttmacher Institute, in 2004 induced abortion was the most common surgical procedure in the western world and approximately 21% of American women in the primary child-bearing age bracket have had an abortion (Lauzon, Roger-
Achim, Achim, & Boyer, 2000). The sociocultural atmosphere surrounding abortion is not a neutral ground for decision making, and significant negative connotations and influences are at work to make a woman's decision even more difficult (Lemkau, 1988). The negative attitudes and perspectives about abortion has created a stigma apparent in our current political and social climate, which can pose additional distress for many women requesting an abortion. This stigma will often persuade women to keep their experience a secret, creating further psychological distress (Littman, Zarcadoolas, & Jacobs, 2009). The social and personal frameworks surrounding the topic of abortion must be considered within the cultural context of each woman, and in many cases, she may receive messages of disapproval. To add to this, the current anti-abortion movements are relentless in demonstrating their graphic and opposing views, adding to the potential stress surrounding a woman's abortion experience. The suggestion of abortion as murder or that abortion is detrimental to a woman's body are some of the angles these groups utilize (Littman, Zarcadoolas, & Jacobs, 2009). Clinic violence is another significant issue that contributes to a woman's experience as well as the safety of the staff in place to facilitate and support her. A 2010 survey conducted in the United States found that approximately 23.5% of all abortion clinics experienced extreme violence and 62.8% of clinics experienced intimidation and harassment (Gilligan, Keating, & Khorsand, 2010).

**Research and Mental Health**

The research examining abortion and mental health has significant problems in methodology and consistency (Ring-Cassidy & Gentles, 2002). The absence or lack of long term follow-up makes it difficult to record any data post-abortion in the weeks or
months following the procedure. With this in mind, there are often studies that aim to present abortions as an easy, care-free procedure and base their results on immediate or short term data (Ring-Cassidy & Gentles, 2002). Other issues that should be considered when examining the research on abortion and mental health are whether researchers may be biased and come from a pro-life or pro-abortion philosophy.

Ring-Cassidy and Gentles (2002) identified a number of illegitimate studies flawed by researcher bias, resulting in exaggerated results that concluded abortions put women at risk for post-traumatic stress disorder. In my review of studies on post-abortion and mental health I discovered biases and exaggerated results based on the beliefs of the researchers. Coleman et al. (2009) published a study on the effects of induced abortion in the context of the national co-morbidity survey. This research suggests that women who have had abortions are at a higher risk for a variety of mental health issues. Anxiety disorders such as panic attacks, panic disorder, agoraphobia and post-traumatic stress disorder, mood disorders such as bipolar disorder and major depression, and substance abuse disorders are identified as mental health issues that are more prevalent in women who have aborted than in women who have not (Coleman et al., 2009). Biases come into question when Coleman et al. reveal that their research finds “abortion contributed significant independent effects to numerous mental health problems above and beyond a variety of traumatizing and stressful life experiences” and is responsible for more than 10 percent of the sample populations incidence of alcohol dependence, alcohol abuse, drug dependence, panic disorder, agoraphobia and bipolar disorder (Coleman et al., 2009, p. 775).
Other research tends to minimize the effects of abortion. In Sweden, Kero, Hogberg, and Lalos (2004) studied the well-being and mental growth of women at 4 and 12 months after the abortion procedure. Their findings suggest almost all of the women in their study experienced relief and felt like they were taking responsibility in their lives. Approximately two thirds of the participants in their study did not experience any emotional distress and reported only positive experiences. Only one fifth of the participants experienced a crisis reaction or some type of emotional distress (Kero, Hogberg & Lalos, 2004).

These dramatic research findings confuse and tangle the truth about what women experience post-abortion by misleading, exaggerating and minimizing the effects an abortion can have on a woman’s mental health and emotional needs. These aforementioned studies are problematic as they hinder the growth of emotional care programs in post-abortion counselling (Ring-Cassidy & Gentles, 2002).

**Risk Factors Relevant to Abortion and Mental Health**

The experience of abortion is a difficult and stressful one physically and mentally. The unique circumstances for a woman seeking this procedure may influence her emotional stability throughout the process, some feeling more emotional distress than others (Ring-Cassidy & Gentles, 2002). Several internal and external sociocultural risk factors are significant determinants in how a woman will cope emotionally after her abortion. Mental health history, relationships with a partner, religious beliefs, age, family and therapeutic support all contribute to the well-being of an individual before and after the abortion (Ring-Cassidy & Gentles, 2002). Pre-existing or former mental health issues will likely influence any emotional difficulty experienced post-abortion (Rosenfeld,
As the procedure can be a significantly stressful life event, it may trigger negative feelings and a need for emotional care (Rosenfeld, 1992).

The quality of the relationship between a woman and her partner is a factor which will affect her emotional needs and feelings post-abortion. Relationship dysfunction or abusive relationships are often primary influences in the decision to have an abortion when compared to women in non-abusive relationships (Glander, Moore, Michielutte, & Parsons, 1998). These relationships often implicate depression, stress and a lack of support, putting the woman at a high risk for post-abortion emotional difficulty (Bluestein, 1993).

Religious beliefs that do not support abortion may also impact the way a woman processes her feelings throughout the procedure (Baker, 1995). Without the support of her denomination and her peers within that group, a woman’s belief system can add stress to decision making and perpetuate guilt, depression or regret following the procedure (Tamburrino et al., 1990). This lack of support will often compel a woman to keep her abortion in secrecy. This secret is representative of shame and fear and is an additional troublesome weight to a woman already trying to cope after her abortion (Ring-Cassidy & Gentles, 2002).

The development of secondary sex characteristics and the hormonal changes that take place during the adolescent’s growth bring awareness to her sexuality and interest in sex (Leishman & Moir, 2007). According to United States abortion statistics, 18% of women requesting abortions are adolescents (The Guttmacher Institute, 2011). A number of factors contribute to this statistic; in some cases it is a lack of knowledge and education on sex and contraception. In other cases, external factors will influence risk taking in
sexual behaviours. Family dynamics, living with a single parent, poor paternal supervision or support, family disruption and older sexually active siblings are factors that can influence an adolescent’s sexual activity (Leishman & Moir, 2007). Socio-economic status, peer pressure, cultural and ethno-racial values and beliefs, and religious beliefs have also been identified as contributing factors to risk taking in sexual behaviour (Leishman & Moir, 2007). Risk taking is a significant aspect of adolescent development, and choosing to engage in sex without contraception is an opportunity to take a risk (Brien & Fairbairn, 1996). Experimenting with drugs and alcohol are additional risk-related activities adolescents engage in. These activities will influence the decision making around sex and contraception as well. Underlying emotional issues may influence an adolescent's unwanted pregnancy; it can be a sign of distress or a struggle for power, attention and control between a young woman and her parents (Brien & Fairbairn, 1996). Adolescents are at great risk for psychological difficulties as they are still developing cognitively and emotionally. Without this maturity adolescents may have significant difficulty coping with the stress of such a significant life event, so much so that it may affect the development of their personality (Campbell, Franco, & Jurs, 1998). Depending on their position regarding the pregnancy and the relationship she has with them, an adolescent can experience additional stress and difficulty when seeking support from her parents (Rando, 1986). Other important aspects of development that may be affected are self-esteem, identity and self-expression (Deutsch, 1982). Having not yet developed a mature cognitive method for processing and planning, adolescents are at a higher risk for unwanted pregnancy and may not be able to understand the full scope of the pregnancy (Ring-Cassidy & Gentles, 2002).
These risk factors indicate the need for emotional care following the abortion procedure and should be considered in the development of a care program. Women who are not considered at risk are still likely to experience significant emotional difficulty. A number of meta-analyses on the research examining the psychological responses pre and post-abortion indicate that 60% of women experience clinical levels of anxiety and depression before their abortion and 40% of women experience emotional distress in the form of depression and anxiety in the weeks following their abortion (Lauzon, Roger-Achim, Achim, & Boyer, 2000). Grief, loss, sadness and guilt are other emotions related to immediate post-abortion experiences (Joy, 1985).

This literature indicates that a woman’s social support system, beliefs, age, relationship and ability to manage stress will affect her emotional response to abortion (Zucker, 1999).

**Significant emotions surrounding abortion**

The stress of an unplanned pregnancy on its own can make coping with the experience of abortion more difficult to manage (Brien & Fairbairn, 1996). Research by Adler (1975, as cited in Zucker, 1999) examining emotional responses experienced throughout the experience of abortion identifies three categories of emotions relevant to the experience of abortion. There are positive emotions, such as happiness and relief; socially based negative emotions, which include shame, guilt, fear and disapproval; and internally based negative emotions, which she identifies as sadness, regret, anxiety, depression, doubt and anger (Zucker, 1999). Ambivalence has also been identified throughout the literature on this subject as a common feeling or attitude surrounding the abortion (Lemkau, 1988).
Abortion is often representative of a solution to a crisis in a woman's life (Zucker, 1999). With this in mind, feeling relief or happiness immediately following the procedure is not uncommon (Zucker, 1999).

Sadness is one of the most common emotions experienced before or after an abortion (Brien & Fairbairn, 1996). The significantly complicated loss of the potential life can be confusing, and since the woman has chosen this termination she may feel like her sadness should not be validated (Brien & Fairbairn, 1996). Blocking or suppressing the sadness may lead to increased emotional difficulty in the future (Brien & Fairbairn, 1996). By identifying the sadness and making space for it, a woman may begin working through her emotional needs and look towards resolution.

Abortion involves a very complicated kind of loss. On an emotional level it deals with two significant human experiences: birth and death (Speert, 1992). The complexity of this loss can make it difficult for a woman to properly grieve and heal from her experience (Brien & Fairbairn, 1996). Grief experienced after an abortion can be related to the loss of the foetus, but also the loss of self-esteem, or the loss of an established self-image (Rando, 1986). The societal, cultural and political influences and beliefs regarding abortion can generate a stressful environment for women seeking support for their emotional needs. This stressful climate can compel women to hold their abortion experience in secrecy and shame, with many women denying their loss all together (Brien & Fairbairn, 1996). Without allowing any space for grieving it is possible that many women do not adequately resolve their grief (Brien & Fairbairn, 1996). Intimate relationships can also complicate or deter a woman from grieving her loss (Gray & Lassance, 2003). When a woman's partner is unsupportive of the pregnancy, or coercive
in her decision to abort, she is dealing with the loss of her unborn baby and potentially the loss of her relationship with her partner (Gray & Lassance, 2003). For many individuals, expressing grief involves several predictable emotions or phases. Shock, numbness, denial, pain, disorganization, acceptance and reorganization are feelings which may occur in sequence, or at the same time and at differing levels (Parkes, 1972). Properly grieving the loss after an abortion is a necessary process where the body, mind and spirit can find comfort and restoration (Gray & Lassance, 2003).

