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How Mothers Experience Personal Growth after a Perinatal Loss

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A Thesis submitted for the Degree of Doctor of Philosophy

City University, London

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Dedication

*Dedicated
to my firstborn daughter
Nafsika
and my beloved dad
Oresti*

*and in Honour of
All the children gone too soon,
their families, and those who support them*

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Declaration

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Abstract

In the UK, babies are considered stillborn when they are born dead after the 24th week of gestation. Death within the first four weeks of life is defined as a neonatal death. Both stillbirths and neonatal deaths comprise perinatal deaths. This type of bereavement constitutes a traumatic loss and although there is a plethora of research focusing on the resulting parental psychopathology, research on adaptive grief resolution and posttraumatic growth is scarce. Qualitative methodologies exploring perinatal bereavement and posttraumatic growth from a perspective of counselling psychology are absent in the literature although repeatedly invited by theorists. To date, only one quantitative study has explored the phenomenon of posttraumatic growth on bereaved parents after a perinatal loss (Büchi, et al., 2007). Moreover, the available qualitative literature on bereaved mothers after a perinatal loss is conducted by disciplines other than psychology and has largely focused on birth, hospital practices, burial ceremonies and the initial grief reactions. Thus, this project aims to address psychology's relative neglect of the topic by exploring qualitatively "How mothers experience personal growth after a perinatal loss". The research methodology employed was Interpretative Phenomenological Analysis (IPA). Eight semi-structured interviews with women who had lost their firstborn baby perinatally were conducted. The analysis revealed four super-ordinate themes; the first and the second mainly present the traumatic quality of this type of bereavement and the multiple losses involved. The third super-ordinate theme presents all the coping mechanisms that were activated by participants in order to work through their loss; while the fourth presents the positive changes that came as a consequence of the experience and their efforts to psychologically survive that loss. The research findings suggest that following this traumatic loss mothers, struggling with distress and anguish, can also experience positive transformations. The possible role of counselling psychologists and psychotherapists in this journey of personal positive transformation of bereaved mothers is explored.

Chapter 1: Introduction

1.1 Theoretical Paradigm and Chapter Overview

The impetus for this research project was the movement of *Positive Psychology* (Seligman, & Csikszentmihalyi, 2000). Martin E. P. Seligman in 1998 in his Presidential Address to the *American Psychological Association* (Seligman, 1999) first suggested that psychology since the end of World War II had neglected the two latter of its three pre-War missions: curing mental illness, helping all people to lead more productive and fulfilling lives, and identifying and nurturing high talent. In other words, psychology had been absorbed by the medical model of treating illnesses and damage, while prevention and support for “normal” individuals had been largely neglected. It was suggested that positive psychology can be seen as “A science of positive subjective experience, positive individual traits, and positive institutions” that “promises to improve quality of life and prevent the pathologies that arise when life is barren and meaningless” (Seligman, & Csikszentmihalyi, 2000, p. 5). Since that time the movement of *Positive Psychology* has received various criticisms on its originality and pragmatics (Linley, Joseph, Harrington, & Wood, 2006; McCulloch, & Snyder, 2000). However it has also attracted great interest from the scientific community and various areas of implication (Linley, Joseph, Harrington, & Wood, 2006).

As a counselling psychologist the present researcher reflected on the definition of positive psychology in relation to her practice with clients, which focuses on helping them to realize and amplify their strengths, inspire confidence in their abilities, and help them engage in a meaningful life rather than limiting themselves to repairing weaknesses. She had always felt that the viewpoint of *Counselling Psychology* is rather different from that of traditional *Clinical Psychology* which tends to identify more with the medical model and with the treatment of abnormal behavior (Joseph, & Linley, 2008; Mollen, Ethington, & Ridley, 2006). One of the most prominent researchers in the field of Positive Psychology, Lopez and her colleagues (2006) provided a historical

framework that underlines *Positive Psychology* as one of *Counselling Psychology*'s "distinctive, defining characteristics" (Lopez, et al., 2006, p.207). And indeed philosophically and historically, *Counseling Psychology* has maintained a strength-based perspective, which has distinguished it from other applied specialties in psychology. However, both in UK and US recently the boundaries of the applied specialties have blurred, that being reflected in the trend for decreased distinction of employment settings between Counselling and Clinical Psychologists (Mollen, Ethington, & Ridley, 2006). Following a literature search the researcher was not able to identify consistent research contributions in *Positive Psychology* from the discipline of *Counselling Psychology*. Working towards the linkage of *Counselling* and *Positive Psychology* was something that intrigued her.

A proposed area within *Positive Psychology* (Harvey, 2001) is the *Psychology of Loss*. *Psychology of Loss* emphasizes the study of healthy individuals, the resources they use for adapting to loss, and the ways they can transform their losses into personal growth and strength. This approach contradicts the unidimensional perception of individuals who have gone through a loss, as only being psychologically and physiologically vulnerable to disease and disorder (Day, 1989; Finley-Jones, & Brown, 1981; Murnoe, & Simons, 1991). Indeed, during the last decades we have learned a lot about the psychopathology that can be triggered from adversity, but our knowledge of the qualities developed and processes experienced by people who despite having gone through adversity remain healthy has been limited (Harvey, 2001). In U.S. for example it has been reported that although 50-60% of the population will experience a traumatic event, only 5-10% will develop *Posttraumatic Stress Disorder* (PTSD; Ozer, Best, Lipsey, & Weiss, 2003), while positive changes following a traumatic experience have been estimated to occur in 45%-90% of the traumatized individuals across cultures (Berger, & Weiss, 2002). Snyder and McCullough (2001) defined the ability of individuals to find benefit in adversity and grow as a human strength and urged its inclusion in the emerging Positive Psychology paradigm. Thus the research question of this project aimed to bridge a newly developed area of *Positive Psychology, Growth*, with *Counselling Psychology*.

The aim of this first chapter is to critically present the available theoretical background and empirical research on *adaptation to trauma*, *posttraumatic growth* and related constructs, focusing on *parental bereavement* and *perinatal loss*. The objective of this presentation is twofold: first to explore all the available literature around the topic of the present research, and secondly to illustrate the scarcity of research on Perinatal Loss through the lenses of *Positive* and *Counselling Psychology*.

1.2 The Concept of “Growth”

1.2.1 The history, development, and establishment of the concept of “growth”

The notion that suffering and struggle with adversity and trauma can bring positive or even radical changes to human beings is neither new, nor a scientific discovery. For nearly three thousand years literature, religion, and philosophy have reflected the idea of growth stemming from the struggle with suffering. The transformative powers of suffering are found in Greek tragedy in the concept of *catharsis*, while in many religions such as Christianity, Islam, and Buddhism, this notion is present, as in the story of Jesus whose suffering had the power to transform others, or in the Islamic traditions where suffering and pain is a preparation for the journey to heaven. For literature and philosophy both Nietzsche and Schopenhauer had stressed the value of pain and suffering in growth and self-development (Calhoun, & Tedeschi, 2006; Hergenahn, 1997; Tedeschi, & Calhoun, 2004a).

In the 20th century, Frankl (1959), Caplan (1964), and Yalom (1980) were the pioneers who addressed the possibility of growth from the encounter with loss and adversity. Frankl (1959), in his classic analysis of how people search for meaning under the most devastating and degrading conditions, wrote about the innate potential of all humans for accomplishment and contribution to others. Through his enormous personal and collective losses, as a survivor of a concentration camp, Frankl believed that humans can transform their losses into personal growth and strength that embodies care and concern for others. Frankl developed *logotherapy* (from the Greek work *logos* which denotes

“meaning”), a form of psychotherapy that focuses on the meaning of human existence as well as on humans’ search for such meaning. Caplan (1964), the founder of *community psychiatry*, had underlined the need for understanding those processes through which individuals undergoing major life crises may draw strength in order to cope effectively and grow out of their adverse experience. Yalom (1980) in his classic book on *existential psychotherapy* described the positive ways that life of individuals facing death and adversity can lead to their personal transformation.

It was not until the 1980’s that a systematic attention has been drawn to trauma-related positive changes. During those early years of scholarly interest the area was still named *trauma adaptation* and the three most well known and influential theories came from Parkes (1975, 1988), Taylor (1983) and Janoff-Bulman (1989, 1992), while the empirical studies were sporadically published (e.g. Affleck, Tennen, Croog, & Levine, 1987; Calhoun, & Tedeschi, 1989-90). With the publication of two quantitative measurement instruments of *Posttraumatic Growth* from Tedeschi and Calhoun in 1996 and *Stress-Related Growth* from Park, Cohen, and Murch in 1996, together with the publication of the book by Tedeschi and Calhoun in 1995 on trauma and its transformative powers, the area of posttraumatic growth started to attract greater scholarly interest. With the rise of Positive Psychology in 2000 (Seligman, & Csikszentmihalyi, 2000) and the inclusion of posttraumatic growth in this paradigm, the publications increased and research was done on various populations and cultures (Tedeschi, & Calhoun, 2004a, Joseph, & Linley, 2006). As reported by the pioneers of posttraumatic growth research, Calhoun and Tedeschi (2006, p. 4), in mid-2005 a search using the PsychInfo system of the American Psychological Association produced 92 references on “Posttraumatic Growth” and 33 on “Stress-Related Growth” with some small overlap. Today, early 2011, an identical search on PsychInfo revealed the astonishing number of 737 publications on “Posttraumatic Growth” and 172 on “Stress-Related Growth”. These numbers underline the intense impact of these concepts on scholarly interest and the dominance of the Tedeschi’s and Calhoun’s theory (2004a) in this area of research.

1.2.2 Theoretical Conceptualizations of Growth after Trauma

Although the very early foundations of the posttraumatic growth concept can be traced back to Lazarus's theory on *stress and coping* (1983), Horowitz's (1986, 1991) *stress response syndromes* and *cognitive schemas*, as well as Heider's (1958) and Kelley's (1967) *attribution theories* or even Bowlby's seminal studies on *human attachment* (1969), the present review will focus on the three theories upon which this concept has been built along with the five most widely cited theories of posttraumatic growth.

Murray Parkes (1975, 1988) first wrote on the shattering effects of challenging life events on our *inner assumptive world*, a concept that greatly influenced all the future theories on posttraumatic growth. According to Parkes, stressful events are *psychosocial transitions*, or turning points in an individual's life that can either lead someone to maturity and self-efficacy or to long-term suffering and disorganization. Based on Bowlby's concept of the *internal working model* (1969), Parkes (1975) developed the concept of the *assumptive world* that:

...comprises the individual's view of reality as he believes it to be, i.e. a strongly held set of assumptions about the world and the self which is confidently maintained and used as a means of recognizing, planning, and acting. [...] Assumptions such as these are learned and confirmed by the experience of many years. They enable [individuals] to make correct predictions about the world and to order [their] own behavior accordingly (p.132).

When an individual is undergoing a psychosocial transition that has challenged severely his or her assumptive world the individual according to Parkes has three choices (a) to abandon the former view of the world, this being more possible for minor losses, or in cases when there was time to prepare for the transition, change was welcomed or the individual had an attitude to the world that enabled the transition to be regarded as provisional; (b) to modify or partially retain the old world assumptions that with time will continue in a habitual way to be present and guide an individual's perception, with this scenario being more possible for individuals employing avoidant coping; and (c) to fully retain the old world assumptions in an encapsulated

form, independently of the new model of the world as an alternative determinant of behavior, again the last scenario becomes more possible when strong denial has been activated (Parkes, 1975).

In 1983 Shelley Taylor articulated the first *theory of cognitive adaptation to threatening events* that described three themes that the adjustment process of individuals revolves around. These themes were *search for meaning*, *an effort to gain mastery*, and *an attempt to enhance the self*. The *search for meaning* in a threatening experience involves not only understanding why the event occurred, but its implications for one's life as well leading to change in attitudes and priorities in life. *Mastery* involves efforts to gain control over the threatening event and life in general by believing that one has control and by acting in order to practice this control. Since threatening events may affect negatively self-esteem even when a negative event was beyond an individual's control, *self-enhancement*, is achieved by construing personal benefit from the experience, or comparing the self with others more unfortunate, or by focusing on the positive aspects of the adverse situation. According to Taylor (1983; Taylor, & Brown, 1988) the cognitions upon which meaning, mastery and self-enhancement depend are in large part founded on illusions. Nevertheless, she argues that if illusions can bring psychological adaptation, they can only be considered beneficial. This, however, contradicts the more traditional views in psychology, which support that healthy mental functioning depends upon being in touch with reality (Lazarus, 1983).

Janoff-Bulman (1989, 1992) elaborated greatly on the concept of assumptive worlds and Taylor's (1983) theory, and her theory found great acceptance among the theorists of *posttraumatic growth* with nearly all citing her basic concepts (Davis, Nolen-Hoeksema, & Larson, 1998; Tedeschi, & Calhoun, 2004a). She identified three *core assumptions* that shape our worldview: (a) *The world is benevolent*, referring to the idea that the world and the people are nice and kind, with good intentions, and that events usually have positive outcomes; (b) *The world is meaningful*, reflecting the belief that things make sense, that there is a cause and effect relationship between events and outcomes and the social laws that are usually applied in Western culture for explaining why things happen, are the laws of justice and control, enabling

individuals to believe that misfortune is neither haphazard nor arbitrary and there is either a person-outcome contingency, with people of certain character deserving misfortune, or action-outcome contingency, with certain behaviors or lack of them causing a misfortune to happen; (c) *The self is worthy*, referring to tendency of individuals to perceive themselves as good, capable, and moral. These self-evaluations include judgments of one's competence and ability to maximize positive outcomes in life (Janoff-Bulman, 1992). The optimistic bias of mentally healthy people has been well reported and although these assumptions might appear naïve it has been repeatedly found that people tend to have exaggerated perceptions of control and mastery, an unrealistic optimism about the future, and a belief that they are less vulnerable and less at risk than others (Park, & Folkman, 1997). In the face of trauma, those long held assumptions providing coherence to human life are found to be optimistic illusions and an abrupt and terrifying disillusionment occurs generating the coping and adaptation efforts of individuals (Janoff-Bulman, 1992).

Janoff- Bulman (1992) described in great detail the process through which a survivor recovers from trauma. The essence of trauma is the abrupt disintegration of the individual's inner world, the shattering of old world assumptions. The rebuilding task of an assumptive world that will incorporate the new, threatening information is described as highly challenging and insidious. The three broad coping strategies described were: (a) automatic routines of processing the new, powerful data that fluctuate between the two poles of denial / numbing and intrusive re-experiencing; (b) efforts to reinterpret the new data, a process of re-evaluation and appraisals that could either maximize the possibility to preserve some aspects of the old world assumptions or to find meaning in their experience in terms of benefits or purpose; (c) interactions with others that can assist or impede recovery, underlining the importance of social support in successful coping . Janoff-Bulman (1992) also addressed the issue of illusion that Taylor (1983) had addressed and made the remark that survivors are motivated by recovery and not by the accuracy of their attributions, coming on the same line with Taylor. Finally, three factors were identified as of particular importance for the process of recovery, the victim's ability to contain distressing emotions, the ability to creatively re-appraise the

traumatic event, and the quality of the support the traumatized individual receives from others close to him/her.

The two former theories of trauma adaptation and growth conceptualized growth as a coping strategy of individuals facing adversity. This perception of growth was also followed by another four theories of coping. Affleck and Tennen (1991, 1996; Tennen, & Affleck, 2002) based on their empirical work on individuals with medical problems made the distinction between *benefit-finding* and *benefit-reminding*. *Benefit-finding* was defined as benefit-related cognitions that are adaptive beliefs about the consequences of adversity while *benefit-reminding* are the benefit-related cognitions that serve as coping strategies during the difficult times. The benefit-finding themes that commonly appeared in their research were the strengthening of relationships with family and friends, the perception of positive personality change, such as development of greater patience, tolerance, empathy and courage, and a valued change in life's priorities and goals.

Davis, Nolen-Hoeksema and Larson (1998), incorporated the Janoff-Bulman's (1989, 1992) concept of the *assumptive world*, and made again a distinction between two processes related to growth as a coping strategy. In their view a major task of trauma resolution is the restoration of meaning, an understanding of the event and the world after the event. According to this theory there are two construals of meaning, *benefit-finding* and *sense-making*. The *benefit-finding*, almost identically to Tennen's and Affleck's concept, is the pursuit for the silver lining to adversity, based on the possible positive consequences of adversity. *Sense-making* refers to whether a particular event fits into one's conception of how the world is assumed to work. The assumptions that Janoff-Bulman (1992) had named regarding *controllability*, *comprehensibility*, and *justice* are challenged and sense-making process are triggered. *Making sense* and *finding benefit* in the adverse experience are two distinct construals of meaning, distinguishable in terms of their focus, their antecedents, and their relations to psychological adjustment. They suggested that while making sense is an important process in the early phases of adjustment, perceiving benefit may be more of a long-term process that unfolds over time, affecting adjustment. Similar concepts had been proposed by Janoff-

Bulman and Frantz (1997), *meaning-as-comprehensibility* being identical to sense making and *meaning-as-significance* being identical to benefit finding. They had also suggested that successful coping requires a shift from early sense making efforts to benefit finding efforts. However, the terms suggested by Davis and colleagues (1998) came to dominate the literature in the consequent years through their many publications.

Crystal Park and colleagues initially published the first quantitative measure for growth, *Stress-Related Growth Inventory* in 1996 (Park, Cohen, & Murch, 1996), while in 1997 they published a more theoretically focused paper on meaning making in the context of stress and coping (Park, & Folkman, 1997). The *Stress-Related Growth Scale* (SRGS) was the first measure to be published, and it was largely based on an infrequently cited theory of Schaefer and Moos (1992, as cited in Park, Cohen, & Murch, 1996) on life crises and personal growth. The three major types of stress related growth measured were *enhanced social resources*, *enhanced personal resources*, and *new or improved coping skills*. They also explored the determinants of stress related growth such as the personal characteristics of the individual, the characteristics of his/her environment and his/her coping behaviors. Although the reliability and validity tests indicators were sound, the sample used in the validation process was significantly problematic. As in common practice, the participants were freshmen college students that had to participate in order to fulfill course requirements. Moreover, only 18% had reported events that could qualify as traumatic, such as illness, accident, or bereavement, with the remainder of the sample reporting stressful events like problems in romantic relationships or academic performance. The latter events can be stressful for a young adult, however, whether they can be considered as traumatic events causing the shattering of world assumptions and generating growth is questionable.

One year later, Park and Folkman (1997) conceptualized growth within a meaning-making coping process. They distinguished between *two levels of meaning, situational and global*. *Global meaning* encompasses a person's enduring beliefs and valued goals. This type of meaning resembles Janoff-Bulman's concept of assumptive world since it includes beliefs about the order of the world, one's life and one's place into the world, and beliefs about

purpose. Global meaning is usually stable, and is affected by optimistic bias and personal relevance. *Situational meaning* refers to the interaction of a person's global beliefs and goals with environment and life events. The three major components of situational meaning are (a) appraisal of meaning or personal significance in any given situation, (b) coping processes in which people search for meaning in a situation, and (c) the meaning that a person makes in the aftermath of an event, also referred to as outcome. Individuals facing traumatic events that contradict their global meaning examine the situational meaning of the event through appraisal and attribution processes. When they use the second component of the situational meaning and reappraise only the situational meaning of the event (by finding benefits for example) but do not revise their global meaning, then growth is only a coping strategy. However, in this theory, growth appears as a possible outcome of the meaning making process, only when the global meaning of an individual is revised to accommodate the traumatic event.

The theories reviewed until now primarily presented growth as both a coping strategy and an outcome of the encounter with trauma, describing only vaguely the processes that can generate growth. The types of events that can generate growth have also been vaguely defined, from adverse events to traumatic events. Regardless of the plethora and overlap of theories with similar terms and concepts, no single theory can provide a wholly persuasive model of posttraumatic growth, a model that will define trauma, growth, its determinants, processes, and consequences. Calhoun and Tedeschi, first published work in this area in 1989 (Calhoun, & Tedeschi, 1989-90) and in 1995 they published their book on trauma and transformation (Tedeschi, and Calhoun, 1995), based primarily on qualitative data, presenting for the first time their theory on *posttraumatic growth*. In 1996 they also published their quantitative instrument, the *Posttraumatic Growth Inventory* (PTGI; Tedeschi, and Calhoun, 1996) that subsequently has been employed by numerous researchers.