There are several external factors which may impact a woman’s experience surrounding abortion; cultural, societal and religious beliefs and influences can create a sense of guilt or shame (Brien & Fairbairn, 1996). Societal ideas about abortion and reproductive responsibility, and anti-abortion media are significant contributors to making a woman feel guilty. Some women see their decision to terminate as selfish, and that they are putting their needs before the unborn, this perspective may also generate feelings of guilt (Brien & Fairbairn, 1996). Other reasons for feeling guilt are related to contraceptive responsibilities and becoming pregnant in the first place (Baker, 1995). Similar to sadness and grief, unaddressed guilt may lead to more severe feelings of shame or depression (Gray & Lassance, 2003).

Another complex emotion that may be experienced around the abortion is anger (Brien & Fairbairn, 1996). Anger can be used to suppress or block other underlying sensitive or vulnerable emotions. Women may experience anger for a variety of reasons. A woman may feel anger toward herself for getting pregnant and her circumstance surrounding the pregnancy; anger may be directed towards the failure of the contraception (Berger, 1984). Targeting emotions towards her partner is another way of expressing
anger; she may feel angry for his role in enabling the pregnancy, for not wearing protection, for a lack of support or for pressure to terminate (Brien & Fairbairn, 1996). Allowing a woman to express her anger without judgment and facilitate an exploration towards the roots of these feelings can promote resolution. By validating her feelings she may be able to gain control and feel like she can move forward emotionally.

In addition to the aforementioned emotions identified, a general sense of anxiety is another common emotion experienced before and after the abortion procedure (Cougle, Reardon, & Coleman, 2005). As with many medical procedures, the uncertainty of the actual physical procedure can generate a feeling of anxiety and the possible pressure and stress during the decision making process can also induce a significant amount of anxiety (Berger, 1984).

These emotions may be experienced concurrently or individually and to different levels of severity, and in some rare cases they may develop into a psychiatric disorder (Casey, 2010). Post-traumatic stress disorder, substance misuse, suicidal behaviour, depressive disorder and generalized anxiety disorder have been identified by several researchers as the more severe outcomes for women post-abortion (Casey, 2010). These findings do not necessarily reveal any positive correlations between these psychiatric disorders and abortion, and it is likely that it will not be possible to study this potential relationship due to the unique nature of each woman's situation and circumstance (Casey, 2010).

Immediately following the abortion procedure many women experience feelings of relief as they have just completed the procedure and can stop feeling anxious about the unwanted pregnancy. These initial positive feelings can often lead staff and counsellors to
overlook any other emotional difficulty and result in a quick discharge with little follow up (Brien & Fairbairn, 1996). Although this may indicate no further care is needed, the possible emotional impact should be acknowledged and cared for appropriately.

These emotions are possible outcomes for many women after going through the experience of having an abortion. Each woman’s circumstance, culture, history, support system and beliefs will make her experience completely unique and therefore counselling approaches within a flexible and holistic framework are required.

**A Counselling Intervention**

Current counselling interventions for women before their abortion involve an examination of options, an establishment that the woman’s decision was uncoerced, support in the woman’s ability to make this decision, identification of the woman’s support system and an exploration of her feelings on the termination of the pregnancy (Baker, 1995). After the abortion, follow-up sessions with counsellors trained specifically for the population are available at the abortion clinic. These sessions are often short term, and due to the stigma surrounding abortion it is not uncommon for clients to dismiss these appointments in an attempt to put the whole experience behind them.

Organizations and self-help groups have been established across North America to support the emotional needs of women coping with an abortion. The National Abortion Federation provides information and resources for women seeking support after an abortion and suggests organizations such as Exhale and Project Voice as unbiased post-abortion support groups (The National Abortion Federation, 2010). These resources tap into themes of personal narratives, grief and loss and forgiveness. In other parts of the world, abortion support resources have long been established. For example, since the
1950s Japan has practiced abortion as a means for birth control and as a result have established 'mourning rooms' in temples available to women seeking a place to grieve after an abortion. Temples in Taiwan have 'baby spirit' programs available to women or couples who have proceeded with an abortion (Ring-Cassidy & Gentles, 2002).

Specialty counselling may be offered or recommended for women in certain circumstances. For instance, second-trimester abortion clients will have had more time to experience and think about their pregnancy, which may intensify the aforementioned emotions surrounding abortion (Berger, 1984). Women who had intended to carry their pregnancy to term who, due to fetal complications, require an abortion will most likely experience feelings of great sadness or depression (Berger, 1984).

Adolescents may also require further counselling to explore their feelings surrounding the experience, since developmentally the adolescent is going through concepts regarding identity, sexuality, intimacy and independence (Brien & Fairbairn, 1996). The event of a pregnancy and motherhood may be very difficult to process or place within the framework of these ideas during adolescence. Having a well established support system from the family or partner is particularly important for these young women. Isolation and a lack of support are factors that can contribute to emotional difficulty coping with the experience (Brien & Fairbairn, 1996).

Although every woman’s circumstances and coping abilities will differ, it is important to make sure a support system is available and accessible to each individual. Informing women about the counselling options and therapeutic services available is another step that should be integral to abortion clinic practice.
Partners of the women requesting abortions are also vulnerable to feelings of guilt, depression, anger and shame, especially if they have ambivalent feelings towards their situation. Partners whom are coercive in the decision to abort often feel an immediate sense of relief, but in later disclosures, express guilt, shame and grief (Ring-Cassidy & Gentles, 2002). The legal status of men in abortion decision making is non-existent, which may influence the emotional experience of the partners. Research suggests feelings of isolation, anger towards themselves and/or their partners and fear for the emotional sequelae of their partners (Rue, 1994). Although there is little research on the effects of abortion on the partners of women, the available research indeed suggests that men do experience a degree of depression, guilt and shame (Ring-Cassidy & Gentles, 2002). The unique experience, history and dynamic between the man and his partner will of course influence the experience of the abortion and his emotions around the situation as well.

**Miscarriage**

**Current Research: Miscarriage and Mental Health**

Aside from several small-scale clinical reports and studies from the 1960s and 1970s, the literature and research exploring the effects of miscarriages on women's emotional and mental health has only recently developed and expanded (Toedter, Lasker, & Janssen, 2001). In the 1980's bereaved parents began to express themselves more about their experiences surrounding reproductive loss (Toedter, Lasker, & Janssen, 2001). These couples began writing and sharing their experiences with the intention to reach out to other bereaved couples. Social scientists followed this initiative and contributed to their movement with information on education and pregnancy, reproductive grief and
loss, self-help books and support groups (Toedter, Lasker, & Janssen, 2001). From this point on larger quantitative studies using standardized measures involving women, couples and families have been designed to explore the emotional impact of miscarriage (McCreight, 2008).

With many studies now being published on reproductive loss and grief, meta-analyses are emerging comparing results from around the world (Toedter, Lasker, & Janssen, 2001). To consolidate and compare all these results, Toedter, Lasker, & Alhadeff (2001) developed the Perinatal Grief Scale (PGS) as a tool to measure the range of feelings, symptoms and emotions when grieving. The PGS involves 104 items formatted on a Likert scale, ranging one to five. The researchers chose the scale items based on previous research in perinatal loss and supported these with additional questions from the Texas Inventory of Grief (Toedter, Lasker, & Janssen, 2001). The authors highlight that the PGS is being used in research throughout the United States as well as “many other countries” (Toedter, Lasker, & Janssen, 2001, p. 207). Until 2001, only one report independent from the PGS authors had been published examining the reliability and validity of the PGS (Toedter, Lasker, & Janssen, 2001). The results of this report are not included or discussed in the aforementioned literature.

Other grief scales regarding reproductive loss have since been developed. The Munich Grief Scale is a modified and shortened version of the PGS and measures sadness, fear of future losses, feelings of missing the baby, guilt, anger, the meaning of the pregnancy and difficulty surrounding lost expectations, hopes and fantasies for the baby (Brier, 2008). The Perinatal Grief Intensity Scale is another tool designed to measure the intensity of the grief following miscarriage (Brier, 2008). The most recent
scale is based on a meta-analysis of theoretical, clinical, counselling and academic research literature on the subject of reproductive loss (Brier, 2008). The Perinatal Bereavement Grief Scale is designed to measure grief post-reproductive loss by directly examining the extent to which the woman yearned for her loss (Brier, 2008).

Wright argues that the research on pregnancy loss is largely inconsistent and contradictory (2011). Inconsistencies in terminology and evidence are apparent throughout the research regarding pregnancy loss. Wright identifies length of time a woman may feel the emotional effects of her loss, maternal age and perinatal grief, subsequent births and perinatal grief and instruments of measurement as primary aspects of the research which show significant inconsistency (2011).

**Emotional Responses to Miscarriage**

Research in the United States finds that miscarriages affect approximately 10% to 25% of all recognized pregnancies (Robinson, Baker, & Nackerud, 1999; Shreffler, Greil, & McQuillan, 2011). Despite this statistic, the emotional needs of women following this event do not often get the attention and care necessary for healing (Speert, 1992). The physical trauma of a miscarriage in combination with the unexpected loss can amount to a traumatic event (Zucker, 1999). A meta-analysis on pregnancy loss and mental health suggests between 20 to 30 percent of women experience a deterioration in psychological functioning and general health following their loss (Brownlee & Oikonen, 2004). Miscarriages can happen from genetic problems, infections, drugs, cigarettes and alcohol, exposure to chemicals or pesticides, multiple pregnancies, abnormalities of the reproductive organs, hormone imbalance and ectopic pregnancy although there are still miscarriages for which the cause is unknown (Hey, Itzin, Saunders, & Speakman, 1989).
The experience of a miscarriage is often minimized by those who have not been through a lost pregnancy, when in actuality most couples genuinely grieve for their unborn (DeFrain, Millsbaugh, & Xie, 1996).

Many individuals are under the impression that the relationship with an unborn or newly born infant and its parent is one that will develop and exist essentially in the future (Doka, 1989). This notion is entirely unfounded for the parents as they have been bonding with their unborn since they knew of his or her existence. In lieu of the aforementioned assumption, many individuals will discount or be unresponsive to the loss (Doka, 1989).

For many couples the standard hospital response to miscarriage or perinatal death is in the form of crisis intervention (Brownlee & Oikonen, 2004). These interventions are provided by a multidisciplinary team of professionals and offer practical support as well as information regarding the loss and emotional support (Brownlee & Oikonen, 2004). While the crisis intervention model validates the loss and meets the immediate needs of the mother, it is brief and cannot address the grief and mourning that will ensue (Brownlee & Oikonen, 2004).

The loss of a pregnancy can have a significant emotional impact on a woman, her partner and her family. Not only is she losing her unborn child, but she will be losing her role as a mother, her hopes for a family and expectations around the future of her baby (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). For some, motherhood is considered a central piece in a woman's lifetime, one that is integral to fulfilling her role as a woman, adult and partner (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). In western culture, the myth of motherhood, where childbearing is the defining role,
idealizes women who become mothers (Zucker, 1999). Potentially losing this experience can have a devastating impact on a woman's emotional and mental health (Gerber-Epstein, Leichtentritt, & Benyamini, 2009).

During the first trimester of pregnancy, women often experience their growing baby not as a separate being, but as a part of, or extension of themselves; this is identified as the narcissistic stage (Gray & Lassance, 2003). Considering almost three-quarters of miscarriages occur within the first 12 weeks of pregnancy, the early miscarriage implies a loss of a part of oneself, in addition to the loss of the maternal role and the dreams of building a family (Gray & Lasance, 2003).

The literature regarding reactions and behaviours following a miscarriage find grief patterns similar to those of other types of significant losses (Brier, 2008). Although this research and information regarding grief following a miscarriage is helpful in understanding a woman's experience, there are unique aspects of this loss that must be considered and identified when working with this population (Brier, 2008). Depression is also of concern when working with the responses to a pregnancy loss. Research on depressive symptoms in women following their miscarriage indicated up to half of the women in the study reported elevated levels of depressive symptoms within the first few months following their loss (Shreffler, Griel, & McQuillan, 2011).

Shock is the most common initial response (Peppers & Knapp, 1980). When a mother has been focused on ideas and expectations of a normal delivery, finding out about a miscarriage is devastating, and has been described as “unreal” or a nightmare from which they will awaken (Peppers & Knapp, 1980, p. 32).
Feelings of guilt are often present and related to blaming the self for failure to protect and nurture the developing baby (Brier, 2008). The sense of failure can instill feelings of uncertainty around future fertility and physical ability to carry a pregnancy (Zucker, 1999).

There are several theoretical perspectives that explore miscarriages and how they can lead to more complicated grief. The first theory suggests grieving a perinatal loss is similar to grieving the loss of a loved person, but in this case the loved one was never an actual, physically present being (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). This absence of a concrete being can aggravate the mourning process and potentially lead to complicated grief (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). The literature on this theory suggests that women may have a difficult time understanding their loss as it was for 'someone who did not exist' (Gerber-Epstein, Leichtentritt, & Benyamini, 2009, p. 23). Although this theory is relevant to understanding complicated grief, I find this description of the embryo to be insensitive to the woman's individual ideas about her pregnancy and the relationship she may have had with her developing baby.

The notion of the narcissistic stage of pregnancy is central to the second grief theory for miscarriage (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). As mentioned, during the first trimester a woman may perceive her developing baby as a part of herself, as opposed to a separate being. This “narcissistic loss” (Gerber-Epstein, Leichtentritt, & Benyamini, 2009, p. 4) can complicate the normal grieving process and may be experienced as a betrayal by the woman's own body (Gerber-Epstein, Leichtentritt, & Benyamini, 2009).
Lastly, the third approach focuses on the traumatic nature of a miscarriage and examines studies that identify significant traumatic symptoms. Research looking at the psychological reactions following a first trimester miscarriage suggests approximately 70% of participants experienced anxiety, fear, helplessness, sleep difficulties and repeated recollection of the experience (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). This theory suggests that not only does a woman need to mourn her loss, but she may also need to deal with the effects of trauma, which can in turn complicate her grief process (Gerber-Epstein, Leichtentritt, & Benyamini, 2009).

The impact a miscarriage has on a woman's mental well-being and the way in which she grieves will vary based on each woman's unique experience, mainly history, culture, beliefs and ideas around her pregnancy. Other influential factors include investment and meaning in the pregnancy, fertility history, relationship quality, age of the mother, previous pregnancy losses, number of children, time and energy involved in conception and external expectations and influences around childbearing (Shreffler, Griel, & McQuillan, 2011).

The degree of planning and anticipation before and in the early stages of a pregnancy can affect the level of distress experienced by the woman. Studies exploring this relationship found that women who lost planned pregnancies endured greater distress than those of unplanned pregnancies (Shreffler, Griel, & McQuillan, 2011). The level of attachment and commitment to the developing baby are also influential in how much distress a woman may experience following a miscarriage (Shreffler, Griel, & McQuillan, 2011). Mother-infant attachment starts to develop before the baby is even conceived; planning the pregnancy, confirming the pregnancy, and preparing for the baby are just the
initial steps in forming a mother infant attachment and they all occur prenatally (Shreffler, Griel, & McQuillan, 2011). Brownlee and Oikonen argue that technology has increased the opportunity for forming stronger attachments to the foetus with 3D imaging, foetal monitoring and ultrasounds (2004). Commitment and attachment can also contribute to the meaning of the pregnancy for a woman, which will affect her levels of distress in the instance of a miscarriage (Shreffler, Griel, & McQuillan, 2011).

Women experiencing their first pregnancy may also show greater distress in the case of a miscarriage. The first pregnancy symbolizes a significant transition into motherhood, and also entails emotional and psychological growth (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). A developing maternal identity, and anticipatory thoughts, fantasies, wishes, hopes and anxieties about the developing baby have great personal significance for first time mothers (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). These developments and processes are well under way throughout the first trimester; losing them or having them abruptly terminated will cause greater distress for women experiencing their first pregnancy, than for those already with children (Shreffler, Griel, & McQuillan, 2011).

Hormones and chemicals during pregnancy have prepared the mother to nurture and care for her baby (Doka, 1989). This fluctuation of hormones combined with the emotional intensity of the loss can further impede the grieving process (Doka, 1989).

Views and beliefs on motherhood and the importance of motherhood are additional factors which will affect the psychological response to miscarriage. Infertility research suggests women who place a great amount of importance on child-bearing experience greater levels of distress (Shreffler, Griel, & McQuillan, 2011).
Theories on Bereavement and Mourning

Psychodynamic theories on grief and mourning provide insight and ideas into the psyche and explore how grief can affect an individual’s character and identity (Berzoff, 2003). While they serve as a foundation for more current theories, they do not address the scope of physiological and emotional experiential aspects of mourning (Berzoff, 2003).

Winnicott’s (1960) model is built around the idea of the transitional object (1960). In his theory a transitional object is symbolic of a special bond or relationship between a mother and her baby. Through the mothers presence and absence a baby will select an object representational for their bond, so when the mother is absent the baby will have her transitional object for comfort and security as an inner representation of the mother (Winnicott, 1960). The ability to maintain an inner representation of the mother will determine the child’s capabilities for self soothing. Eventually a child will build and strengthen their ability to maintain an internal representation and their object will become meaningless (Berzoff, 2003). This theory applies to loss, in that the bereaved may select a transitional object to soothe their pain from the absence of their deceased. Transitional objects may include photographs, diaries, and items of clothing. These items link the mourner to the deceased and create a symbolic tie to the loss. Eventually the mourner should be able to give up their objects as they develop the ability to internalize the memory and meaning of their loss (Berzoff, 2003).

The ‘stage’ model for grieving has been established and interpreted by a number of professionals. Kübler-Ross (1975) developed one of the most significant examples of
The stage model. This model identifies five stages which describe the experience and reactions of individuals experiencing a loss. Kübler-Ross describes the first stage as denial and shock, a sense of disbelief. Anger follows with a sense of outrage and injustice. The third stage is bargaining; the bereaved is seeking control and a way out of their suffering by pleading with higher powers. Depression ensues in the fourth stage and acceptance of the loss is identified as the final stage (Kübler-Ross, 1975).

Worden’s (2003) ‘phases’ model highlights the notion of grief work and active participation in the grieving process. The notion of ‘stages’ is one approach to viewing the mourning process; the term 'stages' implies a specific order of feelings and is primary in the theories on the subject. His criticisms on the stages approach highlight the fact that many individuals will not mourn their loss in an organized, order of stages (Worden, 2003).

'Phases' are another way of viewing the mourning process (Worden, 2003). There are typically four phases associated with grieving: numbness, yearning, disorganization and despair and reorganization (Parkes, 1970, as cited by Worden, 2003). Similar to stages, this theory implies a 'passing through' of the phases to resolve the loss (Worden, 2003).

Worden (2003) proposes the concept of 'tasks' in his theory on the process of mourning. He points out the passivity associated with phases and steps. 'Tasks' give mourners a framework to do something, and actively work through their grief with hope. He acknowledges Freud's concept of 'grief work' in this explanation. 'Grief work' is described as a cognitive process that requires the bereaved to confront their loss and restructure their thoughts regarding the deceased, the experience of the loss and the
different environment that the bereaved must now adapt to and live in (Stroebe, 1992, as cited by Worden, 2002). The tasks model offers grieving individuals some agency and hope in their experience of loss and tells the mourner there is something that he or she can do (Worden, 2003). Additionally, the tasks model provides clinicians with a framework for setting goals and can be implemented in a therapy model for individuals grieving a loss (Worden, 2003).

Worden (2003) notes that it is possible to complete some of the tasks and not others; this incompletion of tasks will hinder any growth and development in healing from the loss. Tasks can be revisited and reworked to meet the client’s needs, and can be worked on at the same time (Worden, 2003). This flexibility resonates with the dual-process bereavement model described earlier in the context of an art therapy intervention.