The most recent revision of the theory was presented in 2004 in a special issue of the journal *Psychological Inquiry* (Calhoun, & Tedeschi, 2004; Tedeschi, & Calhoun, 2004a) and was later presented in an edited book by Calhoun and Tedeschi (2006) in a mildly amended form (Figure 1). In these

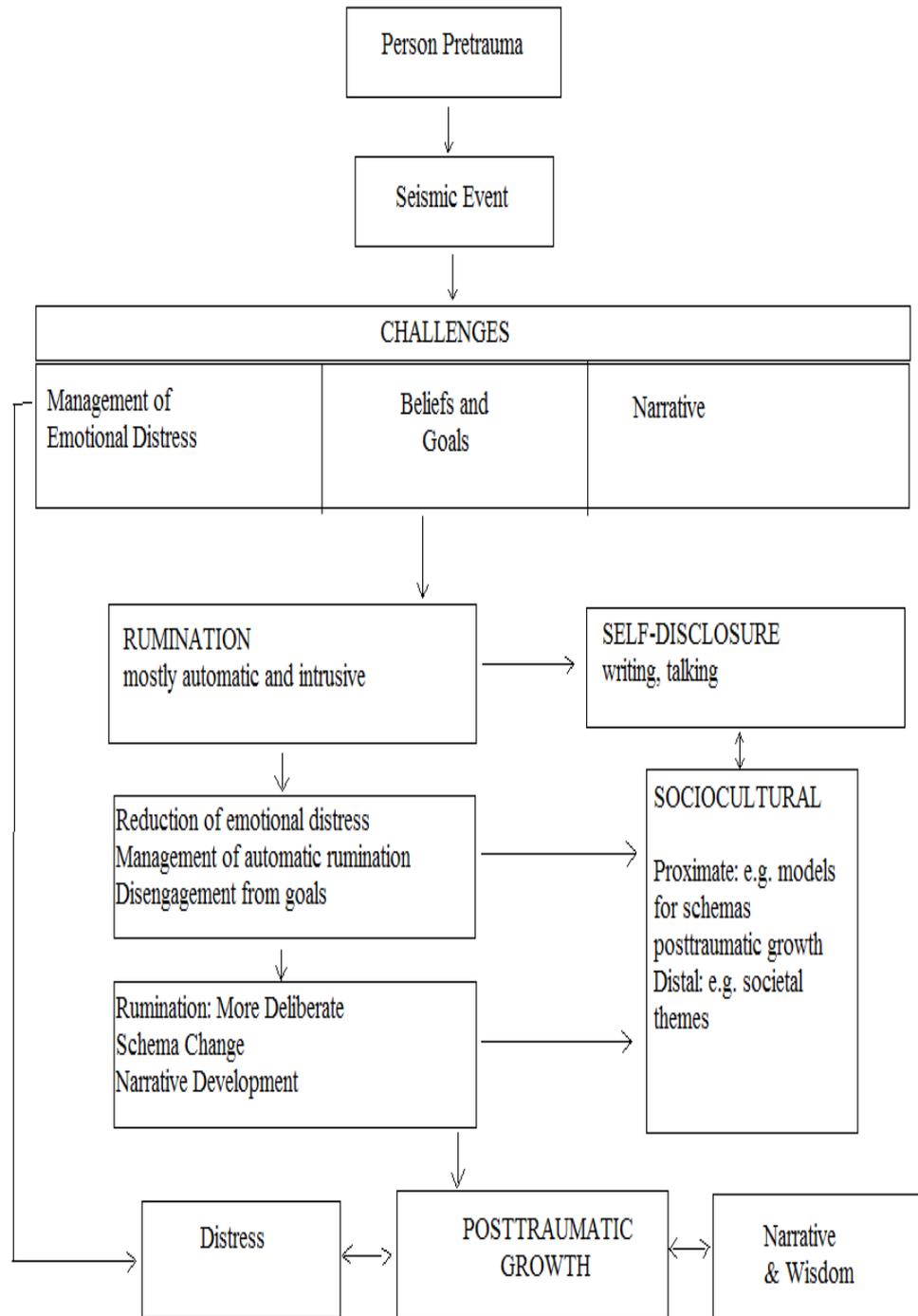
articles the authors defined posttraumatic growth as the “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi, & Calhoun, 2004a, p. 1) outlining their view of trauma as “sets of circumstances that represent significant challenges to the adaptive resources of the individual,[...] that represent significant challenges to individuals’ ways of understanding the world and their place in it” (Tedeschi, & Calhoun, 2004a, p. 1). Thus what is traumatic is not necessarily dependent upon the event itself, but its effect on schemas, or world assumptions exposing them to the necessity of reconstruction. This definition is broader and less restrictive than that of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 2000) and is in full agreement with Janoff-Bulman’s definition of trauma. It has also been recently suggested that the centrality of the traumatic event regarding one’s identity is a key predicting factor for growth. Centrality to identity is the extent to which an individual perceives an event as central to his or her identity (Boals, Steward, & Schuettler, 2010).

Tedeschi and Calhoun (2004a; Calhoun, & Tedeschi, 2004) acknowledge the well documented fact that individuals exposed to major life crises do have an increased risk of developing psychiatric problems, but the focus of their theory is on the rest of the individuals that will not develop a psychiatric condition, who usually outnumber the ones that will, a position in line with the Positive Psychology paradigm. However, they suggest that the widespread assumption that traumas often result in disorder should not be replaced with another generalization that growth is an inevitable result of trauma. In their view, a certain degree of continuing personal distress and growth often coexist. The term *posttraumatic growth* instead for *stress-related growth* (Park, Cohen, & Murch, 1996) or *perceived benefits* (Affleck, & Tennen, 1996) or *positive psychological changes* (Yalom, & Lieberman, 1991) or *positive illusions* (Taylor, & Brown, 1988) is a more appropriate term for the phenomenon described in their model for four reasons. First, this term places the focus on major crises of human life rather than lower level stress. Second, in contrast to the terms emphasizing the idea that reports of growth are illusory, this term emphasizes the veridical transformative life changes that go beyond illusion.

Third, in contrast to the other terms that describe growth as a coping strategy, this theory and term present growth as an outcome or an ongoing process. Finally, this term expresses the significant psychological distress coexisting with trauma, due to the process of restructuring the fundamental world assumptions that were shattered from the traumatic event. Posttraumatic growth possesses a quality of transformation, or a qualitative change in functioning unlike similar terms. What makes the traumatic experiences transformative appears to be the fact that they have an affective component, so that the lessons learned are not mere intellectual reflections. Posttraumatic growth is most likely a consequence of attempts at psychological survival, and it can coexist with the residual distress of the trauma.

Based on the use of the *Post-Traumatic Growth Inventory* (PTGI), Tedeschi and Calhoun (2004a) report five domains of growth (1) *Appreciation of Life*: an increased appreciation for life in general and life priorities; (2) *Relating to others*: closer, more intimate, and meaningful relationships with other people; (3) *Personal Strength*: a general sense of increased personal strength, or the awareness of this personal strength. The identification of this personal strength is often correlated, almost paradoxically, with an increased sense of being vulnerable. Growth in this domain is experienced as a combination of the clear realization that bad things happen and the discovery that “if I handled this, then I can handle just about anything” (p.6); (4) *New Possibilities*: an identification of new possibilities in one’s life, expressed in the choice of new or different paths in life; (5) *Spiritual Change*: a greater understanding of spirituality, existential awareness, and a stronger faith in a higher power. This model predicts different levels of posttraumatic growth, as the above five domains relate differentially to certain personality variables, and there might be different cognitive processes and trajectories to growth for each individual.

Figure 1: The model of Posttraumatic Growth. Adopted from Calhoun and Tedeschi (2006, p.8).



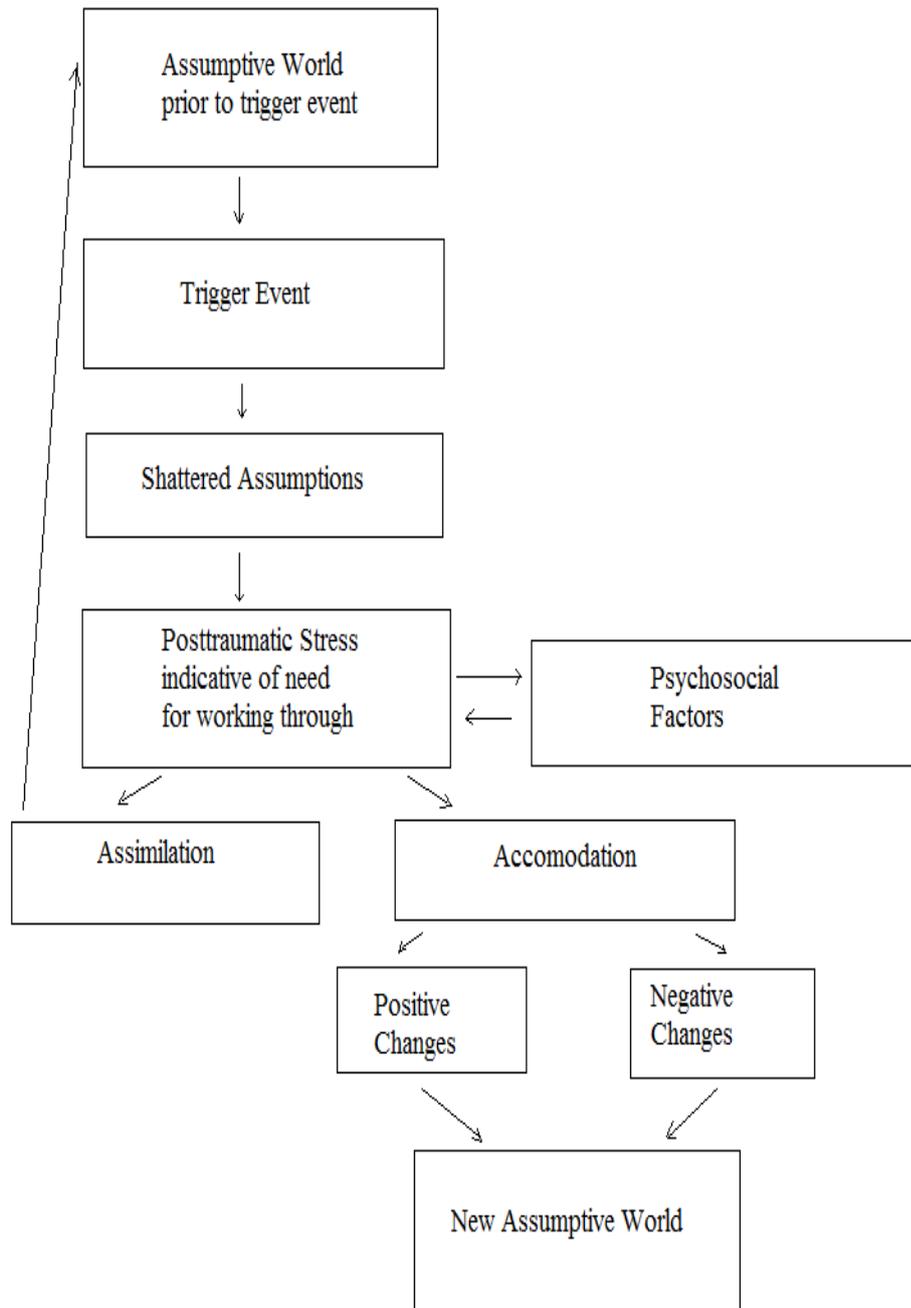
Regarding the process towards posttraumatic growth, Tedeschi and Calhoun (2004a) describe the traumatic events as *seismic*, as turning points, structuring the life narrative of traumatized individuals in a before and after the trauma periods. Those events challenge, shake or shatter the assumptive world of the individual. The shattering of the fundamental schemas and beliefs cause emotional distress followed by intrusive and counterfactual rumination that generates the processing of the traumatic information, rumination that with time changes qualitatively and shifts towards revision of goals and schemas. Disclosure and quality of social support is an essential ingredient for this stage of processing, as social support needs to be stable and consistent over time. Facilitation or discouragement of cognitive processing of emotional material in trauma survivors might be the key to growth. Individuals who are extraverts and hold the characteristics of openness to experience and optimism but also are capable of containing emotional distress have been reported to be better equipped for their journey to growth. Calhoun, and Tedeschi (2004a) as well as Tedeschi, Calhoun, and Cann (2007) respond to the theorists perceiving growth as illusory by raising two points. First, that it would have been more fruitful to consider the long term consequences for the people reporting growth, because if it is illusory it would fade over time. Second, whether growth is inaccurate or accurate (Lechner, & Antoni, 2004) invalid or valid (Park, 2004), fake or genuine (Wortman, 2004) illusory or constructive and transcending (Maercker, & Zoellner, 2004) it may still have consequences for the individual's psychological functioning.

Finally, along similar lines with Tedeschi and Calhoun (2004a), Joseph and Linley (2005, 2008) presented growth as an outcome of the struggle with trauma. Having a strong person-centred theoretical background and important contributions on research on PTSD (Joseph, Williams, & Yule, 1997) they presented the *Organismic Valuing Theory* (Figure 2). Due to their humanistic background Joseph and Linley based their theory on the assumption that human beings are active, growth-oriented organisms. This innate tendency of humans to pursue their well-being and fulfillment is either facilitated or impeded from their social environment. Consequently, their definition of growth appears to parallel

what humanistic psychologists have referred to as *fully functioning* individuals (Rogers, 1959).

They adopted the term of the *assumptive world* from Janoff-Bulman (1989, 1992) and they agreed with previous theories of growth that a traumatic event shatters these fundamental assumptions. The *completion tendency* is considered to be activated and the individual to be intrinsically motivated to integrate the new trauma-information. When the individual strives to integrate the traumatic experience into the self-structure, intrusive and avoidant states are activated, characteristic of PTSD because of the threatening nature of the material. Joseph and Linley (2005, 2008) proposed that the natural tendency of individuals is to *accommodate* in a positive way the traumatic information by modifying their existing models of the world, changing their worldview and growing. However, because this process is very demanding and threatening it requires a supportive social environment that will facilitate the basic psychological needs for autonomy, competence, and relatedness. If this environment is not provided to the traumatized individual, then he/she becomes more vulnerable paving the way towards a *negative accommodation*, a depressiogenic reaction of hopelessness and helplessness. The final scenario in that model is when a person does not engage with the significance of the event, but instead attempts to retain his/her pre-trauma schemata, or to *assimilate* the traumatic material. When assimilation of the traumatic material occurs, according to Joseph and Linley (2005, 2008), the individual's assumptive world is left fragile to future fragmentation and the individual is vulnerable to subsequent traumatization as the processing of the traumatic material was stifled.

Figure 2: Organismic Valuing Theory of Growth through Adversity schematically represented. Adopted from Joseph and Linley (2008, p. 13).



1.2.3 Empirical Research on Growth

Reports of *Posttraumatic Growth* (PTG) and related terms have been located in mostly quantitative but also a few qualitative studies across a wide variety of traumatic events, including multiple sclerosis (Hart, Vella, & Mohr, 2008), near-death experiences (Wren-Lewis, 2004), burn injuries (Rosenbach, & Renneberg, 2008), war (Maguen, Vogt, King, King, & Litz, 2006; Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003; Solomon, & Dekel, 2007), childhood sexual abuse (O'Dougherty-Wright, Crawford, & Sebastian, 2007), natural disasters (Cryder, Kilmer, Tedeschi, & Calhoun, 2006; McMillen, Smith, & Fisher, 1997), cancer (Bellizzi, 2004; Collins, Taylor, & Skokan, 1990; Cordova, Cunningham, Carlson, & Andrykowski, 2001; Morrill, Brewer, O'Neil, Lillie, Dees, et al., 2008), road trauma (Harms, & Talbot, 2007; Salter, & Stallard, 2004), partner violence, rape and sexual assault (Cobb, Tedeschi, Calhoun, & Cann, 2006; Grubaugh, & Resick, 2007; Poorman, 2002; Thompson, 2000), tinnitus (Davis, & Morgan, 2008), heart disease (Sheikh, 2008; Sheikh, & Marotta, 2008), spinal cord injury (Chun, & Lee, 2008), HIV/AIDS (Milam, 2004; Siegel, & Schrimshaw, 2000; Updegraff, Taylor, Kemeny, & Wyatt, 2002), terrorism (Laufer, & Solomon, 2006), the holocaust (Lev-Wiesel, & Amir, 2003), parenting children with disabilities (Konrad, 2006), bereavement and parental bereavement (Calhoun, & Tedeschi, 1989-90; Calhoun, Tedeschi, Fulmer, & Harlan, 2000; Davis, Wohl, & Verberg, 2007; Davis, & Nolen-Hoeksema, 2001; Davis, Wortman, Lehman, & Silver, 2000; Fazio, & Fazio, 2005; Gerrish, Dyck, & Marsh, 2009; Kessler, 1987; Polatinsky, & Esprey, 2000; Znoj, & Keller, 2002; for reviews see Helgerson, Reynolds, & Tomich, 2006; Linley, & Joseph, 2004).

Empirical research has also concentrated on the understanding of character strengths and posttraumatic growth (Peterson, Park, Pole, D'Andrea, & Seligman, 2008; Prati, & Pietrantonio, 2009), outcomes of posttraumatic growth such as altruism (Staub, & Vollhardt, 2008) and wisdom (Linley, 2003), the cognitive coping processes such as rumination and their relationship to posttraumatic growth (Michael, & Snyder, 2005; Nolen-Hoeksema, & Davis, 1999; Nolen-Hoeksema, Parker, & Larson, 1994), causal attribution, and cognitive appraisal (Affleck, Tennen, Croog, & Levine, 1987; Bower, Kemeny,

Taylor, & Fahey, 1998; Carver, Scheier, & Weintraub, 1989; Downey, Silver, & Wortman, 1990; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Mendola, Tennen, Affleck, McCann, & Fitzgerald, 1990). Other factors affecting the coping process and its outcomes that have been explored include social support (Paul, et al., 2010; Prati, & Pietrantonio, 2009), religion, and spirituality (Matthews, & Marwit, 2006; McIntosh, Silver, & Wortman, 1993; Overcash, Calhoun, Cann, & Tedeschi, 1996; Shaw, Joseph, & Linley, 2005; Tedeschi, & Calhoun, 2006). For the purposes of the present research project and in the light of the plethora of published papers, only the studies reporting posttraumatic growth or other positive outcomes following parental bereavement will be presented.

1.3 Growth following Parental Bereavement: Empirical Findings

Research reporting positive outcomes or growth after parental bereavement does not only come from the *Posttraumatic Growth* (PTG) authors and research teams, but also from other researchers (Braun, & Berg, 1994; Miles, & Crandall, 1983; Milo, 1997; Wheeler, 2001). However, the number of research papers on this type of bereavement is relatively small compared to the plethora of available research on PTG in general. The results of a search in PsychInfo database for the keyword *Posttraumatic Growth* came up with 737 journal articles, for *Bereavement* the number was lowered to 32, and for *Parental Bereavement* to six, while for the keyword *Stress-Related Growth* the number was zero. Of all major life stressors, including the death of a family member, the death of a child has been identified as the most grievous of losses (Klass, 1986-7, Sanders, 1979-80, Braun, & Berg, 1994). Literature suggests that non-normative deaths (or “off-time”), violent or un-natural deaths and sudden, unexpected losses are more likely to precipitate longer and more intense grief reactions (Currier, Holland, & Neimeyer, 2006; Stroebe, & Schut, 2005), combining the characteristics of both grief reactions and trauma reactions (Neria, & Litz, 2004; Rubin, Malkinson, & Witztum, 2003), causing people to embark on a process of searching to find meaning and trying to

rebuild a shattered life. This section will review available research reporting positive outcomes and growth after parental bereavement over the previous 30 years regardless of the theoretical background of the researchers.