Accepting the reality of the loss is the first task of mourning (Worden, 2003). Part of this acceptance involves understanding the deceased is gone and will not return and that an actual reunion is not going to happen. When an individual struggles or fails to accept the reality of their loss they may enter into a state of denial. Denying the loss can result in a number of other behaviours. “Mummification” can take place in the case of denial; this involves maintaining the possessions of the deceased in the exact condition they left them in case they return (Worden, 2003, p. 28). Denying the meaning of the loss is another method bereaved individuals may avoid their reality. Bereaved individuals will convince themselves that the relationship with the deceased was insignificant and may immediately remove the belongings of the deceased in a casual manner. Worden describes this as the opposite of mummification; by removing any reminders of the
deceased the bereaved can minimize the loss and will not have to face the reality of their situation (Worden, 2003).

Completing this first task requires acceptance on an intellectual level and an emotional one (Worden, 2003). Rituals honouring the deceased can help validate the loss and encourage the bereaved towards acceptance. The unexpected nature of miscarriage can make completing this task problematic. As Worden (2003) notes, the task can be more difficult to complete in the case of sudden death.

The second task of mourning is to work through the pain of grief (Worden, 2003). This includes physical and emotional pain. Acknowledging, expressing and working through this pain is necessary, and if this does not take place the symptoms of the pain may worsen physically or develop into maladaptive behaviour. Negating the task of working through pain can lead to denial, avoiding painful thoughts, avoiding reminders of the deceased, idealizing the deceased and using drugs or alcohol to facilitate avoidance (Worden, 2003).

The third task is to adjust to an environment in which the deceased is missing. This task focuses primarily on roles; the role of the deceased and how it will affect the bereaved (Gray & Lassance, 2003; Worden, 2003). In the event of a reproductive loss, it is the role of the deceased baby that must be considered (Gray & Lassance, 2003). This task is comprised of three types of adjustments, external adjustments, internal adjustments and spiritual adjustments (Worden, 2003). External adjustments apply to how the loss will affect everyday operations in the bereaved individual's life. Developing new skills, taking on new roles or letting go of old ones and managing different responsibilities are adjustments that may need to take place. Internal adjustments refer to the self; self-
image, sense of self, self-esteem or definition of self (Worden, 2003). When a woman miscarries, she loses her sense of identity as mother and parent, and will need to adjust her sense of self (Gray & Lassance, 2003). Spiritual adjustments challenge an individual’s sense of the world and their fundamental beliefs and values (Worden, 2003). Adopting new beliefs and identifying a kind of ‘gift’ from the loss, such as a message, emotional strength or a life lesson are ways individuals may adjust to their spiritual sense of the world (Gray & Lassance, 2003).

The fourth task in the mourning process is to emotionally relocate the deceased and move forward in life (Worden, 2003). The idea of ‘relocating’ the deceased alludes to finding a place for the loved one that allows the bereaved to maintain a connection with them, but in a way that will not interrupt their way of life. Memorializing the loss is an ideal way to hold their memory while continuing on with life. Getting stuck in this final task can happen when the bereaved will hold onto their past attachment instead of forming a new one. Withholding love and avoiding new attachments as a defence from potential pain of grief and loss can prevent individuals from completing the fourth task (Worden, 2003).

More current bereavement theory models for processing grief involve a form of meaning-making and different stages of processing (Lister, Pushkar, & Connolly, 2008). The dual-process model is a rotation between two sorts of stressors, “loss-orientation” and “restoration-orientation” (p. 246). Loss-orientation involves ruminating and replaying the experience and emotional responses; restoration-orientation refers to the repercussions of the loss. This includes experiences, activities or other people that the individual will lose touch with due to the primary loss and the changes they will make in order to adapt to the
loss. By moving back and forth between these orientations, a confrontation-avoidance
dynamic occurs between positive and negative. With support and acknowledgment of
these transitions, meaning-making can occur in the back and forth between orientations,
allowing the individual to experience rumination and positive reappraisal as they move
through their emotional states (Lister, Pushkar, & Connolly, 2008).

From a constructivist perspective, the meaning-reconstruction model is based on
the individual creating a meaningful narrative and actively participating in the response to
the loss (Lister, Pushkar, & Connolly, 2008). People organize their life and significant
events into meaningful episodes (Neimeyer, R., Harris, D., Winokuer, H., & Thornton, G.,
2011). These episodes reveal themes, validate relationships and offer “personal
significance” and when put in the context of narratives, illustrate our unique life story
(Neimeyer, R., Harris, D., Winokuer, H., & Thornton, G., 2011, p. 10). When the self-
narrative is stable, whole, and makes sense, it can be viewed as a depiction of one’s
identity (Neimeyer, R., Harris, D., Winokuer, H., & Thornton, G., 2011). When a
significant loss occurs, or any other type of momentous life event, the plot of the self-
narrative is convoluted and identity is put into question (Neimeyer, R., Harris, D.,

Research conducted by Keesee, Currier, & Neimeyer (2008) explores the factors
relevant to bereavement outcomes for parents who have lost a child. Their research
suggests meaning-making can lessen the intensity and aid in the management and healthy
adaptation of grief for bereaved parents (Keesee, Currier, & Neimeyer, 2008).

This meaning-making model deals with concepts of identity, the self, and the self-
narrative; the individual may wish to rewrite their internal story, incorporating new
aspects to their identity. This updated self-narrative may open doors for new identities and meaning-making, with emphasis on the process and activity of finding meaning. Finding meaning in the loss and re-constructing meaning around life and the world are therapeutic measures the bereaved may pursue to alleviate complicated grieving and uncover hope in their changed self-narratives (Neimeyer, R., Harris, D., Winokuer, H., & Thornton, G., 2011).

Stories are open to change, so when an unforeseen loss occurs, such as a miscarriage or abortion, the plot can be rewritten (Brownlee & Oikonen, 2004). The flexibility of a narrative makes room for the hopes and wishes of the bereaved, supports meaning-making and allows the individual to express the significance of their loss and how they choose to grieve (Brownlee & Oikonen, 2004).

When considering meaning-making within the framework of a narrative model it is important to recognize the way in which personal stories usually emerge from a social and cultural discourse (Brownlee & Oikonen, 2004). As parents develop their own story about their loss, a social contribution can emerge and alleviate some of their sense of guilt and blame. The social and cultural context will play a role in how the parents respond, understand and react to their loss; the narrative model facilitates a discussion and provides a vehicle for expressing their loss. It should be noted that story telling and retelling of the loss as a general activity is beneficial and therapeutic on its own (Brownlee & Oikonen, 2004). Ultimately, this model views grief and loss as an opportunity for growth, and learning (Lister, Pushkar & Connolly, 2008).

Without any linear path, the dual-process and meaning-reconstruction models can fit well within the context of art therapy and focus on the individual's unique
understanding of their narrative surrounding the loss (Lister, Pushkar, & Connolly, 2008). Through creative expressions, the individual can give life and validity to their emotions, both negative and positive. Creating narratives through the art is an ideal process to promote meaning-making and growth.

Bereavement is a long process, sometimes taking a lifetime, art therapy can facilitate an integration of the loss into the individuals identity through creative expressions, narratives and metaphors (Lister, Pushkar, & Connolly, 2008).

**Grieving Reproductive Loss**

Grieving after the experience of an abortion or miscarriage is a special kind of loss (Worden, 2002). Loss not only means the death of an individual, but can include changes in social roles, expectations, function and body image (Payne, Horn, & Relf, 1999). Abortion is largely viewed as a “socially negated loss” (Worden, 2002, p. 136) and the secrecy and stigma around abortion can leave a woman feeling isolated and unsupported. When a woman experiences an early miscarriage she may not have even announced her pregnancy; family and friends will not have known she was pregnant, so this can bring up feelings of isolation as well (Gray & Lassance, 2003). In addition, the response to an infant’s death can be heightened by the unanticipated nature of the loss (Peppers & Knapp, 1980). In the instance that the infant is the first child, the loss can be particularly disruptive, in that it can interrupt family hopes and plans (Peppers & Knapp, 1980). Considering these circumstances, a woman may not allow herself the time and space to properly grieve or her process of grieving will be stifled or obstructed (Worden, 2002). By identifying the traits and behaviours associated with normal or uncomplicated grief
and framing these behaviours in the context of reproductive loss I will outline how grieving under these circumstances can lead to complicated and disenfranchised grief.

Uncomplicated grief implies the behaviours and expressions most often experienced by individuals in general, it is also sometimes called normal grief, referring to the predictability and frequency of this set of behaviours (Worden, 2002). These expressions include a range of feelings, physical sensations, thought patterns and behaviours, and manifest in the act of mourning (Payne, Horn, & Relf, 1999). These feelings are often overwhelming and can engulf an individual’s personality and ability to function normally (Stephenson, 1985).

Sadness is identified as the most common feeling in bereaved individuals (Worden, 2002). The intensity and depth of sadness from loss is often said to be indescribable; words cannot explain how profound it is (Weizman & Kamm, 1985). When this is the case, art therapy can be an ideal intervention for expressing the intense feelings that occur throughout the mourning process. The potential overwhelming nature of sadness can lead some individuals to blocking it out or repressing their emotional needs, which can lead to more complicated grief (Worden, 2002).

Payne, Horn and Relf (1999) identify anxiety as being one of the most common responses to loss. Coping with the loss and thinking about how they will manage in the future can instil fear and anxiety. Anxiety can induce feelings of restlessness and an inability to feel relaxed, this can lead to a lack of concentration and attention (Payne, Horn, & Relf, 1999).

Experiencing anger after a loss is common and for some individuals can be very confusing (Worden, 2002). Anger stems from a sense of frustration around feeling
helpless about the loss, it can also be turned inwards against the self, or outwards onto others. This displacement is related to blaming, with the reasoning that if there is an individual at fault, they are responsible for the loss, and therefore the loss could have been prevented (Worden, 2002). People often feel the need to express their anger directly to the source. This expression can be particularly difficult because the anger experienced in mourning does not necessarily involve an object for confrontation (Weizman & Kamm, 1985).