The first authors to connect parental bereavement, the parents' search for meaning of their loss and growth were Miles and Crandall in 1983. In that article they reported three studies conducted with a total of 135 bereaved parents through the use of mailed questionnaires with open-ended questions. The questions were asking parents to express both negative and positive resolutions of their grief. In the content analysis of the data many positive themes emerged in all three studies and those themes included that parents had learned to prioritize and organize their lives differently, had become more compassionate, appreciative, spiritual, and helpful to others who suffer, and had ended up feeling stronger while choosing to live their life to the fullest since their loss. Regardless of the methodological limitations of these studies by Miles and Crandall, they were the only researchers who reported positive outcomes after parental bereavement before the early 1990's. During the 1990's three studies were presented regarding positive outcomes after parental bereavement, two of which (Braun, & Berg, 1994; Milo, 1997) had been influenced by the early theories of trauma adaptation, especially by the theories of Janoff-Bulman (1992) and Affleck, and Tennen (1991, 1996).

Braun and Berg (1994) interviewed ten bereaved mothers, who had lost their children unexpectedly, and analysed their interviews using Grounded Theory (Strauss, & Corbin, 1990). However, the sample characteristics like their mothers' age, age of the child at the time of death, or the number of years since the death were not reported. According to the theory that emerged the core variable for the adjustment of bereaved parents was meaning structures or the assumptive world. If the loss was a world shattering experience that contradicted their existing beliefs, assumptions, values and norms, then disorientation occurred and loss of meaning in life resulted. When prior meaning structures failed to account for the death, parents often sought to restore meaning by trying to explain the death, a search that was expressed with questions like "Why?", "Why my child? ". In their last effort to explain the death through their existing meaning structures, parents employed religious

explanations of a God that knows, or experienced feelings of guilt, as if the event was controllable and could have been prevented with a different course of action on their part. When the prior meaning structures failed again to explain the loss, disorientation was experienced. The final theme described was adjustment, the stage at which mothers attuned the meaning structures to account for the death. In this phase of the bereavement process, that was not permanent with parents moving back and forth between adjustment and disorientation, the themes that emerged were an increased awareness of what is important, and a closer relationship with important others. All participants reported that what had helped them adjust was talking about their child and being understood underlining the importance of social support.

Milo (1997) interviewed eight mothers who had lost a child with a developmental disability. The interviews were analysed using constant comparative analysis. The interviews were taken one to seven years after the loss, and the ages of the dead children varied from 10 months to 37 years. The initial theme for those mothers was that they felt they had to justify their pain to others, often receiving messages that their child was less valuable, that their grief should be less, and that they should feel relief. Other themes underlined the special bond of the mothers with their disabled children as they required their full attention and care, due to their health problems, and the multiple losses that these mothers had suffered, first losing the ideal child and then their true child. However, the majority of themes were on the positive transformations these mothers went through parenting and losing a disabled child. These transformations included gaining confidence and strength, being more empathetic towards others, a changed sense of priorities, enhanced spirituality, and dramatic changes in their relationship with others. Milo (1997) presents the different strategies through which those mothers were able to become transformed. Thus, they ascribed a special meaning to their child, like when due to their children the care or policies for other suffering children were changed, they resorted to humor, gaining some control over aspects of the death (such as funerals etc) and they used downward comparisons when thinking of things that could have been worse. The strategies described were

inspired from Affleck and Tennen (1991), Janoff-Bulman (1992), and Taylor (1983).

Talbot (1996-7; 1998-9), a bereaved mother herself, explored personal transformations after the loss of an only child, which results in the loss of parental identity as well. Through a quantitative screening test administered to 80 participants, using the Life Attitude Profile- Revised (LAP-R) reflecting purpose in life, coherence, control and similar terms, as well as the Perceived Well-Being Index (PWB-R), she interviewed ten bereaved mothers, five with the highest and the five with the lowest scores. However, the results presented were mainly quantitative and, though enriched by participants' quotes. The study identified four common factors among the women that had survived and grown in positive ways: (a) they had gone through a spiritual crisis after their child's death, (b) they had made a conscious decision to survive, (c) they had committed themselves in helping others either voluntarily or professionally, and (d) they had integrated their experience into their new identity that was in their view far more compassionate than before. The author concluded that "their [participants] hardiness seems to have been forged in the fire of agonizing grief- grief which has been consciously confronted and transformed into the gift of compassion" (Talbot, 1998-9, p. 184).

Regardless of the methodological limitations the themes that had been already reported from previous research such as new appreciation and new priorities in life, enhanced spirituality, feeling stronger and more compassionate were also reported by Wheeler (2001) that surveyed 176 bereaved parents. The children who had died ranged in age from 0 to 48 years, while the time elapsed since their death varied from one month to 40 years. The children had died from accidents, diseases, murder and suicide. The results reported were based on two open-ended questions of a longer questionnaire. Wheeler (2001) also added a final theme named personal growth that included quotes of parents feeling better about themselves, becoming better persons, experiencing greater self-awareness and pursuing further education.

Employing a mixed design, Murphy, Johnson, and Lohan (2003) obtained personal narratives and questionnaires from 138 parents 4, 12, 24, and 60 months after an adolescent's or young adult child's death by accident,

suicide or homicide. They adopted Janoff-Bulman's terms (Janoff-Bulman, & Frantz, 1997) of meaning-as-comprehensibility and meaning-as-significance to analyse their results. While only 12% of the parents had managed to find meaning-as-significance within the first year this percentage increased to 57% after five years. The parents who found meaning-as-significance reported gaining new insights into the meaning of life and their priorities, had higher existential awareness, valued their deceased child and their bond with him/her, felt more altruistic, felt stronger, and believed that there were benefits for others due to their child's death. Similar themes of positive outcomes and growth have been reported by other qualitative studies of bereaved parents whose children have died from chronic illnesses, accidents, murder, or suicide (Arnold, & Gemma, 2008; Arnold, Gemma, & Cushman, 2008; Barrera, D'Agostino, Schneiderman, Tallett, Spencer, et al., 2007; Barrera, O'Connor, D'Agostino, Spencer, Nickolas, et al., 2009; Parappully, Rosenbaum, Daele, & Nzewi, 2002).

A PsychInfo database search and a search through the references of related articles on *Posttraumatic Growth* (PTG) and related terms yielded only nine articles. Calhoun, Tedeschi and colleagues (Calhoun, Tedeschi, Fulmer, & Harlan, 2000) assessed posttraumatic growth (using the PTGI) in 34 grieving parents along with psychological distress and event-related rumination. The conclusions drawn in that study were that posttraumatic growth and psychological distress are not related, meaning that the presence of growth is not necessarily reflected in a reduction of psychological pain for the parents; furthermore, rumination was significantly related with growth, especially deliberate rumination, implying that denial and avoidance do not appear to be related to growth, while processing through rumination and benefit finding the loss are. A second study reported in the same year (Polatinsky, & Esprey, 2000) assessed PTG (using the PTGI) in bereaved parents while exploring the effects of gender differences, type of loss, and time since the loss. The results of that study though can only be interpreted with caution due to severe sampling limitations. While the total sample could be considered adequate for the purpose (N=67), 49 were bereaved mothers and only 18 were fathers. The study reports no significant differences in maternal and paternal PTG scores.

The causes of death were various including motor vehicle accidents, suicide, homicide and illness. The authors had hypothesized that anticipated losses compared to sudden deaths could enhance PTG scores. The results revealed a potential relationship towards the direction they had predicted but with only 5% of deaths being caused by illness any further analysis was impossible. The time since the loss had a great variance from six months to eight years; nevertheless, results indicated that the longer the time elapsed since the loss, the higher the PTG scores were.

Engelkemeyer and Marwit (2008) assessed PTG among 111 bereaved parents, by examining the effects of world assumptions and psychological distress. These parents had lost a child younger than 25 years of age who lived with them at the time of death caused by homicide, accident or illness. The time since the child's death ranged from 1 to 372 months (31 years). The data analysis suggested that parents who reported growth also had more positive beliefs about self-worth, meaning that they believed themselves to be capable of achieving positive outcomes despite the randomness of the world. Furthermore, the results indicated that parents had higher levels of growth and less grief over time. However, a hierarchical multiple regression analysis did not reveal psychological distress and grief as predictors of growth. In another quantitative study of 128 bereaved parents (Znoj, & Keller, 2002) other aspects of the grieving experience were explored such as adaptive emotion regulation, physical and psychological health, depression, posttraumatic stress disorder, and coping styles. The authors concluded that "the most important result might be the finding that during the course of grief a person learns to cope better with difficult and hard-to-endure emotional states and feelings" (p.559). These findings support the Calhoun and Tedeschi model (2004a) that personal growth and a better sense of functioning can be acquired through traumatic life events.

Davis and colleagues explored, questioned and criticized the concept of *posttraumatic growth* in general and as it relates to bereaved parents in particular through a series of publications (Davis, Wortman, Lehman, & Silver, 2000; Downey, Silver, & Wortman, 1990; Lehman, Wortman, & Williams, 1987; Lehman et al., 1993), finally adopting the term *posttraumatic growth* in Davis, Wohl, and Verberg, 2007. They conducted a numerically aided

phenomenological study on 52 bereaved adults, of which three were bereaved parents following a mine explosion (the rest were spouses, siblings, and other close relatives) eight years after the loss. The cluster analysis revealed three groups between participants: (a) Rebuilt self: where participants described that the loss had struck them to the core, reported that they had made some sense of the loss, and mainly expressed personal growth, in terms of increased self-knowledge but also increased personal strength; (b) No meaning/No growth: participants that still hadn't made any sense of their loss, that their worlds were still shattered, reporting no growth; and (c) Minimal threat/ Minimal growth: where participants appeared as their world assumptions were less naïve before the loss, so the bereavement did not shatter their understanding of the world. These participants reported changes in their philosophy of life. The authors offered some valuable conclusions for our understanding of the phenomenon of PTG underlining qualitative differences in growth that are drawn from differentiated processes. The use of broad definitions and measurement instruments for concepts such as positive changes, benefits, and gains may mask important connections between appraisals of loss (how central the loss was) and personal growth. Changing priorities, philosophies of life and forming closer personal relationships may all be considered positive changes or benefits but not necessarily considered as growth, which should be better reflected in deep changes in self.

1.4 Current theoretical framework on Parental Bereavement and Growth

The early models of grief by Freud (1917/1957), Bowlby (1961, 1969, 1973), Lindermann (1944), and the stage theories of grief by Bowlby and Parkes (1970) and Kubler-Ross (1969) had as the final stage of grief work, for successful grief resolution, acceptance of the loss and detachment, that is, breaking or severing emotional bonds with the deceased. However, Bowlby (1980) in his late-career writing did reconsider the emphasis on severing of the bond with the deceased and suggested that the pain of grief may lead to a

reshaping of the internal representational models and a reorganization of the attachment configuration, both of which include the persistence of the relationship with the deceased. Rando (1985) was one of the first researchers to challenge the prevailing thought regarding emotional detachment from the deceased. Rando found that the bereavement experience that was considered abnormal, or labeled as *unresolved grief*, was actually a part of most parents' experiences. Klass (Klass, & Marwit, 1988-89; Klass, 1987-88, 1993, 1997, 2003; Klass, Silverman, & Nickman, 1996) through his 30 years of experience supporting bereaved parents suggested that bonds should not and cannot be broken with the deceased child but only transformed, introducing the term *continuing bonds*, a term that has received rich empirical support (Neimeyer, Baldwin, & Gillies, 2006; Schut, Stroebe, Boelen, & Zijerveld, 2006). This new understanding of grief and bereavement renewed the interest of scholars in the area and gave rise to many new publications and theories on grief (e.g., Bonanno, & Kaltman, 1999; Currier, Holland, & Neimeyer, 2006; Field, Gao, & Paderna, 2005; Hogan, Morse, & Tason, 1996; Moos, 1995; Rubin, 1999; Stroebe, & Schut, 1999).

Language is a powerful indicator of the change in the area of bereavement research. Balk (2004) in an article initiated the discussion on whether the word *recovery* is appropriate when talking of bereavement (Rosenblatt, 2008; Sandler, Wolchik, & Ayers, 2008; Shapiro, 2008; Tedeschi, & Calhoun, 2008). The word *recovery* tends to relate to the medical model that has dominated psychology; *recovery* means a restoration of health after illness. Even the metaphorical use of this term obscures many of the characteristics, dynamics and processes of bereavement, one of those being that after a significant loss one may never recover in the sense of being as one was before.

Tedeschi and Calhoun (2008) took a clear stance in favor of the abandonment of the term *recovery* and the use of the term *resolution* or *adaptation*. In their view "... the use of particular terminology guides our conception of bereavement, and what is possible or expected in the experience of bereavement." (p. 30). They recommended neutrality of terms in order to protect against promoting viewpoints or assumptions that pathologize the people we study or serve. In their conclusions the authors invited more

qualitative research on the area for a deeper understanding of the experience of grieving persons.

Few theories that suggest the possibility of *growth* instead of *recovery* after bereavement have emerged during the last two decades. Nerken (1993) was the first theorist in this area but has found little support in the scientific community. In her theory she suggested a form of growth distinct of what other theorists on growth have suggested, defining growth as the development of a deeper understanding of the reflective self. Nerken (1993) suggested that some bereaved individuals grow in the sense that through their suffering they gain a deeper understanding of their self and of what they are capable of. She related this deepened self-knowledge with authenticity: “As the reflective self works with the core self [...] a more effective level of self-relation, self-consultation or simply self-awareness is achieved, what is more commonly known as authenticity” (Nerken, 1993, p. 57). In her model what appears catalytic is not the shattering of world assumptions, but the introspection brought by the death of a loved one, who used to help the individual define him/herself (i.e. I am a mother, a wife).

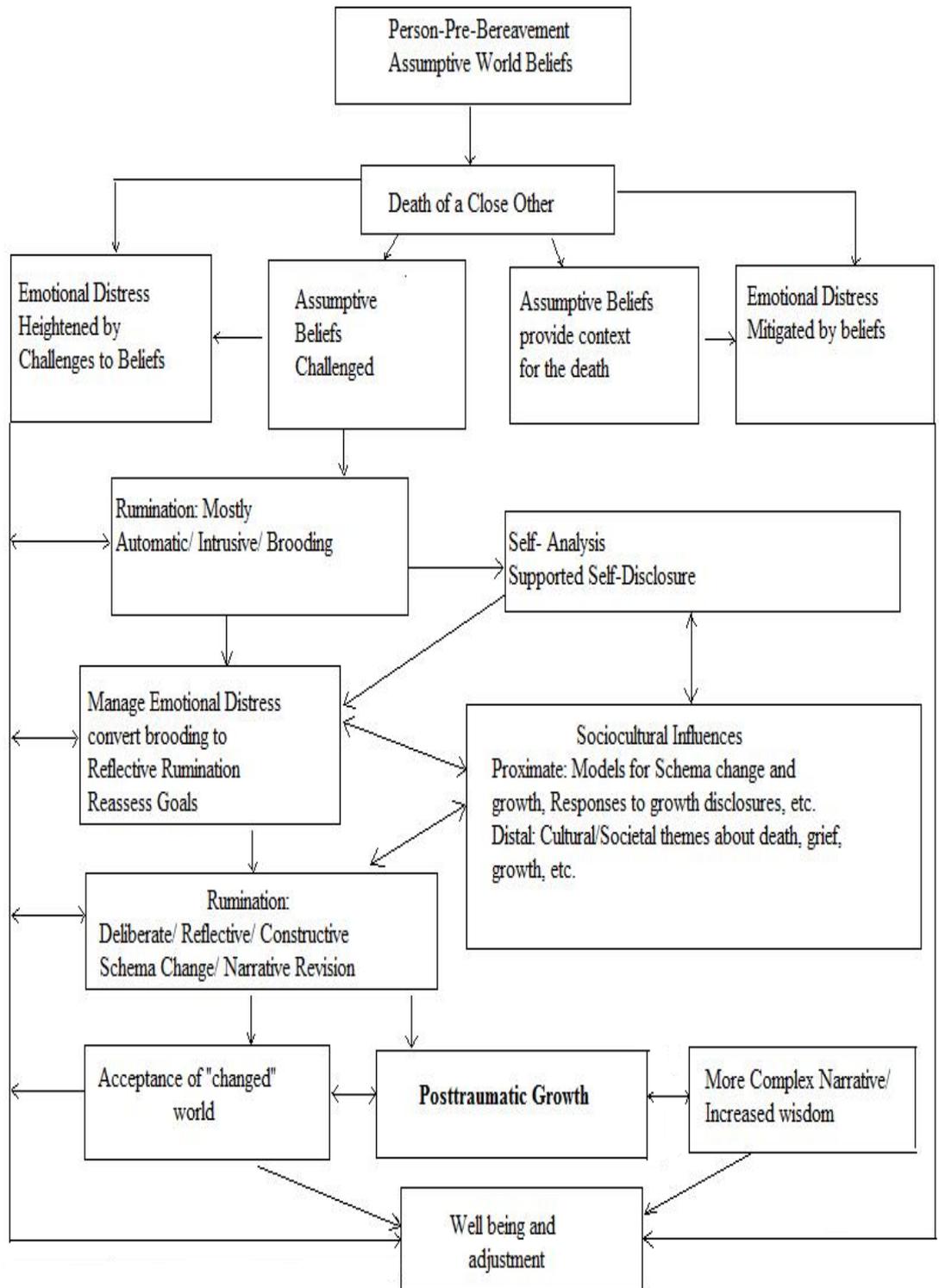
Neimeyer (2005-6, 2008; Gillies, & Neimeyer, 2006; Neimeyer, Prigerson, & Davies, 2002) have conceptualized *grief resolution* from a *constructivist* perspective. For Neimeyer individuals engage in an active process of meaning reconstruction in the wake of loss. This *meaning reconstruction* is divided into three major activities: *sense-making*, *benefit-finding*, and *identity change*. *Sense-making* involves the process in which bereaved individuals question, find and make sense of their loss experience. The way that *benefit-finding* is presented in this theory resembles what have been suggested by Janoff-Bulman (1992) or Taylor (1993), that is, that these benefits are illusory and they serve as positive reappraisals, or coping processes. The final process suggested by Neimeyer is *identity change* that encapsulates the changes in self-perception and life attitude described in other theories of growth such as the theory by Tedeschi and Calhoun (2004a).

Also, in one of their most recent publications Calhoun, Tedeschi and colleagues (Calhoun, Tedeschi, Cann, & Hanks, 2010) presented their theory developed especially for bereavement (Figure 3). On parental bereavement, the

authors support that unexpected deaths that are less consistent with the most assumptive world views, such as the death of a child, are less “natural” and often lead to greater distress and more growth.

As already highlighted, a new model of grief and loss is emerging. This model shifts away from traditional positivistic approaches to research and psychology, taking a postmodern, nonpositivistic approach affecting the way we study and understand grief and loss (Davies, 2004; Rothaupt, & Becker, 2007).

Figure 3: A Model of Growth in Grief. Adopted from Calhoun, Tedeschi, Cann & Hanks (2010, p. 130).



1.5 Perinatal Loss

1.5.1 Definitions and Statistics of Perinatal Loss

In the UK, babies are considered *stillborn* when they are born dead after the 24th week of gestation, while in other countries (e.g., United States of America) the benchmark is the 28th gestational week (www.thelancet.com/series/stillbirth). Death within the first four weeks of life is defined as a *neonatal death*. Both stillbirths and neonatal deaths are considered *perinatal deaths* (www.uk-sands.org).

In April 2011 the widely respected medical journal *The Lancet* launched a new series on stillbirth (www.thelancet.com/series/stillbirth). The shocking numbers provided are that 2.6 million babies are stillborn every year and 265,000 of them in high income countries. When compared with the leading global causes of death in all age categories, all-cause stillbirths would rank fifth among the global health burdens- before diarrhea, HIV/AIDS, tuberculosis, traffic accidents and any form of cancer (Frøen, et al., 2011). If we compare how often the media have covered the issue of AIDS related deaths, it becomes apparent that it is not the numbers that draw public attention to certain problems. Reducing the number of stillbirths was never included in the Millennium Development Goals of the United Nations, unlike the reduction of neonatal deaths that was included. The Editor-in-Chief of the Lancet, Richard Horton, in his video interview commented that “stillbirth has been a neglected, marginalized, and stigmatized issue” and that is “bizarre and wrong” (www.thelancet.com/series/stillbirth). This attitude towards stillbirth might exacerbate a woman’s disenfranchisement from the social groups to which she belonged before the baby’s death, intensifying and complicating her grief (Frøen, et al., 2011).

Regarding numbers in the UK, 11 babies are stillborn every day while 6 die during the first four weeks of their life. According to the 2009 report of the Centre for Maternal and Child Enquiries 4,125 stillbirths and 2,511 neonatal deaths happen every year in the UK, ten times more than babies dying from *Sudden Infant Death Syndrome* (SIDS). United Kingdom is among the high income countries with the highest stillbirth and neonatal death rates (www.uk-sands.org; Frøen, et al 2011). The stillbirth rates have remained constant since

2000, while according to the 8th Annual Report of the Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) it was evident that suboptimal care was present in half of the pregnancies that end up in death (Royal College of Obstetricians and Gynaecologists, 2010). It is indicative of the inappropriate attention this matter has received in the UK that the Royal College of Obstetricians and Gynaecologists published its first guidelines on late intrauterine fetal death and stillbirth only in October 2010 (guideline No. 55, Late Intrauterine Fetal Death and Stillbirth; RCOG, 2010).

1.5.2 Theoretical Conceptualizations of Perinatal Loss

There are available many well-known and widely taught theories exploring the mother-child bond that concentrate on the neonatal period (e.g., Bowlby, 1969; Sugarman, 1977) but only few that concentrate on maternal attachment to the baby during the prenatal period (e.g., Benkendorf, Corson, Allen, & Ilse, 1990; Condon, 1993; Cranley, 1981; Klaus, & Kennell, 1976; Muller, 1993; Rubin, 1975). According to Keefe-Cooperman (2004-5) each trimester of a pregnancy includes psychological tasks that are part of the bonding process between mother and infant. The first trimester involves suspicion and confirmation, resolving initial ambivalence, accepting the pregnancy, reviewing of one's childhood and changing feelings regarding body image and sexuality. During the second trimester, the mother begins to realize the fetus as a separate individual, and bonding is facilitated by the fetal movement and ultrasounds. The mother begins to picture the ideal child (Benkendorf, Corson, Allen, & Ilse, 1990). In the third trimester, the mother establishes a caretaking relationship with the fetus, and mentally prepares for labor and delivery (Bliss-Holtz, 1991).

According to the maternal-infant bonding theory of Klaus and Kennell (1976) a mother's emotional attachment to her child begins to develop early in the prenatal period. They also describe the process by which attachment occurs in the following nine steps: 1) planning the pregnancy, 2) confirming the pregnancy, 3) accepting the pregnancy, 4) fetal movement, 5) accepting the fetus as an individual, 6) birth, 7) seeing the baby, 8) touching the baby, and 9)

caretaking. Mothers that experience an intrauterine death have completed up to eight of these stages, while mothers experiencing a neonatal death have potentially experienced all nine. Research testing this theory has provided sufficient support of this theory concerning various types of perinatal losses (Peppers, 1987-88; Peppers, & Knapp, 1980).

Rubin (1975) described the maternal tasks of pregnancy. These tasks include ensuring the safety of the baby, accepting the baby, binding to the unknown baby, and learning to give of herself to the baby. According to Rubin (1975) the bond between a mother and her baby is apparent at the time of birth, meaning that their bond is developed and structured during pregnancy. Although at the time of birth a mother has no past perceptions of the baby through the usual sensory modalities, there is already a sense of shared experiences and shared history. Robinson, Baker, and Nackerud (1999) posit that maternal attachment consists of a complex set of events that include not only tangible events, such as fetal movement, but also events such as preparation and adjustment to the pregnancy that begin the relationship. Prior to birth, the mother has been able to conceptualize the infant and to project the dreams and future aspirations this baby will bring in her life. Finally, Moulder (1994) suggested that it might not be just the gestational age or time spent with a baby that defines the strength of the attachment, but also the maternal investment of a woman in her pregnancy and her unborn child.

Other investigators have explored the nature of pregnant women's maternal role attainment and emotional attachment to the unborn child and have developed scales that attempt to measure maternal fetal attachment. Cranley (1981) developed the *Maternal Fetal Attachment Scale* and defined maternal-fetal attachment as the extent to which women engage in behaviors that represent affiliation and interaction with their unborn child. Muller (1993) who developed the *Prenatal Attachment Inventory* defines this attachment as the unique, affectionate relationship that develops between a woman and her fetus. Condon's (1993) ideas about fetal attachment are more closely associated to Bowlby's (1988) original definition of attachment or love, as complementary care-giving behaviors. Condon (1993), who developed the *Antenatal Attachment Scale*, posits that the core experience of attachment is love and

proposed five experiences of love expressed through the determination of an expectant mother to know her baby, to interact with it, to avoid separation or loss, to identify and to gratify the needs of her unborn child. It is apparent from the available theories that attachment between a mother and her infant begins before birth but most probably is solidified when physical contact with the infant can be made. The transformation, development or loss of the maternal role that a full term pregnant woman has achieved following a perinatal loss of a first born child does not appear to have been explored until today. A database search using as key words *Maternal Fetal Attachment* (and related terms such as *Maternal Identity*, *Maternal Role Attainment* etc) and *Stillbirth* and *Neonatal Death* yielded no results. The problems with maternal identity after a pre-term delivery have been explored by some researchers and theorists (Mercer, 1995; Reid, 2000), but no exploration of the effects of a perinatal loss to maternal identity has been published.

When applying current bereavement theory to perinatal loss, several factors must be considered. Recent advances in medical technology have had a profound effect on aspects of perinatal loss and prenatal attachment. Early confirmation of pregnancy, repeated ultrasounds during the pregnancy, and prenatal diagnostic tools, such as amniocentesis, lead to an earlier bonding with the baby and the development of a mental representation of the child. Moreover, lower infant mortality rates have led to greater expectations regarding the success of pregnancy. In addition, the predominant media messages convey the impression that perinatal death can be avoided with good medical care and good health habits (Robinson, Baker, & Lackerud, 1999). Consequently, most women are not prepared for a perinatal death.

Losing a child at the later stages of a pregnancy, or immediately after birth, includes a sense of biological failure, isolated grieving, a possible lack of perceived support and lack of time for anticipatory grieving. A mother that loses a baby mourns the death of the idealized baby, but may not receive sufficient emotional support because of a lack of social recognition of that loss (Lee, & Slade, 1996). The absence of a socially visible child to mourn, and the lack of memories of shared life experiences exacerbates the lack of recognition by relatives and friends regarding the significance of the loss (Keefe-

Cooperman, 2004-5). The proportion of empirical research that has underlined the lack of social support for bereaved parents and especially bereaved parents due to perinatal loss is impressive considering the limited amount of research available on this type of bereavement (Brabant, Forsyth, & McFarlain, 1995; Cacciatore, 2007; Cacciatore, Schnebly, & Frøen, 2009; DeMontigny, Beaudet, & Dumas, 1999; Dyregrov, 2003-4; Hass, & Walter, 2006-7; Hazzard, Weston, & Gutterres, 1992; Laakso, & Paunonen-Ilmonen, 2002; Layne, 2001; Malacrida, 1999; McCreight, 2007; Murphy, Johnson, Chung, & Beaton, 2003; Rajan, & Oakley, 1993; Surkan, Rådestad, Cnattingius, Steineck, & Dickman, 2009).

White-Van Mourik, Connor, and Ferguson-Smith (1992) separate grief factors specific to perinatal loss into three areas, each defining a component of self-esteem. The areas of loss include the loss of *biological, moral and social self-esteem*. The fact that the baby that the mother's body produced could not survive, might cause a wound in her *biological self-esteem*, leaving her feeling physically inadequate and a failure. Because motherhood is almost synonymous with femininity, childless women (if the loss is experienced in the first pregnancy) are deprived of validation for arguably the most central element of their gender identity and, hence, personal integrity (Whiteford and Gonzalez, 1995). A loss of *moral self-esteem* might be caused because the mother is usually perceived as the sole responsible for her babies' well being. The death of a baby might cause a mother to feel guilty for behaviors that should have been avoided (e.g., work, exercise) or should have been done (e.g., going to the hospital earlier) in order to avoid the baby's death. *Social self-esteem* is negatively affected by a perinatal death and comes in sharp contrast with the elevated social status often assigned to pregnant women. Women are socialized to view their self-worth and femininity as linked to their reproductive potential and therefore not being able to reproduce somehow diminishes their sense of self and their value in society (Holt, & Slade, 2003). Moreover, society does not attach great importance to pregnancy loss and does not encourage open grieving for this type of death. The mother experiences a loss of self-esteem engendered by this lack of social recognition of the importance of the death. This type of socially unrecognized and unaccepted

mourning is often referred to as *disenfranchised grief* (Corr, 1998-9; Doka, 1987; 1989).

1.5.3 Empirical Research on Perinatal loss

The majority of the available empirical studies focus on psychopathology resulting from a perinatal death (e.g., Cacciatore, & Bushfield, 2007; Rådestad, Steineck, Nordin, & Sjögren, 1996; Vance, et al., 1995); gender differences in grief reactions and marital consequences (e.g., Feeley, & Gottlieb, 1988-9; Gottlieb, Lang, & Amsel, 1996; Hagemester, & Rosenblatt, 1997; Kamm, & Vandenberg, 2001; Kavanaugh, 1997; McGreal, Evans, & Burrows, 1997; Meyer, & Lewis, 1979; Smart, 1992; Vance, Boyle, Najman, & Thearle, 2002; Wing, Clance, Burge-Callaway, & Armistead, 2001); medical exploration of risk factors (e.g., Flenady, et al., 2011); psychological implications for future pregnancies and babies (e.g., Armstrong, & Hutti, 1998; Heller, & Zeahah, 1999; Hughes, Turton, Hopper, McGauley, & Fonagy, 2001); and hospital practices (e.g., Condon, 1987; Hughes, Turton, Hopper, & Evans, 2002; Lasker, & Toedler, 1994; Lovell, 1983; Paul, 1985; Rådestad, Nordin, Steineck, & Sjögren, 1996; Trulsson, & Rådestad, 2004).

Some of the available research on perinatal loss has major methodological limitations either due to sampling, usually resulting in not actually reporting findings on stillbirth, but on miscarriage (e.g., Thomas, & Striegel, 1994-5; Yan, Tang, & Chung, 2010) or due to the use of research designs that are not adequate for the understanding of the experience of perinatal loss (e.g., Covington, & Theut, 1993). Unlike the spurt on publications about *posttraumatic growth*, publications on *perinatal loss* remain sporadic and mostly published by journals specializing in thanatology (e.g., *Death Studies*, *Omega: Journal of Death and Dying*) or nursing (e.g., *Issues and Innovations in Nursing Practice*). Some medical journals or clinical psychology journals publish on issues of psychopathology after a perinatal loss, while a counselling psychology perspective appears to be absent in publications. The absence of information on normative long-term psychological sequelae of perinatal bereavement only serves to perpetuate

simplistic assumptions regarding the recovery process and disenfranchisement of this group of bereaved individuals.

John De Frain has conducted a series of research studies with bereaved parents after a perinatal loss and SIDS (De Frain, Martens, Stork, & Stork, 1990-1; De Frain, 1991). Nearly 850 individuals across many states of the U.S. were interviewed and completed questionnaires from 1975 until 1991. Parents reported feelings of shock, blame, guilt and hardship, and a deep need for carrying, seeing and remembering their dead baby, while they stressed the importance of the reaction of their social circles to their loss and bereavement.

Three qualitative studies coming from three different continents (America, Europe, Asia), none of them conducted by psychologists, are the best and only attempts in the last decade to understand the experience of perinatal bereavement. McCreight (2008) interviewed 23 women in Northern Ireland who had experienced a perinatal loss. The methodology adopted was the narrative approach. The participants mainly talked about their initial emotional responses, the medical procedures they had to endure, and the available burial arrangements. Although the time since the loss varied greatly between participants (2 months to 34 years) the discourses obtained shed light on the emotional responses such as pain, emotional turmoil and spiritual suffering; the insensitive hospital practices from the moment of breaking the bad news to birth; and the denied proper burials for those babies due to religious or hospital practices.

Hsu, Tseng, Banks, and Kuo (2004), in the social context of Taiwan, interviewed 20 women one year after they had experienced a perinatal loss. The research design adopted was the interpretative ethnographic approach. The themes extracted described a sense of lack of control over the deaths of their babies, mainly attributed to fate or destiny; a sense of shattered self, especially in terms of womanhood and their cultural roles; and feelings of guilt and self-blame for the death of their baby, as if they were faulty and unable to produce a healthy baby.

Hazen (2003) interviewed 14 women in U.S.A. Through thematic analysis, Hazen attempted to make comparisons between participants that had experienced the loss during different decades: e.g., 1965-77, 1980-89, and

1991-99. The author reports that all of the women in her study had experienced *disenfranchised grief*, as described by Doka (1989). This type of grief was attributed to interactions in their communities, including hospital and workplace. The improvements in hospital practices and possible employment benefits were reflected in the participants from the three different time periods. The author identified three patterns of healing (a) connection to the self, expressed in a deeper self knowledge; (b) attachment to the dead child; and (c) linking the self and child to the family and community. In particular, the author noted that often the latter was expressed in terms of a career shift of the bereaved mothers to caring professions.

1.5.4 Perinatal loss and Posttraumatic Growth

The literature exploring positive changes or posttraumatic growth of bereaved parents after a perinatal loss is not only limited but scarce. After years of database and reference list searches only two published articles have been located. Uren and Wastell (2002) conducted a survey of 109 bereaved mothers (78 had stillbirths, 31 neonatal deaths), from 2 to 207 months after their loss, incorporating a dual theoretical perspective of attachment (Bowlby, 1980) and meaning-making after trauma (Janoff-Bulman, 1992). A large battery of standardized questionnaires and two open-ended questions were administered. The results obtained conceptualized perinatal bereavement as an attachment-based syndrome. In the responses of participants there was a predominance and perseverance of acute emotional experiences of yearning and despair. An ongoing emotional bond with the deceased child was observed and that was unrelated to time elapsed since the loss. The authors concluded from their findings regarding attachment and the presence of continuing bonds revealed that the common conceptualizations of bereavement “recovery” are simplistic and misplaced. Moreover, the qualitative data offered support for Janoff-Bulman’s (1992) assumptive world model, with evidence that the prenatal loss shatters the mothers’ sense of invulnerability. Support for the model was also obtained regarding the cognitive re-appraisal processes activated for the assimilation of the traumatic material into one’s assumptive world to be

achieved. Bereaved mothers reported downward comparisons, and perception of favorable changes in self-identity.

Büchi and colleagues (2007) assessed grief, depression, anxiety, and posttraumatic growth (PTGI) of 54 bereaved parents, two to six years after the birth and death of their premature babies (24-26 weeks of gestation). The results revealed that 80% of the parents were still experiencing grief for their dead baby, with mothers having higher scores on this measure. Despite the grief reactions, 78% of the mothers and 44% of the fathers had high scores in on the subscale of *appreciation of life* (changed priorities) of the PTGI. Moreover, the majority of mothers (63-67%) had high scores in all other four subscales of the PTGI (*relating to others, personal strength, spiritual change, new possibilities*) and 30-40% of the fathers also scored high on these subscales. So, unlike Polatinsky and Esprey (2000) who did not find gender differences in PTG among bereaved parents Büchi and colleagues (2007) reported significant differences both on grief intensity and posttraumatic growth between the two genders. According to the authors, these results indicate that parents' suffering is largely determined by the severity of their grief but minimally influenced by their personal growth following the death of their baby. Like Calhoun, Tedeschi and colleagues (2000) concluded that posttraumatic growth is independent of affective disturbances and turmoil.

1.6 Conclusions

According to the latest edition of the Diagnostic and Statistical Manual (DSM-IV-TR, 2001) individuals can develop symptoms of Posttraumatic Stress Disorder following exposure to:

...an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or

injury experienced by a family member or other close associate (p.463).

Mothers experiencing a stillbirth are exposed to all these three; their lives are in increased danger during the delivery of a dead baby (RCOG, 2010), they witness an event that involves death, while they have just learned that their healthy baby is dead. Mothers experiencing a neonatal death, although their own life is not in danger, witness the death of their newborn baby that dies unexpectedly.

Perinatal death is a trauma but is also the starting point of parental bereavement. The definition of what constitutes a normal course of bereavement as defined by the latest edition of the Diagnostic and Statistical Manual (DSM-IV-TR, 2001) is that two months after the event the bereaved are not supposed to still feel guilty, have thoughts of death, have preoccupation with worthlessness, have marked functional impairment, or have hallucinatory experiences otherwise they can get diagnosed as suffering from a major depressive disorder. For every clinician that has experience with bereaved families, or has reviewed the literature presented in this chapter, this definition of abnormal grief appears at best bizarre, if not stigmatizing.

Even though, perinatal loss is a trauma and is a type of parental bereavement, only one study (Büchi et al., 2007) has explored the extent to which this traumatic bereavement could lead to posttraumatic growth. There is a plethora of research from the dominant medicalized perspective that focuses on the resulting psychopathology but no research from a positive psychology perspective that would seek information from individuals who coped successfully with this traumatic loss. Qualitative methodologies exploring this phenomenon from a perspective of *Counselling Psychology* are absent in the literature, although repeatedly invited by theorists (e.g., Calhoun and Tedeschi, 2006; Calhoun, Tedeschi, Cann, & Hanks, 2010; Tedeschi, & Calhoun, 2008).

Chapter 2: Methodology

2.1 Chapter Overview

This chapter presents a rationale for the use of Interpretative Phenomenological Analysis (IPA) through a discussion of the epistemological position of the researcher, and the relevance of IPA both to the research topic and the research questions addressed. Moreover, the chapter gives an account of the methods and the procedures used in the current study. Finally, the chapter concludes with the reflective comments of the researcher for the experience of conducting this study.

2.2 Research Design

The study employed a cross sectional research, small sample design incorporating a qualitative methodology.

2.2.1 Research Rationale and Definition of the Research Question

To date only one study has explored the phenomenon of posttraumatic growth on bereaved parents after a perinatal loss. The quantitative nature of that study (Büchi et al., 2007) did not allow for any exploration of the process and the essence of the experience of growth for these parents. Parents bereaved from perinatal loss have never been included in the samples of studies on posttraumatic growth after parental bereavement. Consequently, very little is known on this experience of parents. Moreover, the available qualitative literature on bereaved mothers after a perinatal loss are conducted from specialties other than psychology and have largely focused on birth, hospital practices, burial ceremonies and the initial grief reactions. Thus, the present research project was designed to explore qualitatively, from a counselling psychology perspective, the lived experience of posttraumatic growth after a perinatal loss and the processes involved in this experience. The research

question that emerged for this enquiry was “How mothers experience personal growth after a perinatal loss”.

2.2.2 Philosophical Paradigm

The choice of the research paradigm as well as the choice of the particular method is based on the epistemological position of the researcher. Epistemology is a part of philosophy concerned with the theory of knowledge (Willig, 2008). A philosophical paradigm can be defined as “a set of assumptions about the social world which provides a philosophical and conceptual framework for the organized study of that world” (Filstead, 1979, p.34). According to Willig (2008), the selected philosophical paradigm guides the researcher to philosophical assumptions about the research and to the selection of tools, instruments, participants, and methods employed in the study. The paradigm that the researcher has adopted in order to develop this present study is the *constructivist* paradigm. According to Ponterotto (2005), constructivism adheres to a relativist position that assumes multiple, apprehensible, and equally valid realities. More specifically, relativism proposes that there is no single social reality, only a series of alternative social constructions (Snape & Spencer, 2003). Constructivism holds that reality is constructed in the mind of the individual and that it is not an externally singular approach. Proponents of constructivism emphasize the goal of understanding the ‘lived experiences’ from the point of view of those who live it day by day (Ponterotto, 2005). The methodology that could best embrace the epistemological stance of the researcher was qualitative methodology. Qualitative researchers usually are concerned with meaning. Their focus is on how people make sense of the world and how they personally and individually experience events.