Guilt is also apparent in normal grief; directed towards the self, an individual may take on the responsibility of the loss and dwell on how they could have prevented it (Weizman & Kamm, 1985). Guilty feelings can develop from the quality of the relationship the individual had with the deceased, with people believing they could have improved their relationship or given more attention to the deceased (Weizman & Kamm, 1985). In the case of a miscarriage it is natural for parents to feel responsible for their baby. Putting blame on themselves and focusing on what they could or should have done differently serves to fulfill a fantasy where everything is all right; instead it prevents the parent from accepting the reality of the situation (Weizman & Kamm, 1985).

Other feelings associated with normal grief include helplessness, numbness, yearning, loneliness and shock (Worden, 2002).

Physical sensations are also apparent in cases of uncomplicated grief. Some of the most common sensations reported in grief counselling include hollowness in the abdomen, tightness in the chest and throat, lack of energy, feelings of weakness, a sense of depersonalization and an oversensitivity to noise (Worden, 2002).
Thought patterns may emerge in the experience of uncomplicated grief. Confusion and disbelief around the reality of the loss are common in the primary stages of grieving (Worden, 2002). In the instances of a sudden death, disbelief may surface as the idea that the death must be a mistake or even a dream (Worden, 2002). Mourning is an all-consuming process that uses a tremendous amount of physical, psychological and emotional energy (Weizman & Kamm, 1985). Forgetfulness, difficulty concentrating and disordered thoughts leave many individuals feeling confused immediately following the loss as well (Worden, 2002). Obsessive thoughts about the deceased and a preoccupation with the recovery or return of this person is another experience some individuals may find themselves going through following the loss (Worden, 2002). Hallucinations and feeling a sense of presence from the deceased are other cognitive experiences one may have after a loss; these behaviours are referred to as “searching behaviour” and occur as the bereaved experiences loneliness and yearning for their loss (Weizman & Kamm, 1985, p. 66). Audio and visual hallucinations are also frequently reported by bereaved individuals; this is related to a wish for the person to still be alive and can indicate a struggle with the reality of the loss (Weizman & Kamm, 1985).

Normal grief reactions can also involve a number of specific sleep-related behaviours. One of the most common is sleep disturbances: difficulty falling asleep, staying asleep or very early awakening. Sleep disorders may also be related to fear and anxiety around dreaming and sleeping alone (Worden, 2002). Waking from sleep can feel like the initial realization of the loss every time (Weizman & Kamm, 1985).

Dreams serve as significant psychological events that represent attempts to work through conflicts and integrate or resolve the loss (Weizman & Kamm, 1985). Dreaming
of the deceased is another common experience in bereaved individuals (Worden, 2002). These dreams can often offer insight to the mourning process, and where the individual is at (Worden, 2002). Underlying themes in the bereaved dreams can be useful in understanding and making sense of the loss (Worden, 2002).

**Complicated and Disenfranchised Grief**

Under certain circumstances, some individuals may fail to grieve or their grieving process may be interrupted or obstructed (Worden, 2002). Factors that influence the way an individual grieves include the relationship they had with the deceased, the circumstances around the loss, previous losses, personality traits in coping with distress and social circumstances (Worden, 2002). Disenfranchised grief can lead or contribute to complicated grief and encompasses many of the same conditions as complicated grief. Complicated grief involves prolonged unresolved feelings, a sense of feeling overwhelmed, symptoms of traumatic distress, maladaptive behaviour and persistent disbelief about the loss (Lobb et al., 2010). This type of grief may also reveal exaggerated reactions, such as clinical depression, anxiety disorder, substance abuse and Post-Traumatic Stress Disorder (Worden, 2002). Examining the factors relevant to complicated and disenfranchised grief in the context of reproductive loss will help therapists and clinicians support their clients in the most appropriate ways and contribute to the development of an art therapy intervention.

Disenfranchised grief occurs when the loss does not receive normal social support, is not openly acknowledged or cannot be mourned publicly (Doka, 1989). Grief can be disenfranchised when the relationship with the deceased is not recognized, when the loss is not acknowledged or socially acceptable and when the griever is thought to be
incapable of mourning or the loss did not impact them (Doka, 1989). The circumstances of the death and the way the bereaved chooses to mourn are additional factors that can result in disenfranchised grief (Doka, 2002, as cited by Attig, 2004).

These circumstances are defined by the culture and society in which they occur and imply “grieving rules” that determine who, how, when, for how long, where and for whom the individual grieves (Doka, 1989, p. 4). These “grieving rules” do not allow the bereaved to adequately express their feelings in a way that others can and do under different circumstances (Doka, 1989).

Attig (2004) notes the disenfranchisement of grief as a societal failure to empathize. Denying empathy to the bereaved undermines their suffering, the meaning of their loss and the pain or agony they may be experiencing; this in turn does not support their needs and if anything, contributes unnecessarily to their suffering. Disenfranchising messages from society, culture and family “actively discount, dismiss, disapprove, discourage, invalidate, and delegitimize the experiences and efforts of grieving” (Attig, 2004, p. 198). These types of behaviours interfere with the needs and rights of the bereaved by hindering, disapproving or even prohibiting their grief (Attig, 2004).

The type of relationship the individual had with the deceased is a factor that can contribute to complicated or disenfranchised grief (Doka, 1989). Ambivalent feelings about the death and the relationship with the deceased can make the process of grieving more difficult and lead to complicated mourning (Stephenson, 1985). It is possible to feel glad and sad about a loss. This ambivalence can bring about exaggerated feelings of anger and guilt, prolonging the process of grieving (Stephenson, 1985). In the context of abortions, feeling ambivalent towards the pregnancy has been identified as a significant
reaction (Lemkau, 1988). A woman may feel relieved and happy she has proceeded with the abortion, yet still feel sadness from her loss and its meaning. This would suggest that women going through the experience of abortion are at risk for complicated mourning.

Another type of relationship relevant to complicated grief is a notably narcissistic relationship (Worden, 2002). In this case the deceased has been representational as an extension of the individual suffering the loss. Acknowledging this loss implies confronting and accepting the loss of oneself (Worden, 2002). Reflecting on the research discussed earlier, the first trimester of a pregnancy is referred to as the narcissistic stage, as the woman experiences her developing fetus as a part of herself, as opposed to a separate entity (Gray & Lassance, 2003). In the case of a miscarriage, this particular dynamic can influence the way a woman grieves her loss. The intensity of this loss can be explained by the “affectional bond” a term developed by Kennell, Slyter and Klaus (1970, as cited by Peppers & Knapp, 1980). The affectional bond or prenatal bond is the developing emotional attachment between the mother and infant during the first months of pregnancy (Peppers & Knapp, 1980). Fetal death abruptly severs this bond and results in heightened anguish and grief (Peppers & Knapp, 1980). In addition to this complicated 'loss of oneself', a miscarriage denotes a loss of hopes and wishes which will not be realized (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). Grieving for the loss of anticipated wishes and desires can also contribute to complicated mourning (Worden, 2002).

Type of attachment to the deceased and level of dependency associated with them are additional determining factors for complicated grief (Lobb et al., 2010). Insecure attachments stemming from childhood can affect the way an individual will respond and
manage grief. People with a higher dependency on their partners or family are also at risk for complicated grief and difficulty managing their loss (Lobb et al., 2010).

The suddenness of a miscarriage is primary in how the parents will grieve and feel their loss (Peppers & Knapp, 1980). Having no indication or warning of their loss, the unforeseen death can be shocking and parents may respond with intense anger, frustration, bewilderment and guilt (Peppers & Knapp, 1980).

Worden (2002) notes that grief is a social process and highlights the importance of support systems such as family and friends. Lazare (1979, as cited by Worden, 2002) outlines three conditions which apply to the social aspect of grieving and can contribute to complicated mourning and disenfranchised grief. A socially unspeakable loss refers to circumstances where the individual and/or their family feels a need to keep the cause of death in secrecy (Worden, 2002). How the infant is defined and perceived by the culture can influence the response of the parents (Peppers & Knapp, 1980). In the instance of miscarriage the relationship with the deceased may have never been publicly recognized or even known to family and friends. Parents are deprived of validation through clichés such as “You’re young; you can have another”; “He would have been a vegetable”; “It happens in life” and “You’re lucky it happened now; she would have been such a burden” (Doka, 1989, p. 117). This disregard for the relationship disenfranchises the loss and leaves the bereaved without any normal cultural and societal supports in place for coping with this type of loss.

The community surrounding the parents will not perceive or respond to the death the same way they would to that of an older person. In this case they will dissociate normal grief from the situation and perhaps see the circumstances as “unfortunate” not
“tragic” (Peppers & Knapp, 1980, p. 28). Not having had any social presence or recognition, the loss of a developing baby can be disenfranchised and will be difficult to mourn, as the support from family and friends may not be as strong or immediate.

Additionally, pregnancy is often kept in secret until a specific stage, and the cause of death is sometimes unclear which may compel some families to keep their loss private. In a culture that idealizes motherhood, the experience of miscarriage can feel isolating (Worden, 2002).

Grief is disenfranchised when a loss is socially negated. In this dimension of social factors and complicated grief, the loss is not recognized, and the individual and the people close to them behave as though the loss did not occur (Lazare, 1979, as cited by Worden, 2002). This circumstance is particularly relevant to the experience of abortion. The ideologies and stigma around abortion do not make for a supportive or understanding social response and can put the bereaved in stressful or difficult situations (Doka, 1989). Women who chose to hold their unplanned pregnancy in secrecy often follow through with an abortion in isolation, suppressing the incident and creating a greater risk for complicated grieving (Worden, 2002).

The lack of a social support system or group is the third social factor that can contribute to complicated grief (Lazare, 1979, as cited by Worden, 2002). This support network includes family and friends, support groups and individuals who knew the deceased (Worden, 2002). In the instance of reproductive loss, abortions are often experienced in isolation and the counseling interventions around the procedure are insufficient. The aforementioned research has identified that coping after an abortion is
affected by the support from family and friends, thus emphasizing the risk for complicated and disenfranchised grief in the experience of abortion.