2.2.3 Methodological Considerations

Interpretative Phenomenological Analysis (IPA) and the social constructionist version of *Grounded Theory* (GT) are two qualitative methods that take a *contextual constructivist approach* (Willig, 2008). Both were

reviewed by the researcher in her effort to decide the analytic method that would form and guide the research design, procedure and analysis. The first difference between the two is that IPA was created by a psychologist for research in psychology, while grounded theory was developed more broadly for social sciences. While GT's primary focus is to identify and explicate contextualized social processes, or to map individuals' categories of experience, IPA aims to gain an understanding of the quality and texture of individual experiences, or in other words the essence of an experience for a specific individual.

While both adopt a symbolic interactionist approach, which claims that the individual experiences and perceptions from the world are influenced by social reality, GT places a far stronger emphasis on that theoretical underpinning. Although both approaches suggest that themes should emerge from the data and categories of themes should be identified by the researcher, the role of the researcher is conceived very differently by the two approaches. The social constructivist GT allows more freedom to the researcher, who is supposed to actively construct a particular understanding of the phenomenon under investigation still the private assumptions and expectations are not supposed to influence unduly the analysis, which in turn should not move beyond the data. The role of the researcher is described very differently in IPA. For IPA, any insights the researcher experiences from the data are considered to be a product of interpretation. A much greater emphasis is placed on the researchers' reflexivity during the process of analysis, on their being aware of any personal, epistemological preconceptions. IPA is phenomenological as it aims to represent the participant's view of the world and interpretative because it is dependent on the researcher's own conceptions and standpoint (Willig, 2008).

The present researcher reasoned that IPA is more congruent with her personal understanding and attitudes on qualitative research. Qualitative methodologies ought to be different from quantitative methodologies, so denying the central role of the researcher in the analysis of data is unnecessarily mimicking the role of the researcher in classic experiments. The researcher was comfortable with the high standards of reflexivity set by IPA

but also in deep agreement that as a researcher, who is a counselling psychologist, one way to make sense of the participants' accounts was through interpretation to varying degrees and levels. Finally, the aim of the present research project was to explore individual accounts of a significant experience that had a transformative power on their personal and social identities. The founder of IPA, Jonathan Smith, has repeatedly stated that it is precisely this type of events that are usually the concern of IPA (Smith, & Eatough, 2007; Smith, Flowers, & Larkin, 2009).

2.2.4 Interpretative Phenomenological Analysis (IPA)

The major theoretical underpinnings for IPA are *phenomenology* (Moran, 2000), *hermeneutics* (Palmer, 1969) and *idiography* (Smith, Harre, & Van Langenhove, 1995). With regards to phenomenology, the aim of IPA is to explore individually lived experience and to examine how participants make sense of their personal and social world. Thus, for an IPA study the main currency is the meanings that certain experiences hold for participants (Smith, & Eatough, 2007).

IPA emphasizes that research is a dynamic process, ascribing the researcher an active role in that process. Although the research process is dependent upon the researcher it is also complicated by the researcher. A double hermeneutic is required in an IPA study. The first level of this double hermeneutic is that while the participant is trying to make sense of his or her world through language, the researcher is trying to make sense of how the participant tries to make sense of the world. The second level of this double hermeneutic is that IPA combines both empathic but also critical hermeneutics. While the researcher tries to understand the world from the perspective of the participant and get in his/her shoes, the researcher has to also stand as far as possible from the participant and ask curious and critical questions in order to unravel the more subtle meanings of the participant's experience (Smith, & Eatough, 2007; Smith, Flowers, & Larkin, 2009).

Finally, IPA is an idiographic mode of inquiry and comes in sharp contrast to the nomothetic quantitative approaches in psychology. Instead of

focusing on probabilities and generalizability of results to the population it focuses on in-depth, detailed analysis of the lived experience of a small number of individuals. Smith, Flowers, and Larkin (2009) have argued that through a sensitively conducted interview, on a topic of considerable importance to the participant, which was insightfully analysed, a researcher can make a significant contribution to psychology; that this type of data matches and does justice to the complexity of human psychology itself.

2.3 The researcher

The researcher who conducted this research project is a 31 years old female newly qualified counselling psychologist (since 2008). The research proposal was submitted in July 2008 and she had completed the 3 year course requirements in March of that year. On the 27th of January 2007 she had given birth at the 38th gestational week to her stillborn daughter, Nafsika. At that time she was completing the 3 year postgraduate course in Counselling Psychology (leading to the Chartered Status) and she had just been accepted in the DPpsych programme in Counselling Psychology. In April 2007 she suspended her studies and re-entered the course in October 2007. Further discussion on the experience of the researcher during the research can be found in the Reflections section.

2.4 Ethical Considerations

There are numerous ethical issues to consider when conducting research with bereaved individuals because of their possible emotional vulnerability due to the loss. However, conducted relevant research sheds some light on these dilemmas (Balk, 1995; Beck, & Konnert, 2007; Bonanno, 2001; Briller, Meert, Schim, Thurston, & Kabel, 2008; Burnell, & O'Keefe, 2004; Cook, 1995; Dyregrov, 2004; Parkes, 1995; Rosenblatt, 1995; Stroebe, 2001) and suggests that bereaved individuals value bereavement research and even appreciate the opportunity to participate in it (Beck, & Konnert, 2007; Cook, & Bosley, 1995; Stroebe, & Stroebe, 1989-90; Stroebe, Stroebe, & Schut, 2003; Talbot, 1996-

7). Because the analytic strategy adopted places emphasis on the deep understanding of personal experience, participants may feel valued and free to express themselves, as they are offered space for their voice to be heard. The fact that mothers were self-selected as research participants by responding voluntarily to a website flyer simplified some ethical issues around intrusion and violation of privacy of participants.

As recommended by Dyregrov (2004), before agreeing to participate in the study participants had access to thorough and written information presented in a detailed flyer and information sheet (see Appendix A). They were also able to choose the location in which the interview would take place, in order to help them feel comfortable and safe with the setting. The researcher, being a counselling psychologist utilized her therapeutic skills, such as the ability to express warmth, communicate empathy, establish good rapport, listen actively, summarize and paraphrase what said in order to help the participants feel contained, respected and safe in the context of the interview. Participants had adequate time before, during, and after the interview if they needed to ask further questions or reflect on the process of the interview. They were asked to sign an informed consent before commencement of the interview (see Appendix B), while after the interview they were provided with a detailed resources pack which included contact details of professional counselling and psychotherapy bodies, charities offering free support for bereaved individuals and their families, and some books on bereavement and perinatal death (see Appendix C). Finally, all participants were given the option to see their transcript before the analysis was conducted and to be informed of the results of the study.

The fact that the researcher is a bereaved mother herself raised some further ethical considerations, regarding her interaction with the participants and her ability to analyse the data. The researcher had 8 months of personal therapy prior to submitting the research proposal (additional in to that required by the course), and had therapy throughout the recruitment process. Furthermore, during the months that the interviews took place she was not working therapeutically with any clients in order to avoid further strain or distraction from the research process. Although it is not at all unusual that

researchers conduct research on an area of personal relevance, particularly in the area of parental bereavement this appears to be common practice (see for example Cacciatore, Talbot, Hazen). The skills that the researcher acquired through the training years in counselling psychology, especially the ability to be self-reflective, were essential for the completion of the present research project. The researcher had worked as therapist with bereaved mothers and traumatized individuals before the commencement of the research project and continued while the research was running (but not during the recruitment process). Being able to handle a therapeutic relationship with bereaved and traumatized individuals gave the researcher additional insight, and self-awareness to carry out the interviews and the analysis. Support was sought from the principal supervisor of the researcher especially during the first stages of analysis. During the analysis period the researcher attended study groups in IPA and shared transcripts and themes with other doctoral students in order to check the validity of the interpretations. Further discussion on the experience of the researcher during the research can be found in the Reflections section, while additional details on the measures taken in order to ensure the validity of the analysis can be found in the “Analysis of Data” section.

2.5 Procedure

The rationale for the sampling and for using semi-structured interviews is presented below along with the description of the methods of data collection, interview context and procedure, and processes followed in transcribing the interviews.

2.5.1 Sample Inclusion Criteria

In IPA studies’ samples tend to be small in numbers, because of the commitment to a detailed and in depth interpretative account of the cases included (Smith, & Osborn, 2008). However, small samples are expected to be fairly homogeneous so that individuals recruited belong to a closely defined group and feel that the research question carries a personal meaning for them.

To ensure the homogeneity of the sample used the following inclusion/exclusion criteria were followed: 1) It has been well established in the literature that women generally appear to experience more grief reactions with greater intensity and for longer duration, and that there are gender differences in both how grief is expressed and how mothers and fathers cope with their loss (Büchi, et al., 2007; Gilbert, 1996; Moriarty, Carroll, & Cotroneo, 1996; Peppers, & Knapp, 1980; Schwab, 1996; Sidmore, 1999-2000; Vance, Boyle, Najman, & Thearle, 2002; Vance, et al., 1994), while gender differences have been reported also in studies on posttraumatic growth (Büchi, et al, 2007; Calhoun, & Tedeschi, 2007; Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010; Znoj, & Keller, 2002). Consequently, since the exploration of gender differences was beyond the scope of the present study, only bereaved mothers were recruited. 2) Only women that experienced a perinatal loss (death from 24th week of gestation until 28th day of life) of their first baby were included to the present research project. The compounding effects of multiple secondary losses when a child dies at that age have been stressed (Bennett, Litz, Sarnoff Lee, & Maguen, 2005; Wing, Clance, Burge-Callaway, & Armistead, 2001). Mothers who lose their first babies become childless mothers, unlike mothers who lose their baby but have other children. It has been suggested that having other children at the time of the loss can greatly affect the process of grieving and the ability of parents to find new meaning in their life and existence (Barrera et al., 2007; Davis, Wortman, Lehman, & Silver, 2000). 3) No age restrictions were applied since there is no evidence to suggest that age is a factor affecting the process of finding meaning and growing after a perinatal loss. 4) The same principle was followed for the inclusion of women from any socioeconomic, ethnic, religious or educational background. However, age and educational level, religious views and ethnic background were included in the demographics questionnaire in order to assist the researcher in an accurate description of the sample. 5) Pre-birth factors and other maternal characteristics such as the method of conception (natural or IVF), relationship with the father of the baby, or medical history, were not considered as inclusion criteria since there is no literature relating these factors with the potential of the mother to experience growth after the loss, but only

with the intensity of the grief reaction (Bennett, et al., 2005). 6) Whether the mother has had therapy during the bereavement period was not considered as an inclusion criterion firstly because in the studies reviewed there was no evidence to suggest that therapy makes a fundamental difference in the ability of individuals to find meaning and grow through the experience (Linley, & Joseph, 2004) and secondly because individuals can be helped to process their grief and find meaning in loss by their personal strengths and support networks (Joseph, & Linley, 2006; Linley, & Joseph, 2004). 7) Mothers participating in the study had experienced a perinatal loss at least a year before the interview and not more than eight years before. The researcher preferred to exclude the mothers during the first year of their grieving or around the first year's anniversary because it was more likely for them to be in an acute grieving phase, and not to be fully able to engage in a search for meaning or benefit from their loss. Research on bereaved individuals usually is conducted within the first three years (Calhoun, & Tedeschi, 1989-1990; Davis, & Nolen-Hoeksema, 2001; Edmonds, & Hooker, 1992), however because bereaved parents do appear to grieve for longer periods (DeVries, Lana, & Falck, 1994; Gerrish, Steed, & Neimeyer, 2010) the time range after the loss was extended to eight years. 8) An effort was made to include mothers who did not proceed to another pregnancy for at least a year after their baby's death. Babies' that come immediately after a perinatal death in the family are often called *replacement children* and an association has been suggested with complicated and unresolved mourning by the parents (DeVries, Lana, & Falck, 1994; Leon, 1987). However, the researcher failed to control before the interviews whether mothers had tried to conceive within the first year. While none of the participants had conceived and completed a pregnancy within the first year, four participants had either tried to conceive or had an early miscarriage during the first year. 9) Whether the mothers have had another child during this eight year period might be considered as a possible factor affecting the process and the potential for growth; however the literature reviewed for the present research does not describe this as an influential factor for each individual's potential for growth. The researcher was aware that research in the area was very limited to provide clear guidance; thus, limiting the sample only to people

who remained childless for five years or only to the ones who had a child at a later time would imply an assumption from the researcher's perspective about the process and the factors affecting growth. 10) Finally, mothers who at the time of their baby's death had another major loss to grieve such as the loss of a spouse or a parent were excluded. An additional bereavement could possibly affect the process of their bereavement, and its development and outcomes.

2.5.2 Sample Size and Demographics

Because *Interpretative Phenomenological Analysis* (IPA) is an idiographic approach, IPA studies are conducted on small sample sizes (Smith, Flowers, & Larkin, 2009). During the earlier years of IPA research projects researchers had been cautious in their designs and predicting the criticisms from quantitative colleagues had adopted larger sample sizes. But as the approach matured and qualitative methodologies became more widely accepted sample sizes became smaller. Detailed accounts of individual experiences are the primary focus of IPA and this goal is better served by small homogenous samples. The current study had eight participants since saturation was reached at that point with similar themes appearing for the vast majority of participants. Interviews were analysed after each interview. A full summary of demographic information and personal characteristics of participants can be found in Table 1. All names have been changed in order to ensure confidentiality.

Table 1: Demographic and Personal Characteristics of Participants.

Name	Age	Educational Level	Religious Views	Gestational age or age in days of the dead baby	Pregnancy Complications	Time Since The loss	Other Reproductive traumas	Children after the loss	Bereavement counselling or support
Charlotte	28	Bachelor Degree	Church of England	41 st gestational week	None	2 years	2 miscarriages before and 1 after the loss	1/ 10 weeks old	Support group, SANDS forum
Laura	26	GCSE/ 0-LEVELS	Christian	39 th	None	4 years	None	2/ 30 and 8 months old	None
Wilma	44	Medical Degree	None	36 th	Anterior Placenta None	4 years	1miscarriage after her 2 nd child	1/ 2 years old	None
Patricia	42	Diploma	Methodist	34 th	None	8 years	Prior to loss-fertility treatments	3/ 6- 2 years old	None
Claudia	39	Barrister	None	34 th	Feared Bicornuate Uterus None	20 months	Ectopic pregnancy 10years ago	Stepdaughter/ 14 years old No biological children	4 sessions + Support group
Regina	27	GCSE/ 0-LEVELS	None	41 st	None	2 years	None	Stepdaughter/ 14 years old No biological children	2 sessions
Lorna	37	Bachelor Degree	None	42 nd	None	18 months	1 miscarriage post-loss	Pregnant/ 12 weeks	6 sessions
Julia	30	Post-graduate degree	None	2 days old	Symphysis Pubis Dysfunction	30 months	Fertility treatments	1/ 3 months old	1 year + Support group

* Ethnic Background: Seven participants were White British and one White American/ British.

* Relationship Status: Six participants were married, and 2 in long-term, cohabitating relationships with their partners. All participants lived with the fathers of their dead babies.

* Regina and Claudia had a stepdaughter living with them (before and after the loss) who was from previous relationships of their partners.

2.5.3 Recruitment of Participants

Seven participants were recruited via the website of the Stillbirth and Neonatal Death Society (SANDS). SANDS is a registered charity, founded by bereaved parents, which works to support bereaved parents and to promote awareness on perinatal loss. The operation and bereavement support manager of SANDS was initially contacted to explore the willingness of SANDS to allow the advertisement of the research project on their website. After the research proposal was granted Ethical Approval from City University, London, the research proposal was submitted electronically to SANDS and gained local ethical approval. The only condition SANDS imposed on the researcher was to explicitly share in the information leaflet for potential participants the fact that she was a bereaved mother herself. The research was initially advertised on the main page of SANDS and later archived on the “Research” section. The materials uploaded on the SANDS website can be found in Appendix A. One participant was contacted through a specialist midwife at Kings College Hospital. This midwife was aware of the present research project and distributed the information sheet to several bereaved mothers that had gone through labor with her and they maintained contact with her personally. The initial contact with all participants was through emails and in some cases an initial telephone discussion was held for the researcher to clarify the purposes of the study and the participation procedure.

2.5.4 Interview Procedure

The interviews lasted between 30 minutes and two and a half hours, with an average of one hour. The interviews were recorded on a digital voice recorder. Participants were asked to fill out an informed consent and a sheet on demographic characteristics (see Appendix B). Participants kept a copy of the informed consent together with an additional leaflet with resources for support for bereaved parents (see Appendix C). Throughout the data collection period, the researcher completed a field notebook in order to record her reflections on the process, and any additional information about the participants (information seen in Table 1).

Regarding the location of the interviews, participants were given the choice of having the interviews in a room at City University, London or their homes. Seven participants engaged in their interviews at their homes while one preferred to have the interview at the researcher's house for her convenience (central London area). In order to reach the participants the researcher had to travel across the UK. For security purposes the researcher notified a person in her close environment about the exact location and time of the interview.

On some occasions there were interruptions during the interviews due to the participants' children requiring attention. However, all participants appeared to have made all the necessary arrangements to have the time for the interview (childcare, tidy living rooms, having enough free time) and offered to the researcher very warm hospitality (offering car lifts, arranging taxis, offering tea, sharing family pictures, introducing family members).

All participants were encouraged to ask anything they wished about the research project procedures and goals. All participants expressed their enthusiasm that such a research project was done, allowing them to share their personal stories and help scientists and society gain a deeper understanding of their experience. The participants that were not attending support groups expressed their feelings on the fact that the researcher was the first person they were meeting that had gone through a similar experience with them. Participants explicitly expressed the belief that the researcher's personal loss would allow her to understand them and not be surprised with their emotions and experiences or be judgmental towards their feelings and attitudes (e.g., *Claudia*: "I know you understand but I think most people don't understand" 44/1180). Typically, participants asked the researcher about her personal story and loss. The researcher followed a rule of giving to the participants minimum information about her loss prior to the interview (when the loss happened, how many gestational weeks, cause, and gender of the baby), allowing a more informal discussion to take place after the interview.

Some of the mothers felt upset and cried during the interviews. They were encouraged to say if they wished to stop the interview, and were offered the opportunity to stop at any time. The researcher also used her clinical judgment to monitor participants' levels of distress. None of the mothers who

participated stopped the interview process because of feelings of distress, nor did anyone withdraw from the study. One participant was 12 weeks pregnant at the time of the interview. When this participant made her initial contact the researcher expressed her reservations for the participant to give her interview while being pregnant. The participant expressed her confidence that she would be able to emotionally handle the interview. This was discussed with the principal supervisor of the research project who gave her consent for the participant to be interviewed. Another potential participant who was in the last trimester of her pregnancy at the time of the initial contact was dissuaded from participation until her newborn baby was three months old.

Of great interest was the amount of bereaved mothers that contacted the researcher although they knew from the information sheet they did not meet the inclusion criteria or could not meet the researcher in person. The researcher received emails from about 30 women from UK, Ireland, USA and Australia that had lost babies very recently or many years ago. The researcher replied to all the emails. These emails were usually followed by lengthy telephone conversations. It was apparent that these women wanted to share their story, a story that most of them never had the chance to share socially. The researcher conducted an additional four interviews with some of those women who did not fit the inclusion criteria and were from the greater London area, where commuting was easier. Although participants knew that their interviews were not going to be included in this research project they were interested in talking about growth and their loss with the researcher. These mothers were given exactly the same materials and rights with the rest of the participants. All interviews were undertaken over a period of seven months.

2.5.5 Interview Questions

Semi-structured interviews are recommended as the most appropriate method for data collection for an IPA study (Smith, & Osborn, 2008). Unlike structured interviews, they enhance the establishment of rapport with the participant, while the interviewer is more flexible and able to follow the respondent's interests or concerns and is able to probe interesting areas that

arise. At the same time the initial interview questions can evolve and develop in light of the participants' responses (Smith, & Osborn, 2008). Initially, a research proposal was submitted and a critical review of the relevant literature was carried out providing the material for the initial formulation of the interview questions. An interview schedule was constructed to ensure that the questions did address the research question. Questions of an IPA study should be neutral, not leading or value-laden, should not express any jargon, assumptions or technical proficiency, and should be phrased as open questions (Smith, & Osborn, 2008; for the interview questions please see Appendix D). The researcher attempted faithfully to follow these suggestions and the questions were reviewed by the research supervisor.

2.5.6 Transcription

All interviews were transcribed by the researcher. IPA transcribing does not require prosodic features of talk but according to the IPA criteria for transcription all words spoken should be transcribed including false starts, pauses, laughs, crying and other behavioural expressions that are worth recording (Smith, & Osborn, 2008).

2.6 Analysis of Data and Validity

The essence of IPA lies in its analytic focus. In IPA that focus directs the researcher's analytic attention towards the participant's attempts to make sense of his or her experience. So an analysis that adopts an IPA approach is characterized by common processes such as moving from the particular to the shared and from the descriptive to the interpretative and from common principles, such as the commitment to an understanding of the participant's point of view and the psychological focus, to personal meaning-making in a particular context (Smith, Flowers, & Larkin, 2009). For this particular project each interview transcript was initially treated as a case study report. The researcher kept notes on the process of the analysis and the different strategies and turning points that emerged during the analysis period.

The steps outlined by Smith, Flowers, and Larkin (2009) were followed for every transcript. Thus, the researcher initially read and re-read the transcript while making some initial notes on the left side of the text. At first these comments were descriptive. Key or repeated phrases were underlined, while terms or turns in the participant's narration were noted. These initial notes opened the dialogue with the participant's account, by closely exploring the individual way every participant chose to express her thoughts and feelings, the key concepts that appeared to be of concern (e.g., pain, anger, empathy), or by noting the researcher's questions or thoughts.

The next stage involved more questioning and abstract style of thinking in an effort to move to more conceptual comments, taking the analysis to a more interpretative and less descriptive stage. During that stage the researcher was very aware of her experiential and professional knowledge. Being a bereaved mother and also a counselling psychologist undoubtedly informed her perception of the interview narratives. The main focus was that the interpretations should be inspired from the interviews by attending to the participant's words rather than being imposed by the researcher. However, IPA accepts that the researcher uses him/herself in order to make sense of the participant's words and that the reflexive engagement with the transcripts differs from analyst to analyst. Although initially the conceptual comments were written on the right side of the transcript page, they gradually expanded to all the margins of the page. Initial themes emerged when these notes were expressed with phrases reflecting psychological terms that captured the participant's words as well as the researcher's interpretation.

Various techniques were employed in order to make connections across emergent themes such as: (a) abstraction, by placing together titles of themes that could be understood as conceptually related (e.g. loss of a child, loss of maternal identity, loss of self-esteem); (b) polarization, by trying to identify the themes that were describing the two opposing poles of a single experience (e.g. vaginal delivery); and especially (c) temporal contextualization, by carefully grouping themes based on the temporal moment in which they emerged (e.g. at the hospital, during the first year of bereavement, after the 1st year anniversary). At this stage the researcher moved to the next transcript and

followed the same procedures. A table of themes was produced for all eight participants.

After extracting themes from all participants, the researcher wrote each title on cards and looked for connections between themes from different participants. A next level of interpretation involved the merging of themes into super-ordinate themes. The method of polarization was also very useful for the researcher at that point, allowing for the creation of themes that would shed light not only to the similarities among participants but also to the differences. Super-ordinate themes were reviewed and reorganized so that the final table of super-ordinate themes captured the essence of participants' experiences (see Appendix E for a sample of a transcript and Appendix F for the Master Table of Themes). In the process of synthesizing the emergent themes from all eight participants numeration was applied, in order to check the frequency with which a theme was supported, as Smith, Flowers, and Larkin (2009) have suggested for samples bigger than six participants. This approach has been suggested to increase the validity of the analysis (Smith, Flowers, and Larkin, 2009), and the researcher decided that themes expressed from at least three participants could be included in the master table of themes. This stage of the analysis was a constant negotiation between the focus on the individual voice and the claims that could be done for the larger group. The organization of the super-ordinate themes and their constituent themes was further clarified in the writing-up of the results; three drafts of the analysis section were produced by the researcher and each of them in turn enhanced the depth of interpretation.

Throughout the analysis process special emphasis was given to validity of the analytic process according to the principles set by Yardley (2000, 2008) and accepted by Smith, Flowers, and Larkin (2009), and the knowledge gained from the IPA study group attended by the researcher. The researcher initially attended a study group on IPA organized by Birkbeck College of the University of London to further refine the view of what constitutes a "good" IPA analysis and develop a network with other doctoral students. The researcher exhibited sensitivity to the context both during the interviews, by being attentive to participant's needs and difficulties, but also throughout the research process. Awareness of the existing literature and inclusion of a

considerable number of verbatim extracts in the analysis report gave the participants a voice in the project and allowed the reader to check the interpretations. The interpretations suggested are offered as one possible understanding of the data while general claims have been avoided or offered with much caution. Transparency of the analysis was safeguarded with the help of a research supervisor and colleagues. The researcher has kept clear and detailed records of every step of the analysis. The supervisor conducted a mini audit by following thoroughly the analysis of data from one participant. Smaller segments of transcripts and specific interpretations were checked by fellow doctoral students. Triangulation involving sharing the analysis with participants was not attempted. That was a conscious decision on the part of the researcher in order to protect her participants from facing interpretative themes that they were not able or willing to acknowledge at that particular moment (e.g. denial or other protective strategies).

2.7 Personal Reflection on the process of conducting this research

This research topic was born through the stillbirth of my daughter Nafsika on the 27.01.07. Nafsika was a healthy baby who died due to unexplained feto-maternal bleeding after 38 unremarkable, healthy, even perfectly normative gestational weeks. Through the first most painful months of my bereavement, among other coping strategies, I turned to my discipline, counselling psychology, to find answers related to the bereavement process, justification for my feelings, and containment for my numerous emotions. Surprisingly, I did not find any of these. I did not find any relevant publications in the journals that first came to my mind such as *Counseling Psychologist*, or *Counselling Psychology Review* or any books written by psychologists. This led me to feel that my loss did not exist for psychology, as it did not exist socially. I had gone through varying degrees of rejection and dismissal in my proximate and distal environment. The Greek orthodox religion does not acknowledge any burial rights for non-baptised babies, and I had to fight my ground through unorthodox strategies to bury Nafsika. Possibly due to these

religious beliefs and many other cultural and personal factors most of my Greek context actively failed to acknowledge her life, the importance of her death, and my right to grieve. I decided to wear only black clothes for as long as I felt “black” in myself, a colour that bereaved people are supposed to wear in Greece, though not after this type of bereavement. Then I decided to remove from my life whoever did not wish to accept Nafsika and me as I was at that point, including my daughter’s father and many other friends and acquaintances. I also welcomed the help and acceptance of family, colleagues, close friends and friends who became close. During that stage of my bereavement I went back to Greece (from London) and my parents’ house and gave myself the space to process her loss and to move forward as slowly as I wanted.

A few months into my journey, I was back in London, started therapy, and went back in my placements as a counselling psychologist in training, trying to start working again on my doctorate on the therapeutic relationship, and feeling as if a new me was emerging from the abyss of pain. A close friend gave me as a birthday gift the book “Women who ran with the wolves” (Pinkola- Estes, 1992) which I was reading in the train on my way to therapy. That was the first moment that the topic of this thesis was conceived. The message that I perceived in this book was that a woman after an extremely important experience in her life can discover and get in touch with the wild woman, the wolf archetypal woman inside her, and become genuine, brave, and dedicated to her aspirations and needs. At that time I had no theoretical and scientific grounding in literature, just a first feeling that this could be my new research area. When I first mentioned this idea to my therapist and my then tutor and later supervisor Fiona Bailey, I felt I scared them that I would sink even deeper to my bereavement, yet I was encouraged to explore this idea more.

The gestation of this idea took me several months, during which I was completing my client hours working in a women’s prison and seeing as a therapist women that had abused their bodies and their babies with drugs during their pregnancies. This felt as another milestone in my adjustment, overcoming my own personal feelings and difficulties and being there for those

women, seeing their lives from their perspective, facing my anger over the injustice of my loss. Also during those months I completed all other course requirements and I applied to the British Psychological Society for the Chartered status. I was searching sporadically for articles in the literature with keywords like “stillbirth”, “perinatal death”, and “bereavement”. My search findings were poor with articles and books written for bereavement after the death of a spouse, and psychopathology that can result after the death of a child or epidemiological research on causes and numbers of instances of perinatal death. I was also reading extensively on qualitative methods of research in psychology to become familiar with the rationale, the philosophy and processes of qualitative research because until then I was a person following the rules of quantitative research and SPSS software since I had been schooled as a psychologist with the doctrine “In God we trust, all others must have data”, and until then semi-structured interviews did not qualify as data. This need for a research methodology which would be more holistic, able to provide an in-depth knowledge with a more philosophical grounding was part of my personality transformation, the integration of my very logical world with the more emotional, existential, analytical part of personality that was now emerging.

During those months I formalized my wish to stop research on my previous topic that focused on the therapeutic relationship, and changed my supervisor. In my search for a research question, an appropriate qualitative methodology, and the literature to start building my research proposal, I finally found the first book chapter that felt relevant to my interest area, the chapter *Positive responses to loss: perceiving benefits and growth* by Nolen-Hoeksema and Davis (2002) in the *Handbook of Positive Psychology* (Snyder, & Lopez, 2002). This chapter provided me with a psychological concept and a theory on the phenomenon I was wishing to explore, and was the starting point in the search for relevant literature. Once more, I realized that the experience of a perinatal loss had not been investigated as an experience which could lead to posttraumatic growth, and this was how my research question emerged, “How mothers experience personal growth after a perinatal loss”. By the time I submitted my research proposal it was 18 months after the death of my

daughter, and I had achieved clarity in terms of the reasons why I wanted to do this research.

The process of the interviews was the next step I had to face. I met women that had gone through a similar experience to me but in a completely different cultural and religious context. In order to conduct the interviews I travelled for hours in the British countryside and got lost in big cities, I stayed alone in dodgy pubs, hotels and train stations. I felt scared, cold, and in pain but I never considered giving up. It was becoming clear in my head through those months that this is what I will do for my daughter. Since Nafsika never existed for the society, this doctorate and the publications that would follow will be her tangible footprint in this world. For me my daughter is not only pain, she is also everything but pain. With this research I wished and still wish to raise awareness on perinatal loss, to help scientists and practitioners understand the experience and enable them to provide to their patients, clients and consumers better care and possibly light a pathway to growth for them. I had the luck to be strong, to have great friends, a great midwife, and a great therapist and I found my way to learn from my daughter's short life and death but other mothers might not be as lucky. Most of my participants were inspiring persons, and for the ones that were still struggling with their loss I could feel deep and genuine empathy for their pain and personal circumstances.

Transcribing the interviews was very difficult. Although I was wearing my therapist hat during the interviews and was very self-contained, during transcribing I was quietly breaking into pieces. When participants described the "there is no heartbeat" moment I was unable to transcribe. Although my interview schedule was on growth even the single ice breaking question about the history of their loss made the majority of mothers narrate every detail of the birth and the first days. Having my therapist doing trauma work with the use of my body and not my intellect was the way that I moved forward and healed that part of my loss.

The analysis took me considerably more time than expected. After finishing the interviews, I moved back to my home country and started working in three different settings, one teaching post and two clinical settings. My clinical work started focusing on trauma and posttraumatic growth. This was a

choice but also a thing that just happened. In one of the jobs that I found (when you are a young professional in Greece you do not have many options) I was working therapeutically with cancer survivors and people suffering heart failure. The process of my grief was progressing, still missing Nafsika in all the happy days (i.e. the first day I taught at the University), but I was also building a new life while the trauma reactions were fading away. There were days that I could not touch the transcripts because I was too sad or because I was too happy and wanted to forget the bereaved identity and live like everybody else. But still I could not even consider giving up the doctorate. I was meeting with other doctoral students to discuss our themes; I was travelling back in the UK to meet my supervisor; I was asking for feedback from my colleagues at work. Some times when I was consumed by the thesis, physical illnesses were hampering me. I was always very strong, stubborn and determined and through my loss I realized my vulnerable self, that there are some things that I cannot do, and that is fine. So when I felt that I just could not pay the toll I took some time off the project.

The final stage of this process started in the winter of 2011. Because I was again ill I took a substantial break from all my professional responsibilities and went for two months to my village of origin in Kefallonia (Greek Ionian island). That were the last sickness days I experienced. I spent my “nature days” as I call them with dear family friends, my transcripts and a cat. From this moment on it all started to make sense and I felt ready to tell my participants’ stories and let go of this chapter of my life. Nafsika will always be a part of me, so as long as I live I will cherish her gifts to me. This research project will be her footprint, her gift to others. As soon as I came back I resigned from one of my jobs and considerably reduced my obligations to the other two. I was assigned to a new supervisor, Malcolm Cross, as Fiona Bailey had left the University. I started writing the introduction and I will remember forever the day I wrote my first 650 words. In spite of adverse family circumstances as soon as I wrote those first 650 words the greater part of this thesis unfolded in my mind. Then the first feedback from my supervisor came and that allowed me to start dreaming the day of submission; while, following his suggestion, I was transferred to a PhD programme instead of the DPpsych.

Spending the whole summer in Athens writing the results was the next step of this long journey. Deciding not to include some of the mothers' words was hard, as I felt that I was erasing the voices of my generous participants. I struggled to find a balance between a presentation with many quotations that could suggest that I felt insecure regarding my interpretations and a presentation that would include enough extracts to allow my readers to test themselves those interpretations while trying to respect my participants. The rest of the thesis was written while I was working almost full-time during many sleepless creative nights. When I reached the discussion section I felt strange because I realized I was treating participant interview extracts as just data that I was struggling to connect with existing literature and find all possible connections in order to enhance our understanding of posttraumatic growth and the processes involved.

If I were to look back and explore the ways this research project has changed me as an individual and professional I would definitely realize that it is an experience that defined me to a such an extent that a "me before" and a "me after" emerged. Regarding my professional identity after this process I feel that the positivistic perspective does not fit me anymore, and this change applies both to my clinical practice and my research interests and tools. Although all my training was on Beckian cognitive behavioral therapy, I have become increasingly interested in other psychotherapeutic models that could be applied to traumatized individuals and be used to foster growth. Regarding research, I am still amazed by the richness of qualitative data, and I believe that my future research work will be qualitative, employing models that are even less formalized than IPA, like ethnography. I realized how awkward I initially felt with the style and attitude of qualitative research and how gradually I became proud of the differences my qualitative study had with a quantitative study. Although I am still new in qualitative methodologies I am sure that through them I can explore and serve better my perception of psychology as a science and I am really looking forward to teaching these methodologies to my students. I wish to combine both my clinical practice and my future research projects in order to explore which therapeutic techniques and approaches can be growth promoting.

Realizing the changes in my personality and attitude because of this research project is rather difficult for me since it is still an open chapter in my life. As mentioned before I feel as if a new me has emerged through these years, and this thesis has been an essential part. It seems to me that when somebody “breaks into pieces” only the core, essential, true parts are used for the rebuilding process. This circle of my life opened with me deeply grieving for the death of my daughter and this circle closes with me deeply grieving for the death of my dad. The words of a participant come in my head “I am not afraid of the darkness”. I was in such darkness when Nafsika had died that visiting it once more is not that scary. Being in touch with my pain and sorrows and creating light and hope out of them, was a function of this research project during these years. I was proving to myself that no matter what happens and how random life can be I can fight it back, rise above the situations, by not giving up and continuing to serve my morals and dreams. I learned this attitude from my dad, and even now that he cannot hold my hand anymore and tell me “You can do everything”, I still hear his voice and fight back randomness of life by committing to my life, my dreams, and the people I love. My research project is complete, the project that gave me the time and stimulation to process and integrate the essence of my experience to my new identity. Now it has to reach out to people and this is going to be one more way to make both Nafsika and my dad proud.

If Nafsika had never existed I would have never endured what a PhD research entails, I would have given up years ago. If my dad had not taught me to be a fighter, and had not provided all the safety in the world, I would have given up years ago. Although I have been repeatedly warned that doing research in an area of such personal relevance can have negative impact on the quality of the work produced, and attract various criticisms, I feel that my personal experience has offered depth and quality to my work that an outsider might have not achieved, at least in the same way.

Chapter 3: Analysis of Data

3.1 Chapter Overview

In this chapter the four main super-ordinate themes which were derived from the interpretative phenomenological analysis are presented together with the sub-themes that constitute them. The objective of these themes is to provide a rich portrayal of the breadth and complexity of the experience of growth following a perinatal loss. Each theme will be presented and evidenced by using verbatim quotations from the interviews. In the quotations, empty brackets ([...]) indicate material that has been omitted; while parentheses with comments in bold (**(abcd)**) have been added by the researcher when clarifications seemed necessary or helpful to the reader. Parts of the interview extracts presented in **bold** are the researcher's words during the interviews as they appear in the transcripts. Participants and their children are referred by pseudonyms throughout. The source of quotation is indicated by page and line reference numbers as they appear in the transcripts.

3.2 Analysis Overview

This section provides the master table of the four super-ordinate themes (in Arabic numerals - 1, 2, 3, 4), their constituent themes (in capital letters -A, B, C,...) along with the sub-themes (in small letters – a, b, c,...) that emerged from the interviews through the application of Interpretative Phenomenological Analysis.

1. The Experience of Perinatal Loss as a Trauma
 - A. Maternal Determination and Investment
 - B. The absence of Predictability: Experiencing perfect pregnancies and babies
 - C. “No heartbeat”: The moment when the world collapses
 - D. Having a silent birth: The entrance to a lonesome motherhood

- E. Death in the face of one's baby: The first and last meeting with the baby
 - F. Iatrogenic Psychological Trauma
2. The Ripples of Loss
 - A. The amputated object relationship
 - B. A socially unrecognized maternal identity
 - C. The threatened reproductive ability
 3. Working through the Trauma
 - A. Rumination and Disillusionment
 - B. Oscillating between Action and Avoidance
 - a. Avoiding the Pain
 - b. Active Emotional Coping Mechanisms
 - C. Religious or Spiritual Coping
 - a. Spirituality preserving an orderly world
 - b. Spirituality preserving an ongoing bond
 - D. Quality of Social Support as a Catalyst
 4. Trauma Resolution and Growth
 - A. The fountains of Growth
 - a. Growth as an affirmation of the baby's importance
 - b. Growth as an outcome of the awareness of personal vulnerability
 - B. The Ripples of Growth
 - a. Transformations in Self Perception: Self-worth and Self- efficacy
 - b. Transformations in Perception and Attitude: Appreciation of Life and Changed Priorities
 - c. Transformations in Relationships: Empathy and Companionship

3.3 Presentation of Analysis

3.3.1 Introduction of Super-Ordinate Theme 1: The Experience of Perinatal Loss as a Trauma

When mothers were initially asked by the researcher to share the story of their personal loss, they all described their pregnancies, and the hours around the death of their child with very vivid details. They all described the special meaning and characteristics of their babies' death. The way they had experienced the pregnancy, their determination to become a parent, or the way they experienced labour were their first weaponry or wounds with which they had to start their journey to resolution and growth.