**Healing after Reproductive Loss**

Pregnancy loss support groups were first established in the United States in the mid-1970s (Layne, 2003). By the 1980s these groups had spread throughout the country, and by 1993 had reached approximately 900 groups (Layne, 2003). Around this time support groups were also showing up in Canada, Australia, Israel, Italy, England, West Germany, South Africa and the Virgin Islands (Layne, 2003). These groups offer support from women and couples who have had similar experiences and are described as “a storytelling population” (Irvine, 1999, as cited by Layne, 2003, p. 47). Goals of the groups involve promoting and aiding parents in the positive resolutions throughout their grief experience and encouraging physical and emotional health of the bereaved (Peppers & Knapp, 1980). By bringing individuals with this shared experience together, support groups build a network of peers and friendships that can be relied on for support, comfort, compassion and telephoning at any time (Peppers & Knapp, 1980). It is not uncommon for support groups to publish newsletters featuring poetry, narratives, excerpts from journals, and letters from bereaved parents. Articles written by professionals on related topics are also a part of the newsletters (Layne, 2003).

Other resources for healing include therapy models designed specifically for reproductive loss. The Healing Process model is a program specific to reproductive loss and was developed by Gray and Lassance in *Grieving Reproductive Loss* (2003). This body of work intends to educate and train professionals and volunteers working with individuals grieving reproductive loss. In consideration of the diverse backgrounds of
their workshop participants, the HPM accommodates individuals who may have little or no bereavement counselling training through a holistic way of looking at grieving and healing (Gray & Lassance, 2003).

The HPM (2003) does not follow any sequential order; it takes cues from the bereaved individual much like the tasks of mourning and the dual-process bereavement models. Components include acknowledgement, story telling, outlining the individual's history with reproductive loss and other losses, describing and normalizing grief reactions, establishing, reconnecting and continuing the bonds of the relationship with the deceased, addressing the questions around the loss, distinguishing 'grief work' from 'guilt work', expressing forgiveness and anger, letting go of the pain and encouraging self-care (Gray & Lassance, 2003).

Acknowledging the loss is an initial healthy response in the grieving process, as it gives the bereaved permission from themselves to grieve and accept the reality of their situation (Gray & Lassance, 2003). Acceptance of the loss may require repeated reviews of the relationship with the deceased, the events which surrounded the loss, its meaning and its implications (Rando, 1986).

Acknowledgement from family, friends and health professionals is also important in supporting the bereaved; dismissing reproductive loss minimizes and disenfranchises the grief of the bereaved. Women may hear phrases like, “You're young, you can have another baby” or “It’s natures way” (Gray & Lassance, 2003, p. 37). The initial acknowledgement and acceptance of the event, whether it be an abortion or a miscarriage, can be the most helpful intervention for the grieving woman or parent (Gray & Lassance,
Explaining normal grief reactions and responses will help the bereaved understand and validate what they are going through (Rando, 1986).

Identifying, expressing and accepting the variety of emotions present in the grieving process encourages grief resolution and is critical to the process (Rando, 1986). Societal, cultural, ethnic or religious influences can influence the expression of these emotions. In some cases, symptoms of grief may not be viewed as tolerable or normal (Rando, 1986). Identifying and working through these influential factors will facilitate free expression throughout the grieving process (Rando, 1986).

Secondary losses as a result of a death are often overlooked in the case of reproductive loss (Rando, 1986). A woman and/or parents will endure symbolic losses regarding their pregnancy that are related to the future; their hopes and expectations, their wishes for a family, their roles as mother and father and their fantasies about their child will be lost (Rando, 1986). Identifying secondary losses is an equally important step in the acknowledgement of the primary loss (Rando, 1986).

Telling a story to someone who will listen without judgment and offer compassion is integral to healing (Gray & Lassance, 2003). The story around the loss helps in processing the grief and gives the bereaved an outlet to express their own experience of the loss. Writing the story is an ideal way to record, develop and share the bereaved individual’s experience. Writing can also be useful in communication exercises between a couple coping with loss; it offers clarity and distance in the wake of confusing and painful feelings (Rando, 1986). Journalling is another writing activity that can be used as an outlet for the bereaved to express their experience and emotions. The process of writing provides the bereaved with an opportunity to organize and control their thoughts;
journals can also be reviewed and reread to give the writer feedback on where they are at in their process of mourning (Rando, 1986). Helping the client remember even the smallest of details and sensations will help in re-creating their story (Gray & Lassance, 2003).

Noting the history of reproductive loss and other losses is necessary on behalf of the facilitator. This history will inform them of any unfinished mourning and of their coping abilities (Gray & Lassance, 2003). Recovering this history should be done at the pace of the client, for recalling more than they are prepared to remember too fast may cause additional distress (Gray & Lassance, 2003). Other significant losses and the time at which they occurred can give further insight to the needs of the client and their ability to cope (Gray & Lassance, 2003). Identifying significant stressors will also impact the way a woman grieves and manages her loss; these peripheral losses may contribute to complicated grief or maladaptive coping behaviours (Gray & Lassane, 2003).

Explaining how grief affects the body, mind and spirit can give the bereaved a sense that what they are going through is normal, and that others have experienced the similar reactions (Gray & Lassance, 2003). At this time the facilitator may underline that although grief reactions are similar among bereaved women and couples it does not take away from the individuality and uniqueness of their loss and ways of responding (Gray & Lassance, 2003).

The relationship or bond between the parent(s) and the deceased baby is important to establish, reconnect and maintain throughout and beyond the grieving process (Rando, 1986; Gray & Lassance, 2003). As the bereaved experiences some form of reorganization and restructuring in their life, they must form a new relationship with their deceased
infant and establish a healthy way to remember and relate to them (Rando, 1986). Nurturing this relationship is a comforting and effective way to promote healing. Naming the baby will validate the baby's uniqueness and individuality (Gray & Lassance, 2003). At a time when the mother may see or feel the baby as a part of herself, baby naming can help the mother separate her identity from the infant’s (Gray & Lassance, 2003). Parental attachment grows when a mother can hold, gaze upon or interact with her baby (Savage, 1989). These acts are inherent in giving the child a soul and identity, which are necessary for the comprehension of a loss (Savage, 1989). Many women will not have had a chance to experience these acts, therefore naming and giving the unborn baby an identity helps the bereaved to acknowledge and grasp the loss (Savage, 1989). Writing a letter or a poem to the baby may be an ideal way to reconnect and establish a bond with the baby.

Bereaved individuals or parents can often get stuck on the question of “Why?” (Gray & Lassance, 2003). Blaming is not uncommon and can be directed towards the self, the partner or the health care professionals; thus naming the reason for their loss may make sense, or give order to the stress and pain the individual is experiencing. The question of “Why?” can bring up beliefs about spirituality and the meaning of the pregnancy. This question may come at a time of intense grief and heightened emotion. Validating their question and letting them know meaning will ultimately find them, is one way to support the mother or couple (Savage, 1989). Bereaved individuals may identify a purpose or reasoning for their loss. At this time, and only then, should the therapist explore this notion with the client to support healthy grieving (Gray & Lassance, 2003).

Feelings of guilt are inherent in grieving reproductive loss (Gray & Lassance, 2003). Mothers and parents reprimand themselves for not taking better care of
themselves, or for doing an activity that may have compromised the health of the developing infant; ultimately the mother feels like she was not able to protect her baby from death (Gray & Lassance, 2003). Confronting these feelings and identifying their source can be helpful in coping with guilt (Rando, 1986). Irrational beliefs can be the source of guilt and some individuals may need assistance identifying these and better understanding them (Rando, 1986). When phrases such as “should have”, “must” and “ought to” occur over and over they become irrational beliefs (Rando, 1986, p. 114). Transforming these thoughts into something more realistic can help the bereaved manage their guilt (Rando, 1986). Bereaved parents can get stuck feeling guilty and experience difficulty moving forward. In these cases, working on seeking and granting forgiveness from the self can encourage mothers and partners to continue their mourning process (Gray & Lassance, 2003). Focusing on forgiveness can be necessary when the bereaved are dealing with intense feelings of anger as well. Mothers and their partners may feel anger towards themselves or each other; they may be angry with family, friends or health care professionals for minimizing or dismissing their loss. To avoid obstructing the healing process, the therapist must be sure to adequately acknowledge any feelings of guilt or anger before focusing on forgiveness (Gray & Lassance, 2003).

Healthy closure from the experience of reproductive loss can start by having clients preserve memories, keepsakes and mementos from the loss (Gray & Lassance, 2003). Rituals are a specific behaviour or activity representational for feelings, thoughts, memories and meaning of an individual, group or event (Rando, 1986). They can signify transition, healing, connection and progression through powerful therapeutic experiences (Rando, 1986). Daily rituals can help with the initial coping after the loss; lighting a
candle, journalling, or sending an internal message to the deceased can bring a sense of peace to the bereaved (Luebbermann, 1996). In Japan, parents hold a candle ceremony, sending out small candles on paper boats down a river (Luebbermann, 1996). Having the parents create their own memorial service or basic ritual can enrich a meaningful closure and provide a framework for the parent(s) to recall their loss and express their feelings in the future (Gray & Lassance, 2003; Rando, 1986). Planning a memorial service with the possibility of inviting family and friends or creating a ritual to commemorate the loss are ways to respect and accept the infant’s death (Luebbermann, 1996).

The therapist may assist the client in exploring options for self-care, as this is an important practice to highlight for the bereaved. Bringing awareness to the importance of caring for the self in a holistic manner is critical in a time of emotional distress; clients should be encouraged to create a self-care plan to be mindful of the mind, body and spirit (Gray & Lassance, 2003). The hormone fluctuation that takes place after a pregnancy loss can make a woman feel out of control, hypersensitive and moody (Luebbermann, 1996). It is important to be aware of these changes taking place and nourish the body with proper foods and liquids (Luebbermann, 1996). Coping with grief requires a great amount of energy and can deplete the bereaved in many ways (Rando, 1986). Adequate rest and nutrition should be encouraged and maintained to support proper health and immune function during a stressful and overwhelming time (Rando, 1986). Connecting with support groups, learning about grief and encouraging the bereaved to be gentle with themselves are suggestions the therapist may address (Gray & Lassance, 2003).

Rituals can be especially therapeutic in coping with loss. They offer a sense of meaning and structure to transitional times in people’s lives and symbolically, they bring
individuals together to acknowledge, celebrate or honour an event (van Gennep, 1960, as cited by, Kobler, Limbo, & Kavanaugh, 2007). Rituals around transition often focus on past and future, holding on and letting go or life and afterlife (Anderson & Foley, 1998, as cited by, Kobler, Limbo, & Kavanaugh, 2007). They offer an opportunity to maintain a healthy connection to the deceased and create space for them in creative ways (Kobler, Limbo, & Kavanaugh, 2007). Practicing, establishing or developing rituals has been a means for coping with loss across cultures. Through the gathering of relatives and friends, social supports are put into place and made available to the bereaved (Rando, 1984). Messages of care and support are expressed to bring comfort to the bereaved (Rando, 1984).