3.3.1.A Theme A: Maternal Determination and Investment

Some of the mothers who participated in the project had lost babies after many years of reproductive challenges or losses, or after many years of longing for a child. Charlotte, had two miscarriages before the stillbirth of her son:

*Charlotte: "My partner, James, [...] we, er, got together about six years ago and tried, um, and tried starting really a year after we got together. I had, um, the first time we tried, I had a miscarriage at six weeks, and on the miscarriage scan it confirmed that I found a big cyst on my ovary which was probably why I miscarried, so they took out the ovary and the cyst and the tube and everything. [...] So I had that out and I got pregnant again but I had a second miscarriage at six weeks but I was okay with that really. So my third time, I was third time lucky with Edward (**her stillborn son**) and after I got to twelve weeks I thought everything was fine because you do, you get to the safe stage..." (1/2-13).*

While Patricia had gone through various treatments and minor operations:

Patricia: "we had a real struggle trying to get pregnant [laughs] so when we did I had many treatments and things, [...] I had a couple of operations and, er, and drugs and stuff. [...] I had one course of IVF and that failed and this was time – this was time out we were talking before the next course and then [...] I got pregnant naturally (1/2-9).

Julia was suffering from the polycystic ovaries syndrome and was longing a child from quite early in her life:

Julia: “we started trying to conceive probably just before we got married, because I’ve have been desperate for kids since I was eighteen [laughs] ...**Okay** ...I’ve always wanted kids, um. I knew from – well, I had to wait for my partner first [laughs] and I wanted to wait until I’d done – finished Uni and then I wanted to wait until we were married really, you know, but if we were pregnant when we got married that wouldn’t have hurt [laughs]. Um, so we started trying then in 2004. **And you got pregnant in?** 2006, so it took two years to conceive with Angela” (1/6-13).

Their determination to become mothers was also expressed during their pregnancies. Regina and Julia shared their experience of the medical procedures that they had happily endured during their pregnancies in order to safeguard the health of their unborn babies.

Regina: “I haven’t eaten anything I shouldn’t have eaten, I’ve exercised properly, I haven’t, you know I’ve done everything by the book [...] Um, I also had, um, in the early stages of my pregnancy, um, what’s it called?(**amniocentesis**) Er, you have a needle put in because of the risk of um ...(**Down Syndrome**) (8/189-92).

Julia: “I was very very sick. Um, I thought it was morning sickness at first, um, but it carried on most of the time. I had a bit of a respite part of the second trimester, but I was sick for most of it and I had a little bit of SPD towards the end as well. **SPD?** Symphysis Pubis Dysfunction. **What is that?** It’s to do with the pelvis and the hips so it’s painful to walk, but I was only on crutches a little bit at that time.[...] I was off work for most of it because I was being so sick all the time.[...] I tried all the different remedies but nothing really worked” (2/18-25).

They described their pregnancies as the time when they were creating the space for their babies, both physically and psychologically. They were moving homes, preparing nursery rooms, but also establishing a parental identity and an emotional attachment with their baby for the first time in their lives.

Laura and Claudia had moved to new, bigger houses in order to offer to their babies houses that would accommodate their needs:

Laura: “I had a house ready to move into for when I had Jade, I had it all sorted and things” (2/40).

Claudia: “we moved here[...] just before I got pregnant.[...] part of the idea of moving was we wanted a bigger house because we were trying for a baby [...] and lots of things – what I found difficult at first, lots of things in this house have been done with that baby in mind like, for instance, when I was pregnant we were worried about the stupid things like where I’d keep the buggy because there’s steps up the front so my parents bought that shed in the back garden – that was to be Lucas’s shed for all his things [laughs] so the house was all set up for this new baby, um, and the pregnancy was fine...” (1/9-19).

But participants also described how the practical adaptations to their physical environment, like decorating a nursery room, were adding substance to their newly formed parental identity. Patricia and Wilma, described this process for them:

Patricia: “we were just kind of making lots of plans and sorting out – I think sorting out mentally as well as anything else, just prepare for the baby as you do, you know, you change from this couple into these people that are expecting a baby and almost, er, well you’ve almost become a family then, haven’t you, I always thought” (1/10-14).[...] “we had adjusted to being this family and all that was missing was the baby being born, you know. We’d done his nursery, we’d decorated, his cot was ready for him, er, you know, we’d made these adjustments” (19/520-523).

Wilma: “at thirty five weeks you are a parent, you’ve got used to it, you’ve had daydreams, you’ve bought stuff, you’ve set up a nursery. Your life’s moved on, you’re not that couple anymore...” (3/50-53).

Lorna presented herself differently than the rest of the participants. She had conceived very easily and during her pregnancy she had more of an emotional distance from the things that were happening in her body and in her life.

Lorna: “I think what made a difference to the way I dealt with, er, what made it slightly easier for me...all through my pregnancy I sort of – I carried on and I’ve always had the attitude that I’m going to have a baby but it’s not going to be, you know, it’s – obviously I’ve waited this long so it’s not the be-all- and-

end- all, it will be part of my life but it's not going to take over my life. So all through the pregnancy I didn't stop anything – I didn't let it interrupt my – well, luckily, it didn't need to interrupt my normal life so I did it completely normally, I didn't really kind of, um, change my life much...and then when it didn't happen, um, thought okay, right, I – I've just got to, um, it's back to how things were before and I've got to make the most of the opportunities that I've got without, um, and then try again”(9-10/164-75).

3.3.1.B Theme B: The absence of Predictability: Experiencing perfect pregnancies and babies

The way that participants described their loss fulfills many of the well known criteria for trauma. In the section to follow, mothers described ideal pregnancies. During their pregnancies the vast majority of the participants never had any complication that would have allowed them to foresee the tragedy that was about to strike. Charlotte, and Lorna described their pregnancies as “textbook” and “dream”:

***Charlotte:** “I got to twelve weeks and I thought it would all be okay and I had a textbook pregnancy, you know, I had a beautiful pregnancy, I had no morning sickness, no bloating, no swelling, nothing and then I got to thirty – I got to forty weeks and then to forty plus five weeks, I still hadn't had any signs of labour so I was getting really bored and really fed up and I was moaning to everybody about how bored I was...” (1/14-18).*

***Lorna:** “I had a very – very easy pregnancy...a dream pregnancy and kind of, um had got preg – had got pregnant very quickly and it had all been very easy and, um, and I don't know, I think I got – once I got – I didn't really worry – I didn't really at any stage worry about it and – and I didn't really know anyone who'd had any – anything particularly go wrong at that stage...so I – I guess I was sort of a bit, um, yeah, I was – I was kind of just looking forward to it. [...] so I got to the – got to the end part [...] I'd got to the point where nothing really could go wrong because, um, er, because I was – I was due and it was – the baby was fine seemingly”(1/3-12).*

As seen in Lorna's words, many of these bereaved mothers underlined their lack of knowledge about the possibility of stillbirth, as only miscarriage is most typically foregrounded as the primary risk for pregnancy loss both socially and medically. The ignorance they describe together with the lived experience of healthy pregnancies deprived them of the ability to predict and initially understand the course of events.

Patricia described how secure she felt in the last stages of pregnancy as she had escaped the danger of a miscarriage:

***Patricia:** "There's all this big push, isn't there, about, um, everybody normally – well not normally but until the twelve week scan a lot of people keep it quiet, don't they, and they say, you know, we won't tell people till then. The risk of miscarriage is always the big focus is on the twelve weeks and kind of once we get there we're done and we're sorted" (3/47-51).*

Charlotte and Laura the incomprehensibility of their loss when they had reached the very last stages of their healthy pregnancies and everything was ready for their baby to come:

***Charlotte:** "especially after my last scan, you know the one they do at twenty two weeks and I'd checked and after that it didn't even occur to me that anything could go wrong, we bought the whole nursery, we bought the pram, all the clothes, nappies and things, all laid out just like Phillip's (**her living child after the stillbirth**) is really and, you know, you don't get told, as you say, that something could happen, you'll be overdue and you won't bring the baby home" (2-3/46-50).*

***Laura:** "It were a big shock really because we've never heard of, you know, well you don't – it's not something that's ever talked about when you're pregnant. You talk about miscarriages [...] but you don't think for a minute that that, you know, periods that you've been – because we had everything ready and it was horrible" (2/32-5).*

Claudia was the only participant that during her pregnancy was diagnosed with a feared bicornuate uterus (this diagnosis was disproven after her pregnancy), a condition that could impair the growth of the foetus or cause preterm delivery. However she was never aware of the possibility of a stillbirth. Throughout her pregnancy she was under the care of a consultant

obstetrician and she had weekly scans. These procedures though made her feel more secure and arguably led to a heightened attachment to her baby after seeing him weekly on the scans.

Claudia: “the pregnancy was fine in that I felt fine although, as I’ve told you, the hospital had worries” (1-2/19-21).[...]“in fact I felt quite reassured that I was getting more attention than-most women” (3-4/66-7).[...] “I was so used to it, I was doing this every week and I was quite happy and I was quite looking forward to seeing the little fella again” (6/124-6).

None of the participants who experienced a stillbirth had been aware of the possibility of their babies dying during late pregnancy, but also Julia, who lost her daughter 2 days after birth, was equally unaware of the possibility of death for her baby since her daughter appeared perfectly healthy for the first 30 hours of her life. Julia describes their first moments together:

Julia: “I had a ventuse delivery at twenty past two.[...] she came out and she had good Apgar score and she was well and there wasn’t even a mark on her from the ventuse [...] she was fine and she came over to me straight away and she fed immediately. She just lay on me and grabbed on and fed [laughs]. It was brilliant, she fed for about an hour, I think, she was really into her feeding and she was really healthy” (3/41-50).

These eight women had gone through all the stages of preparation and foresaw a lifetime with their children. Some of them had tried really hard to reach that stage in their life, while all of them had done both the practical and psychological preparations to welcome their babies into this world. They had no warnings, or signs to trigger the necessity to prepare for the unforeseen and the unknown.

3.3.1.C Theme C: “No heartbeat”: The moment when the world collapses

Nearly all participants described in great detail the moments around the announcement from the medical professionals that their babies were dead. Before that, some participants had worries about their baby’s health and they went themselves to the hospital, while for others the realization occurred during a routine examination.

Charlotte and Regina illustrate clearly their inner knowledge that something was wrong with their babies:

Charlotte: *“I thought something was really wrong, really wrong, even though I hadn’t had it confirmed I knew that he had died because, um, I didn’t feel pregnant any more really. Straight to hospital and I had a scan and a CTG and they couldn’t find his heartbeat and then they obviously say, you know, I’m sorry, I went in to be induced the next day and he was born the next day after that” (1-2/21-5).*

Regina: *“I had rung my mum and I said “Something’s not right” and she said “Oh don’t be silly, Regina” she said “you’re just worried about the birth, don’t be silly” and I said “No, there’s something not right” because I used to be able to sort of poke my belly and get a response with the feet or ... something, and then I thought “Well maybe it’s ‘cause he hasn’t got enough room” you know, er, he was very big” (1/11-7).*

While for Laura and Claudia the death was discovered during a routine examination:

Laura: *“I know I went to the doctors and I had the – just the normal antenatal things and they did the heartbeat and they couldn’t find it and that’s when it all went really bad, yeah, and the midwife that were there she were dead upset and she were crying and it were horrendous and we had to go up and get a scan [...] and then they scanned me and couldn’t find anything. But right up to being scanned they said oh no it’s probably just hiding, you know, not in the right place but, yeah, it were horrible” (9-10/216-222).*

Claudia: *“I remember jumping up onto the bed, you know, I was so used to it [...] and I wasn’t expecting anything to be wrong until there was this silence and I went what’s wrong?, what’s wrong? and she said “it’s not good news, Claudia” and I just went “what?” and Paul continued eating the crisps and that’s an image I can’t get out of my head and, as I say, I hate crisps now. And then she suddenly went “there’s no heartbeat” and I started screaming, I think, or wailing or – and he carried on eating the crisps. I had a go at him about it and he just said I didn’t know what to do and he was sitting there eating – and I could hear this – I was wailing – I vaguely – I was screaming “no, no, no, you can’t tell me that!” and she went and got another woman and the other*

woman came and she said no, and then she said you don't want to see him do you and I said of course I want to see him. [...] And I still didn't believe them, I said you're lying and Paul said no, I can see him, look he's not moving and every time normally I went for a scan he'd move [...]. So that's when we were told and then – and I was just – it was the worst moment ever, um, I didn't know anything that terrible could happen to be honest” (5/124-147).

The moment when the medical professional confirms through the ultrasound that the baby does not have a heartbeat appears as the most devastating moment for mothers. As it commonly happens with trauma, even irrelevant noises or images can become associated with trauma functioning in the future as trauma reminders (Joseph, Williams, & Yule, 1997). That was confirmed by the experience of Claudia for whom crisps continued to be a trauma reminder nearly two years after her loss.

Patricia, nearly 8 years after her loss and after giving birth to three healthy children, describes the moment she was informed that her child was no longer alive very vividly:

Patricia: “I know it was – it was bizarre as well because that was the first night that we were meant to be starting Parent-craft classes at the hospital [...] the midwife came and she did the basic, er, you know, jelly – jelly on the tummy and couldn't get a heartbeat. [...] you didn't know what she was looking for and no alarm goes off, does it. [...] when the penny did start to drop she said look we're going to take you in now [...] I want the doctor to come and we're going to get an ultrasound scan [...] the three minutes that he (the doctor) was looking – he obviously knew what he was looking for and it wasn't there and he had to then impart the information to us, you know, and, er, and it was just horrendous, absolutely horrendous. It was like – it was like the whole world fell in [starts crying], it was absolutely awful, absolutely awful. [...] they don't use words like death to you, do they, they just said your baby's passed away, we can't find a heartbeat and I just went to – Mark was absolutely devastated, you know, and we just – obviously you get very emotional and you kind of fall, you know, you literally fall on the floor [...]. You can't possibly take in, you know, you can't – you can't understand what they're saying, you know, but what do you mean, I don't understand what you're saying” (3-4/68-92).

Lorna, being few days overdue, realized that her baby hadn't moved for few hours and went in the hospital where she describes:

Lorna: “saw people going into labour – saw people in the waiting room in labour and was just laughing, didn't really think that anything was really wrong and then had the scan and a horrible moment [laughs] when he said there's no heartbeat and – which I do – I sort of – it's that one moment I tend to have – I sort of relive many times in my head as the – the – the moment of horror in the whole thing and so, yeah, so that – that – we were just in an utter shock and – and then we drove home, um, and, you know, the plan was to be, um, induced the next morning” (1/26-34).

While Regina is narrating the same moment and remembers her initial thoughts and feelings:

Regina: “Got in there and put into a room, they done, er, some more listening for the heartbeat, she couldn't find it. So she said “Okay, I'm going to have to send you down to the ultrasound”. So got in the lift, went downstairs, got on the bed for the ultrasound, jelly, put the monitor thing on my stomach and I just looked at the woman's face and I said “He's dead isn't he?” no I said “The baby's dead”. And she went “I'm so sorry”. So then at that point it was like, um, going into a different world, getting off the bed and then having to walk down the hospital sterile corridors and get into the lift to go up to the maternity ward. I can't remember who was with me at that point. It was like being in another world, like you weren't – it wasn't the same corridor I'd just walked down, um, and then, it's a reasonable blur even though it's not that long ago, obviously, you are in shock, but I can remember being quite [pause] almost philosophical about it and saying you know, “He wasn't meant to be, you know, he wasn't, he's not meant to be with us now” (1-2/22-35).[...] “I didn't really care to be honest with you, whether I was alive or dead at that point anyway, I could've quite easily slipped off and been quite happy” (3/78-80).

The vivid way mothers describe the moments when they were informed about their baby's death is indicative of the intensity of this experience. As some of them shared, these were moments that today they still have vivid, intrusive recollections; the moments when their world collapsed.

3.3.1.D Theme D: Having a silent birth: The entrance to a lonesome motherhood

The standard medical procedure in cases of stillbirth is the induction of labour. Women are strongly discouraged from going through a caesarian procedure (RCOG, 2010). Labour and delivery is the process through which an expectant mother becomes a mother, the physically demanding process through which she can hold her baby for the first time. Many of the participants had an intense fear of labour, since they already knew their babies were dead. However, all the participants that chose to discuss their labour described it as a very positive experience.

The initial feeling about natural delivery for Claudia and Regina are reflective of the participants' emotions at the time. They thought of natural delivery with horror and they begged for a caesarean:

Claudia: *“because I remember while we were still in that scanning room, I said to Paul – I said to Paul they’re going to make me have the baby – and he said no they’re not, don’t be stupid, they’ll operate. I said Paul they’re going to make me have the baby, you don’t understand. **You didn’t want to?** Oh at the time no, I thought that was awful to have to do that, I just wanted them to go in – to give me a caesarean” (7/173-8).*

Regina: *“I begged for a caesarean, “Please let me have a caesarean”. I can’t, even my dad, my dad came in and he said “You know, you can’t make her give, go through giving birth surely” (2/52-4). [...] I was a bit, you know, pissed off that I was going to have to give birth knowing that obviously the baby’s dead” (3/59-60).*

However, these same participants later said:

Claudia: *“I have to say now having gone through labour I’m glad I did and didn’t have a caesarean. Other people who haven’t been through it are appalled at the idea of having to go through a natural labour of a stillborn child but personally I felt at the time at least I did that for him, you know, what was something I could do for him, um, although other people are just appalled, they say it’s dreadful, they shouldn’t make you do that but, having done that now, I am – I feel glad about that, anyway” (10/245-50).*

Regina: “No, I’m pleased that I went through the experience of birth, um, a) because um I was able to go through the process rather than have a screen up, cut, baby gone. You know, it was the whole process. The experience of birth itself, which is amazing really, so many people that can’t even a) get pregnant, b) experience pregnancy and birth that deserve to be mothers that are wonderful people and can’t. So even that you know really I should see (it) as a privilege, um, and you know, do try to. Um, I also know I can converse with mothers that have normal, healthy babies about birth. You know, I can say “I know what you mean, I know what you mean by contractions, I know what you mean by the fear, I know, I know what you mean because I’ve been there” (4/101-10).

For those two mothers the process of natural labour was a milestone closer to maternal identity, either through feeling that they did something for their child or because together with pregnancy, labour enables them to converse with other mothers. The achievement of maternal identity was also true for Charlotte, who also like Claudia felt self-conscious in expressing her paradoxical joy about delivery.

Charlotte: “Well that it was okay, I know this sounds bizarre but I actually really enjoyed my labour, really really enjoyed it because that’s what I’d been waiting for...and I really enjoyed it and I would do it again, [...]. But I really really really enjoyed my labour with Edward and I thought it was an amazing thing [laughs]. I thought God, I mean, it was obviously quite a harrowing thing in a way because you’re having a silent birth, aren’t you essentially...but I thought it was an amazing thing and I’m still amazed about it now, how it works and they come out. He didn’t cry but I still had a nice labour” (4/79-89).

There was a general view amongst participants that people would find the delivery of a stillborn child an appalling concept, and that their joy was bizarre, however, giving birth was to them what they were waiting for, it was their last maternal behaviour towards their babies.

Natural delivery also appeared to function as part of a restoration of their feminine identities. During natural delivery, their bodies, which had produced a dead baby, had managed to cope successfully with labour. For Regina, who

was amazed from her body, natural delivery brought her even closer to her feminine identity:

Regina: *“So I think that, that helps, and you know, as I say, it, it is amazing what our bodies can do, you know, it just shows you, oh my God, I can, I can do it, you know” (5/115-8) [...]. “I feel not more whole, but I feel almost more woman, I guess it’s probably whether your baby lives or dies, the experience of birth makes you feel, “Hang on, you know, I’m not, I’m not a little girl anymore, you know, I, I am a woman” (10/241-44).*

Both Patricia and Lorna felt pride for making it through labour:

Patricia: *“I was proud of myself that I gave birth to my son, you know, I didn’t have a caesarean or anything, it was a natural birth, so I’m proud of that, you know” (18/492-3).*

Lorna: *“I kind of knew that I wanted to go through and give birth myself because, um, I thought that that was a challenge and I wanted to do that” (3/45-6). [...] “I don’t regard it as a horrific experience, um. I had an epidural and it was quite hard at the end but, um, you know, I did it and, um, and, yeah, you know, you do feel – you feel a sense of achievement after having done it although obviously it would be most people have a very different result...” (4/58-60).*

Whether their labour produced a healthy screaming baby or a dead and silent baby, those women felt joy during their labour. Delivery was the moment they were expecting, it was the last maternal behaviour they could perform and it proved to them that their bodies were not defective. As with normal births, these stillbirths transformed these women from expectant mothers to mothers.