Reproductive losses do not receive significant social acknowledgement, nor do the bereaved have any traditional ritual in place to honour the deceased in the same sense we would hold a funeral for an child or adult (Kobler, Limbo, & Kavanaugh, 2007). For bereaved parents the extent of a ritual involves meaning-making and participation (Kobler, Limbo, & Kavanaugh, 2007). Rituals provide an opportunity to give new meaning to the loss and therefore whatever activity is chosen must be meaningful to the individual (Kobler, Limbo, & Kavanaugh, 2007). The process of ritual requires active participation on behalf of the bereaved. Developing and deciding on the ritual activity can be facilitated by the therapist and led by the mother or parents, with options to participate in the ritual at a level they are comfortable (Kobler, Limbo, & Kavanaugh, 2007).

Practical grief and loss counselling techniques, rituals and meaning-making are significant to coping with reproductive loss. These suggestions and directives for
supporting individuals dealing with reproductive loss can be integrated into an intervention that capitalizes on the individual’s positive coping skills (Rando, 1986).

**An Art Therapy Intervention**

Art therapy can offer a flexible and comprehensive approach to reproductive-loss counselling. Upadhyay, Cockrill and Freedman (2010) have identified supportive client-therapist relationships, group therapy, and support in decision making, addressing stigma and artistic expression as practices central to counselling and reproductive loss. These components are inherent in a client-centred art therapy model and will be further developed to generate an art therapy program for reproductive loss counselling.

Daria Halprin (2002) suggests creativity can connect clients to the natural processes that take place on biological, emotional, mental and spiritual levels. Engaging creatively encourages a healthy flow of energy, allowing clients to release, tolerate or make space for the constricting and difficult emotions they may experience. Through creative work individuals may connect with their unconscious and imagination; this connection creates opportunities for active exploration and development of the client’s life stories and outlooks. Clients are put in a position to respond and give attention to what is happening within them and make decisions about how to attend to it through the art (Halprin, 2002). The art therapist can offer the benefits and safety of the therapeutic relationship while helping facilitate the client’s exploration of their images and objects. In this exploration and reflection the client may gain a better understanding of themselves and their difficulties and find meaning in their work (Edwards, 2004).

Art therapy models have been developed for individuals dealing with grief, anxiety, anger, depression and guilt and can be modified to meet the needs and unique
circumstances of women coping with reproductive loss. Art therapy can also prepare or coach an individual through triggers or significant milestones relating to the loss with memorial works (Lister, Pushkar, & Connolly, 2008).

Art therapy can be used to work through and identify anger within the individual. Art materials are used to release anger in a safe environment, allowing the individual to externalize their feelings and engage with them outside themselves (Smeijsters & Cleven, 2006). Utilizing non-verbal expression and creative energy, one may tap into unconscious levels allowing anger issues to reveal themselves.

In managing the experience of grief and loss, Hooghe, Neimeyer, and Rober (2012) suggest the bereaved need to suppress or enhance certain emotions throughout and after the grieving process. Art making can offer individuals a place to put these emotions and express them at different intensities. The flexibility of the materials adds to this experience, giving bereaved individuals the tools they need to regulate their emotions. Art therapy can work to facilitate these expressions in a way that allows the bereaved to continue or maintain healthy daily functioning.

McNiff’s (1992) theory on artistic images as angels can be of particular use when working with the bereaved. He explains how artistic images function as messengers from our inner world; images arrive through the art making process from another realm. Angels are represented cross-culturally and are a symbol for protection and guidance; they help people stay in contact with the soul and life outside of their own. Angels may present themselves in the messages that emerge in the art work; these angels are forever changing shape and form, manifesting in different materials, gestures, and pieces of work. Meeting or discovering the angel in the art work can offer the creator assistance,
inspiration, guidance, consolation, meaning and elicit emotions. This perspective views
the art work as “tangible and personal figures that influence the lives of people who
mediate on them” (McNiff, 1992, p. 76). In the context of reproductive loss, the notion of
discovering angels and receiving messages from the deceased within the art, can bring
comfort and understanding to the bereaved.

Establishing a ritual in the wake of reproductive loss is another effective way for
coping and healing (Kobler, Limbo, & Kavanaugh, 2007). Ritual through art is an
optimal means for remembering and maintaining a connection with the deceased.

When working across cultures the language around loss varies greatly. For some,
there may not be a word or words to describe the emotions they are experiencing. Art
provides individuals with a means to express these indistinguishable feelings and
articulate them in a tangible manner, one language cannot grasp.
Reproductive Loss and Art Therapy: A Program Proposal

Introduction

This program is an outline for art therapists working with individuals who have experienced some type of reproductive loss. It is informed by current bereavement models, art therapy techniques and 'The Healing Process Model' By Gray and Lassance, a program designed to educate and train professionals at the Centre for Reproductive Loss in Montreal. The proposed program is not a fixed set of directives, but a guide for therapists to adapt and draw from. The exercises are not limited to specific sessions or sequences, and are designed to work with the emotional pace of the client. This program may also be adapted to fit a group therapy setting should the facilitator have the resources to offer group services. The program was designed to ensure respect for the unique circumstances of the grieving individual and can be adapted to each of their situations.

The following outline provides program goals, facilitation considerations, program limitations, ethical considerations, and suggested exercises and art therapy materials.

Goals

1. To facilitate healing from the complicated or disenfranchised grief of reproductive loss.
2. To offer an alternative to traditional counselling and therapy for women grieving reproductive loss.
3. To acknowledge and work through the difficult emotions surrounding abortion on a sociocultural level.
4. To provide art therapists with suggested resources and exercises for working with individuals in this population.
5. To acknowledge and support the need for emotional care in women's reproductive health and advocate for women's reproductive rights.

6. To encourage and create a supportive space for dialogue about reproductive loss.

**Facilitator Considerations**

Facilitators for this program will be certified art therapists who have a desire to contribute to the emotional care in women's reproductive health. Having an interest and some background knowledge in women's health and reproductive rights is recommended. Facilitators should be aware of their attitudes and beliefs regarding abortion. These opinions should not be imposed upon or come into conflict with the client's experience or beliefs at any time. Facilitators should also be familiar with the aforementioned theories on bereavement, mourning and grief and loss. Through clinical art therapy training, fundamental counselling skills are expected of the facilitator. Unconditional support, compassion, acceptance and positive regard for the client’s circumstance are required to build a safe space for them to express and explore their feelings around their loss. In a time of deep emotional distress, empathetic listening and understanding on behalf of the facilitator is of utmost importance. Cultural intelligence regarding the attitudes, values, beliefs and practices in women’s health should be put in check and assessed on behalf of the facilitator.

**Ethical Considerations**

Grief, loss and mourning are experienced within a cultural framework. Culture defines how individuals make sense of their world and will therefore determine how individuals express and represent their grief (Neimeyer, Harris, Winokuer, & Thornton, 2011). Behavioural norms across cultures will govern the emotional expression of grief.
and determine what is acceptable and for how long (Neimeyer, Harris, Winokuer, & Thornton, 2011). Additionally, gender roles across cultures will moderate the expression and acceptability of emotions around the loss. Therapists and facilitators need to be sensitive to the unique backgrounds and histories of each client. Maintaining cultural and emotional intelligence is imperative for understanding the bereavement needs of each client.

**Program Format**

The program is designed for a minimum of eight one-on-one art therapy sessions and is loosely based on grief and loss therapy models. These directives may be re-visited multiple times and can be used at varying times. Should the facilitator encounter an opportunity for group therapy, the directives may be modified and adapted to fit a group model. Information on grief and loss and the complicated nature of reproductive loss will be addressed and made available to the participants. It is important for the therapist to check in with the participant regarding other reproductive losses, as well as losses in general. The participant’s history of other losses may influence the way they manage their current loss. The therapist will present the suggested directives and encourage reflection and exploration of the art work. The directives follow a suggested sequence but do not need to follow any particular order, with the exception of the introductory and closing activities. Based on the needs of the participant, the directives may also be revisited or repeated. This program can take place at any time in a woman’s life, immediately following or long after she has experienced her loss. Descriptions and explanations of each directive will be provided to support the activity and aim to give the participant a holistic understanding of the program and process.
Participant Criteria

This program is intended for women who have experienced reproductive loss and are seeking support in their process of mourning. Participants may be of any age and their loss does not need to meet any time limitations. No previous experience in art making or artistic skill is necessary. Should this program be offered to a group, no more than five participants should be cared for at one time. Should the partner of the woman wish to participate in the program, the directives may be adapted for that individual or for joint participation.

Theoretical Underpinnings

Art making and working within the creative process allows individuals to think and act in a way they could not from an ordinary standpoint (Morgan, 2000). The arts give individuals a vehicle for communication in another language that can perhaps better suit their needs for expression. This program is based on a client-centered approach and promotes reflection and exploration of the artwork from the perspective of the participant. This program works with the notion that art making and its processes facilitate healing, growth, compassion and understanding. The meaning-making and reconstruction theory supports the story-telling components of the art therapy program and is reinforced by the research identifying the dynamic and effective ways this model can impact bereaved parents (Keesee, Currier, & Neimeyer, 2008). McNiff’s theories regarding images as messengers and angels from our inner world can be applied to these directives should the client wish to explore and dialogue with their work. The therapist’s role in this process is to provide a safe and nurturing environment for the participant, and to observe, notice, reflect and empathize with the participant throughout the process.
Art Materials

A variety of art materials allow participants to fully explore and express their emotions and mourning process. Paint (watercolour or acrylic), pencil crayons, charcoal, oil pastels, clay, images for collage, embroidery floss and hoops, fabrics, and a variety of paper should be sufficient for the program directives.

Introducing Art Therapy

A brief introduction to art therapy and the program design should be addressed at the beginning of the sessions to provide some understanding of the methods and goals of the process. Key concepts that may be discussed include:

• the importance of the process and not just the product
• no artistic skills are required for participation
• the artwork will not be interpreted by the therapist
• there is no correct or incorrect way to do the directives, each activity is open to the participants own interpretation
• each session will begin with a ‘check-in’, whether it be verbal, written or visual. A journal may be provided for this purpose.

Suggested Exercises

1. Exercise title: Warm-up and Explore

Directive: Give participants watercolour paper and ask them to drop or gently spread water on the paper in any way they feel comfortable. Participants will do the same with watercolour paints, creating different shapes and patterns with the paint. Participants may have an opportunity to look for images, feelings or actions within the paint.
Rationale: A gentle warm-up activity allows participants to get acquainted with some of the materials and begin their art therapy journey with a low-pressure activity. For individuals who have not had much experience in art, this activity facilitates building a relationship with materials, colour, shapes and feelings. Watercolour paints can be softer and lighter than acrylic or tempura and may promote a sense of relaxation. By looking at random colours, patterns and shapes the participant may find a way to express their feelings and reflect on their situation. This activity will allow time and space for the participant and the therapist to develop a relationship before they move on into other directives.

2. Exercise title: Telling Your Story

Directive: Ask participants to write, draw, or paint their story around their loss. Encourage the participant to recall as many details they can remember around the event, the weather, their clothing, the food they ate, etc. This activity may be written or expressed artistically on paper or in a journal or book.

Rationale: Telling the story or re-telling the story around a loss to a non-judgmental and compassionate listener is integral to healing. Story telling can aid in processing the loss and provide a framework for mourning. Additionally, story-telling, or writing the self-narrative, is an ideal way to develop and facilitate meaning-making.

3. Exercise title: Body Scan—Practicing Mindfulness

Directive: Guide clients through a body scan while encouraging deep breathing. Clients will focus on relaxing their bodies from head to toe, noticing where they feel discomfort or changes in temperature and what feelings arise. Possible
questions during the body scan may include: Does your discomfort have a colour, shape or pattern? How big or small is it? Does it move? Following the body scan, clients may draw or use a template of an outline of a body to express what they experienced and where.

Rationale: A variety of emotions may come and go for someone going through grief and loss. Feelings of anger, shame, guilt, blame, relief or regret may resonate with the participant throughout their grieving process. Identifying these emotions, allowing them to come forward, noticing them the in the body and expressing them outside of the body will contribute to healthy processing and growth.

4. Exercise title: Making Connections

Directive: Participants may be asked if they have named or wish to name their deceased foetus. Once this has been established (or not), participants will create a memorial piece for their baby. This piece may take any shape or form and may be worked on over a couple of sessions. Suggested activities or materials include using clay to create a statue or small monument; embroidery floss and fabric to create a patch or quilted piece; collage using any documents or materials related to the pregnancy.

Rationale: Establishing a name and acknowledging the baby as a unique individual can affirm the reality of the loss. Naming the baby will establish its own identity and distinguish it from the mother’s; it will give the baby a place on the family tree. The lost baby will have never been known or seen on her own, naming will establish her identity. Creating a memorial piece will allow the
bereaved to maintain a connection to their loss by honouring, and making a place for the piece in their home.

5. Exercise title: Identity Landscape

Directive: Using a piece of card stock or heavy watercolour paper, fold each side inwards to meet in the middle. This will be a template for exploring the outer and inner landscape of the self. Ask clients to design their inner landscape on the inside of the card, where are they situated? Where is their deceased situated? What season is it? What time is it? Encourage clients to address all facets of their landscape. The client may continue by designing the outside of the card, or revisit this piece at a later session. The outside is intended for exploring the self which they present to the world, the primary pieces that have always been a part of who they are.

Rationale: Reproductive loss often implies a loss or confusion of identity. Not only are women dealing with the loss of their baby, they are dealing with the loss of motherhood, and their unique hopes and wishes that may accompany that. Exploring the woman’s identity and making a space for the loss can aid in integrating this life event into her self-narrative. Reflecting on the woman’s story, her coping abilities and her strengths, participants are encouraged to make a place for their loss within their identity.

6. Exercise Title: Creating a Vision

Directive: Direct clients to create a vision of how they would like the future to look through a collage of images, words, fabrics, natural found objects or any
other appropriate materials. This vision may include how they will remember their loss, and how they wish to live their life from this point forward.

Rationale: By providing a future-oriented directive the client will have an opportunity to realize their goals and organize their thoughts and feelings about where they are and where they would like to go in regards to living after the loss and integrating the loss into their altered world.

7. Exercise title: Self-care Mandala

Directive: Instruct participants to place a piece of fabric in a round embroidery hoop and make sure it is secure. By using paint, collage or thread, participants will identify what they need to make sure they are giving themselves the compassion and care they need.

Rationale: Coping with grief and loss is a stressful life event and being gentle with the self is important. Physical, emotional and psychic energy have been depleted. Therefore participants should be encouraged to take care of their mind and body, seek further assistance should they need it, and maintain a spiritual connection or practice. This may involve a ritual, poem, prayer, meditation, piece of music etc. The term ‘spiritual’ in this activity can be interpreted or used however the participant wishes to use it.

8. Exercise title: Planting a Message- Creating a Ritual

Directive: Ask participants to write a letter, poem or message on to their deceased baby. The message should be written on recycled paper or newsprint. Once the letter is complete participants may plant the letter in a garden with a flower, tree or other type of plant. If the participant does not have access to a garden or space
where they feel comfortable planting, the facilitator may provide a small planting pot and soil. Encourage the participant to choose the plant they wish to use.

**Rationale:** Sending a message or poem to the deceased allows the participant to maintain a connection and show love and care for the lost baby. By planting the letter, the message will be represented by the plant; this plant can serve as a memorial piece for the deceased. Some participants may find comfort in the notion that the living plant may carry their message out into their world and to their deceased baby. Visiting the plant or tree on a regular basis is an opportunity to create a ritual which honours the loss.

**Summary**

Given the unique nature of reproductive loss and the possibility for disenfranchised grief, traditional models for coping with grief and loss are inadequate. By taking into consideration the unique nature of reproductive loss, these directives will facilitate healing and growth, while promoting self-care and well-being. Acknowledging and discussing the nature of disenfranchised grief will further support the healing process. Through the nurturing and flexible art materials clients will be able to tell their story, honour their loss, practice mindfulness, create a ritual, explore their identity, set goals and practice self-care. It is recommended that therapists take notes following each session to maintain a record of the clients pace and progress. Reviewing these documents will aid in choosing, following or revisiting the suggested directives.

In addition to supporting women who have experienced reproductive loss, this program brings awareness to and makes room for dialogue regarding women’s reproductive and mental health.
Discussion

The research presented in this review outlines the needs of women experiencing reproductive loss and what interventions or support are currently in place. After reflection on this information I believe there is a need for more support and alternative methods for care and healing. The proposed art therapy program provides clients with a holistic and flexible framework to mourn, grow and heal from their loss.

In my research for this program I discovered only a few articles regarding art therapy and reproductive loss. The research provided and the subsequent program proposal are important for the study of women’s mental and reproductive health. Additionally, this unique work will contribute to the field of art therapy research, providing information and resources for other art therapists working with this population.

The program is designed to work with standard grief and loss counselling models, offering clients a safe and non-judgmental space to grieve, gentle methods for self-expression, directives to facilitate growth and healing, and a client-centered pace for the program. Based on the current research on the resources for mental health and emotional care for individuals experiencing reproductive loss, I see an opportunity to help women and their families, and to contribute new work and research to the field of art therapy and women’s health.

The proposed program was developed with careful consideration of the process of grieving and mourning and provides clients with an opportunity to experience healing through art making. Art therapy can provide a safe space for exploring and expressing intense feelings from loss that words may not be able to describe. Art making works on a conscious and unconscious level, therefore allowing any unmet needs of the bereaved to
be acknowledged and explored (Simon, 1982). Clients are able to create tangible pieces of their emotions, memories or sensations they experience throughout the grieving process. Choosing directives that promote relaxation can assist clients in coping and managing their energy during an intense and stressful time.

**Strengths and Limitations**

Scant research and specificity of this program has made it difficult to practise the proposed directives in a practicum setting specific to this population. The social and cultural nature of abortion has posed challenges in gaining access to experience in this field and has also limited or skewed the research available. Having noticed significant inconsistencies in the methodology and findings, analysing the research regarding abortion and mental health was a challenging task. These biases reduce the number of sound studies available for review. Additionally, resources and information on counselling interventions or programs in place for women post-abortion are uncommon.

Research regarding miscarriages and mental health has grown significantly in the past 30 years. Meta-analyses of a range of studies and scales measuring grief from perinatal death have been developed and tested. These studies and books offer ample information on the emotional outcomes of miscarriage and are significant in informing healing programs and women’s health care. Within this body of research inconsistencies do emerge; terminology, length of time a woman grieves, maternal age, subsequent births, and perinatal grief measurement tools are all identified as inconsistent factors in the research.

The literature on reproductive loss and mental health suggest grief patterns similar to those of other major losses. Considering the amount of writing, theory and research on
grief, loss and mourning, there were ample resources to review and synthesize for this program proposal, providing this body of work with a sound foundation to build on. Additionally, being able to focus on disenfranchised grief and identifying why and how it applies to this subject has been integral to designing this program to meet the needs of clients whom have experienced a reproductive loss.

General resources and information on art therapy have been sufficient in contributing this document. Art therapy models and directives regarding grief and loss are available but limited and art therapy research and writing on the subject of reproductive loss relatively is nonexistent. These circumstances were not optimal for finding work experience within this population; however, they left substantial room for creative thinking and a unique program design.

**Further Considerations**

Continued research and education on the subject will help in continuing the development of this comprehensive program and in securing an opportunity to practice this work.

Based on my attempts to find a placement related to this project, I am anticipating challenges in finding a work opportunity since it is not common to have art therapy practices in abortion clinics or maternity wards. I believe there will be a sufficient client population, the challenge will be reaching them and securing a site for the work to be done.
Conclusion

This literature review and program proposal are based on a synthesis of research in the fields of abortion, miscarriage, reproductive loss, grief and loss, and art therapy. It is apparent that there is not enough attention, emotional care or therapeutic interventions for women experiencing reproductive loss. The proposed program will provide a much needed service to women coping with this type of loss. It will offer new resources and directives for other art therapists working with this population, and stimulate further research and discussion in the field of women’s health and art therapy.
References