3.3.1.E Theme E: Death in the face of one’s baby: The first and last meeting with their baby

Today, mothers of stillborn babies are offered the chance to see and hold their babies after delivery (RCOG, 2010). The participants were aware of that option. However, the lack of information regarding the process of death for unborn babies, and their appearance, as well as the unfamiliarity with death and corpses, made some participants to fantasize about decomposed corpses or malformed babies. Most importantly the shock of seeing their babies dead

instead of pink and screaming created for some of the participants' great ambivalence about seeing their babies.

Claudia feared that her baby would look horrible and deformed, a fear that was disputed when she finally held him:

Claudia: *“the worst part of all that was a) trying to get my head round the idea he actually was dead and b) as I mentioned to you earlier, I had this awful fear because I knew nothing about stillbirth and nobody had told me any details or given me any information, I thought my baby was going to look horrible and deformed. I thought he'd be rotten with mug – you know, you think of a dead body and I thought he'd be all emaciated and rotten and, I was disgusted by it actually and that was what was actually really really making me scared and it would have been helpful, I think, if somebody could have sat down and said, actually you're going to go through labour which is just like having labour with a live baby, and your baby may have thin skin, if he's been dead a little while, and he may be bleeding a bit from the nose and the ears and, you know, all of that but he's not going to be disgusting, it's your baby. Yeah, you still have that because you have such an unknown...fear, um, I was absolutely paralysed with fear” (12-3/316-29).*

These fantasies were also true for Regina, despite the fact that she had performed amniocentesis and she knew that her baby had no chromosomal abnormality.

Regina: *“And I said “Can you take him away?” because I didn't want to see him, I was too, I don't know why I didn't thinking about it, I really don't know why I said “I don't want to see him”, but it was obviously a fear of me giving birth to some sort of monster, you know, like you know that this, why has, I didn't know why the baby had died, maybe he was deformed or there was something weird and I was too frightened to see the baby” (6/126-30).[...]*
“And he was in a little Moses basket and I can remember saying “Why are his lips red? Why does he have blood on his lips?” and she said “Well he hasn't had any oxygen, so it's, it's because there's no oxygen there”. So that freaked, you know that freaked me out because okay your baby's dead but you don't expect then to see basically what looked like bruising over him and big red lips,

big hands, you know. But I didn't feel like I wanted to pick him up or anything like that, I sat quite a distance away, I let the priest say prayers (6/154-60).

However, the majority of mothers did chose to hold their babies and they described these few moments with great intensity. Their dead babies were still beautiful in their eyes, quiet as if they were sleeping:

Charlotte: *“But it was weird having a labour and not having a baby, well having a baby but not a live baby. Now I've got Phillip (**the baby she had after her loss**) it's quite bizarre the parallels of it but then he was born and he was beautiful, just as though he was sleeping, which they all do don't they sadly...” (2/30-3).*

Claudia: *“I couldn't take my eyes off him, he was the most beautiful thing I'd ever seen. Any – any mother says about their child dead or alive, I know, but I really thought he was and then I remember saying – I remember saying to my mum – I said look mummy, his hands are cold, she said yes Claudia, um, and his little – everything was so perfect but his little feet – I couldn't get over his feet and his hands being cold. That – that hurt me, you know, but he looked very peaceful and he looked – he was very handsome, you could say, and his little mouth was like this, like he was about to kiss” (18/496-503).*

After months of fantasizing about their babies and hours of labour these mothers could finally hold their babies, however, their babies were dead, cold, and silent. Although they knew that this short meeting with their babies was the only one they would have, giving away their babies forever was very hard for some of them:

Wilma: *“You tend to think about holding him now, how your arms ached and – silly things, that you didn't want to leave him and all – all this nonsense rather than just feeling the absolute pain which was all I could feel. At the time that's all I could feel, was just pain” (16/377-80).*

Claudia: *“the next thing I remember is her coming back and saying we've got to take him now and I was pleading with her not to – I said please don't take him, don't take him, and Paul said no you've got to let him rest now, honey [...] the worst moment for me because I didn't want to let him go” (19/521-5).*

These women faced death and cold silence in the face of their fantasized, ideal babies. They were allowed to hold them briefly, but soon they had to let them go forever.

3.3.1.F Theme F: Iatrogenic Psychological Trauma

During the hours these women spend in the hospitals giving birth and saying goodbye to their dead babies, or during the first weeks after delivery many of them shared many perceived shortcomings of the medical professionals, shortcomings that varied, in their view, from insensitivity to negligence.

Nearly all participants had to wait at their homes two to three days from the moment the death was discovered until the day birth was scheduled. After death was diagnosed, they reported that they were sent home with minimum information about what the delivery would involve.

Laura: "Well, they gave me some tablets and it took two or three days, I was just wandering round at home knowing, you know, what were going to happen. It were awful, still thinking that maybe they'd got it wrong and, I don't know" (10/228-30).

Patricia: "I didn't really – I didn't know what was going to happen. Um, so that was a very strange day because it was just every hour was like a year, you know, um, but we got through it, got through it" (6/137-9).

Claudia: "between Thursday evening and Saturday morning it felt like two weeks, it's the longest period in my life ever, I didn't sleep – obviously I didn't sleep. I didn't want to give birth because I wanted – I wanted to keep him inside me as weird as that sounds" (12/305-9).

These women were placed in standard delivery suites, with cots, and among other women delivering their healthy babies. Regina remembers the delivery room with an empty cot:

Regina: "Um, and then sitting on the windowsill at the hospital in the maternity room looking at the little cot, the plastic cots they have in there, ready for your baby to go in, knowing that there wasn't going to be a baby to go in there" (2/40-3).

Claudia described the hours she spend waiting in a delivery room hearing other women giving birth to their alive babies and staring an empty cot: **Claudia:** “And all this time, of course, it’s in the Labour ward so I can hear women screaming in the background in the middle of birth which isn’t really helping massively” (11/284-6). [...] “Anyway, eventually we were shown to a room, a delivery room which was just amongst all the other delivery rooms, it wasn’t away from anything and, um, we were left there for about three hours [laughs] during which – I remember this awful, it was luminous grey walls and they had a cot in the room as well which really upset me” (14/367-70).

During delivery Laura describes the midwife as helpless as she was: **Laura:** “Um, they didn’t really know how to deal with it, I don’t think. Some of them were quite upset and they were crying and things” (2/16-7). [...] “and the midwife that were there she were dead upset and she were crying and it were horrendous...” (10/218-9). [...] “It was the same midwife, you know, the one from the doctors who actually had baby with. They were quite sensitive and stuff although they did cry which made me think, you know, you shouldn’t be crying...you’re supposed to be strong, you know” (10/236-8).

Claudia was left to give birth on her own and on enquiry about this she narrated the following experience. A doctor who was not there during delivery excused himself with the following statement:

Claudia: “then there was a horrible incident with the doctor who came, um, and was, I thought, very offensive to me because when we asked why we’d been kept waiting so long. He said we’ve been very busy with other patients and with all due respect your baby’s dead already which I thought was a most insulting comment. Although it was true factually it was just so insensitive and I took it as an insult to my child” (14/375-84).

Due to what was later proven to be negligence, Claudia was admitted to the hospital twice after this delivery, with blood poisoning, as the placenta was left in her uterus. According to Claudia even on the birth certificate of her son the wrong hour was written, since no midwife or doctor was with her when the baby was delivered.

Charlotte was sent home only six hours after delivery, she was not offered any counselling and was not offered any contacts with charities such as

SANDS. She also saw her son after the post-mortem examination naked with his clothes lost, while the only pictures that were taken of her baby were lost. **Charlotte:** *“The aftercare we got from the hospital was appalling to be honest with you [...] it’s appalling now and shocking but I didn’t think it was anything different then because I hadn’t been through it before, I wasn’t sure how it was supposed to be, you know, um, but they’d had such a lot of – countless mistakes. [...] so he came back from the post mortem completely naked and he had no clothes or anything. I know it’s such a minor thing but I didn’t want him to be naked and I thought, well you know, if I’d had the chance I’d have had that clothes probably because they were the only thing I’ve got of him that are tangible, you know, really. I didn’t get a chance to get them and that photo we’ve got there, we’ve got one copy of that [...] they said I could have the prints anytime I wanted but they lost it, they lost the CD. [...] we’ve got a lock of his hair and some prints. It’s nice I’ve got that but I’d like to have some more copies of the photo but, you know, obviously I can’t now, it’s one of things, but I think the aftercare was really really poor. I think that probably held us back a long time in our grief really because we had so many things to get our head around that had made a bad time even worse really (4-5/90-121).*

The importance of the pictures was underlined by participants especially by those who were deprived of them. In the case of a stillbirth, pictures, clothes, hand and foot prints, or hair, may be the only tangible proof of their baby’s existence.

Claudia: *“another thing that I resent a little bit to this day, and it wouldn’t bring my son back I know, is that I’ve only got these – three images I’ve got and the quality’s really bad because they had a little Polaroid, you know the instamatic camera that your granny had twenty years ago” (19/513-6).*

The participants went through the trauma of realizing that their healthy baby was dead, and then they were sent home for 2 days on average with minimum information about labour and delivery. Then, they had to endure hours of natural labour in the midst of the maternity ward, in standard delivery suites equipped with cots, held shortly the dead body of their babies, and then they were sent home 6 hours on the average after delivery with few pictures and prints of their dead babies. The physical and psychological status of these

women during those days was so highly vulnerable that some of the hospital procedures appeared to create for them an additional and arguably unnecessary trauma.

3.3.2 Introduction to Super-Ordinate Theme 2: The Ripples of Loss

The second super-ordinate theme to be presented involves the multiple layers of loss a perinatal death can instigate. The participants had lost their firstborn child, while at the same time they were experiencing many secondary losses like hopes, dreams, and social roles while their sense of personal identity was thrown in disequilibrium. Although they perceived themselves as mothers, this identity was not recognized by society. Their feminine identity and physical integrity was also wounded in the sense that they had failed to reproduce a healthy offspring and they were facing the possibility of never being able to have a child again.

3.3.2.A Theme A: The amputated object relationship

The relationship and attachment participants had created with their unborn babies involved a great many fantasies related to their shared future. With the death of their babies their anticipated future was collapsing, leaving a gulf of emptiness in their lives. Their relationship with their child was abruptly terminated, and was left incomplete.

However, they were still experiencing, without the physical presence of their child, maternal love for the first time. Charlotte and Claudia attempted to describe the type of love they experienced for the first time in their life together with the sharp pain they experienced simultaneously:

Charlotte: "to feel, er, so much love for someone and so much pain at the same time, I think. I've never felt anything like that before really. [...] Yeah so that's kind of pain and love really. I've lost people when my dad died and I've lost friends and things, you know, grandparents and things but I hadn't ever felt the same kind of loss I had with Edward because so obviously he's my child and I think – and some of that I realize I haven't found – and I could love somebody. Because before I read in papers and magazines that oh I couldn't believe all

the love I had for my child and I thought it can't be that good and I thought it is, it really is..." (12-3/292-300).

Claudia: *"I think also because he's – he was my first child there is that – I'm not saying there's any less of a bond when it's a second child but a) you're dealing with the bereavement having lost a child but b) it's the first time you've gone through that experience of being so close to somebody, um, so it's a double shock. You didn't know what was going to happen having a stillborn child and you didn't know quite how overwhelmed with love you were going to be yourself" (33-4/914-20).*

Their everyday lives were so different from what they expected. They had maternity leave but no baby to care for. Charlotte and Wilma describe this emptiness and their feelings of desperation during the first months of their bereavement.

Wilma expressed the despair she felt initially, her baby was dead so it was hard for her to find meaning in her life:

Wilma: *"I remember lying in bed when I got home, um, after I'd had him thinking what's the point. Not that I was suic – I wasn't suicidal or anything like that, but I remember thinking what is the point, what's the point in getting up, there isn't, if I disappeared tomorrow it wouldn't matter. And that – that was sad but that is how I felt about it, is that, you know" (7/155-58).[...]"because I'd been expected to be a mother and be a parent and time taken up so I'd really – in a way maybe not so much the meaning of life but I had to find myself again and that took me quite a long time" (10/225-7).*

Charlotte, underlined two aspects of hardship during the first months, first, the pain of the loss, and second the emptiness in her life, as her routine was not what she had anticipated to be:

Charlotte: *"I felt so lost, I think half because I was just grieving so much and half because I'd been expecting to have a different kind of life afterwards really. I mean, like when I was having Phillip (**her second child**), you know, tearing my hair out all day and having sick everywhere and just being – yeah I think it was a shock not having all the kind of responsibilities that I had. Also having – still having all the after effects of a birth" (11/262-266).*

However, losing a child appeared to be a loss that unravelled its pain for a long time after the child's death. When participants faced their dreams and fantasies about their family life without the presence of their firstborn children the pain for their loss was emerging again:

*Wilma: "George (**her second child**) loves older children, like all children, but in my head it's like oh he'd have been great with Antony, he would have loved him, it would have been great fun, um" (17/417-9).*

Claudia: "There's a little park over there and it was all covered in snow and these children were playing and making snowballs and I just sobbed all morning watching them thinking my son could never do that, you know" (29/801-2)[...]. "If we go to a beautiful place I always think I wish my son could see this or you're going for a walk and see the bluebells in the woods or – we go for walks in Epping Forest, you know, we went there the other day for a walk and I said oh Lucas would love to be kicking up the leaves" (44/1190-3). [...] "Even once you have recovered, if you like, not recovered but once you're learning to live with it, you're still not only dealing with that grief but you're dealing with – you still have all those thoughts – that frustration of not seeing that person grow up, you know, and I think that's really difficult, um" (47/1251-1255).

The lived experience these women had with their babies was mainly during pregnancy, when the child does not exist as a completely different person than the mother. The attachment to their unborn children was mainly built through the care they expressed for their pregnancies but mostly through the dreams and fantasies of a shared life with these children. For these women the attachment to their babies was abruptly amputated since they never got the chance to make these fantasies a reality.

3.3.2.B Theme B: A socially threatened maternal identity

When talking about their sense of identity as mothers, many participants implied that although they perceive themselves as mothers, as it is not a title taken away with a death of a child, their social networks did not perceive them as such.

Wilma said that although she did not have a child to show to others, so they can perceive her as a mother, she definitely felt a mother in herself:

Wilma: “and also he made me – he – he made me – I mean, I was a mum from having him, I didn't have a baby to show for it or – or experience but I'd still experienced that love that you feel in carrying that child around with you...and all those hopes and those dreams” (18-9/450-3).

Patricia as well described others as if they threaten her maternal identity:

Patricia: “And I – before I even knew I was going to have a baby I was a mother, even though I gave birth to a stillborn baby I was a mother and nobody could take that away from me” (18/489-91).

While Claudia talked about her socially unrecognized maternal identity although she, as any other mother, had been redefined by the sort life of her son:

Claudia: “Its life changing having a baby and what I feel strongly about is that people should recognise it's equally life changing that even if your baby has died, that doesn't mean you're not a mother, it doesn't mean you don't have all the same feelings that any other mother does. It doesn't mean – it still redefines your life” (44/1171-1174).

Even Julia, whose daughter lived for two days, described this feeling of a socially threatened maternal identity:

Julia: “Yeah, it was difficult with the whole being a mother but you're not a mother thing, that was very hard because she was my first. If you've already got a child I guess they distract you and you're already a mother but if it's your first you know you're a mother but because you've got no child no – one sees you as a mother” (13/221-24).

Losing a firstborn children created the paradox of being a mother without a child to mother. That paradox was often overlooked by the women's social worlds as they were lacking the evidence of motherhood, a child. The conflict between their personal sense of identity and how others perceived them was to unfold on many occasions in their life causing them to engage in additional struggle.

3.3.2.C Theme C: The threatened reproductive ability

Participants spoke about their sense of failure; their bodies had let them down being unable to give life to a baby. Charlotte, Lorna, and Wilma described their injured relationship and mistrust towards their own body.

Charlotte felt like a freak since she did not manage to bring to life a baby:

Charlotte: *“I mean, I felt such a freak at first. That’s the only way I can describe it really, because I didn’t know it could happen, I really had no idea and James (**her husband**) either, he didn’t know anything could happen” (3/66-8).*

Lorna, who always felt competent in her life, felt that her own body had let her down:

Lorna: *“because I – I felt my body had let me down because I – I’ve always been someone who – who was always top in every sport and I was strong, I’m never ill and I’m always stronger than anyone else doing anything and for once my body had not – had let me down. So I felt – I – I felt that was a big part of it” (6/108-111).*

While Wilma, who was in her very early 40’s, felt that she could not trust her body anymore, a body that had already let her down once:

Wilma: *“Everybody said oh you’ll be fine next time but you-you don’t trust your body” (6/122). [...] “because of my age I had to – although the consultant said oh you got pregnant quickly with Antony, you know, you’re obviously fertile but – it sounds disgusting this but my – my periods went weird, I was hardly having periods at all, they were very light, they just didn’t feel – they weren’t my normal periods. You can’t – you can’t” (10/236-39).*

Because their bodies had ‘failed’ them once, but also since some had gone through miscarriages or fertility treatments before their loss, participants felt unable to even think at that point that they would eventually have a biological child to raise.

Julia: *“After we’d waited like ten years to have a baby and then we didn’t have one, so I was still desperate to have a child, but during those three months when we weren’t supposed to be trying anyway we didn’t talk a lot about*

biological options because we'd been told there was likely to be a risk for future children" (22/381-85).

Patricia: "I wouldn't even believe I could have another baby or from that point, you know" (9/235-6).

The participants experienced the emptiness in their lives and dreams after the loss of their much awaited first child. They had to face the paradox of being childless mothers and to cope with their personal sense of failure and the possibility of remaining childless for the rest of their lives.

3.3.3 Introduction of Super-Ordinate Theme 3: Working through the trauma

The third super-ordinate theme to be presented involves the cognitive, behavioural and emotional challenges that participants had to face within their social contexts during their bereavement. This theme describes the most industrious phase of participants' bereavement process, where all the necessary internal challenges were confronted in order for the resolution and growth to follow. During this time of personal struggle, the participants were members of their social environments and the powerful effects of those environments were carved on the participants' pathways to psychological survival and growth. The sub-themes presented do not necessarily follow a chronological order in which participants employed the different coping processes, nor do they suggest a step-wise process of coping. They have been organized this way for presentation purposes only.

3.3.3.A Theme A: Rumination and Disillusionment

Initially participants appeared to try and cognitively process what had happened. Often their first efforts to comprehend the loss entailed a search for a medical reason. Although the vast majority of participants reported that a post-mortem was performed on their babies, the results obtained were inconclusive in all cases. Some participants found out how their babies had died (e.g., by bleeding) but not why their babies had died (i.e. why did they

bleed?). Laura was afraid that maybe she had done something wrong, and Regina was wondering whether amniocentesis had harmed her baby:

Laura: *“I wanted a reason, I really did, but there wasn’t one, um. I don’t know, I sort of blamed myself a lot because I thought maybe I was too stressed or something but I don’t know” (2/36-8).*

Regina: *“So um, yeah, again that was a trainee (**the person that performed the amniocentesis**), and so again I look back and think “Well maybe what if? What if?” Like everyone does I suppose with their lives. Well what if I hadn’t had it, would that made a difference? If I hadn’t had that, would I have had a stillbirth? But ... we’ll never know” (9/217-221).*

Patricia initially engaged in an exploration of the medical causes of her son’s death but moved on to accepting that she may never find out why, and that she needs to accept his death without having definitive answers.

Patricia: *“we never got a sort of reason, never had a reason which – I don’t think whether – I wasn’t, er, I wasn’t terribly devastated about that, I didn’t – that didn’t knock me back in any way. [...] I think knowing, knowing that it had been explored, even whatever answer that came back from that, allowed me to find an acceptance somewhere about it, if that makes sense. Um, but it was just – it happened – it happened, that was what happened, my baby died, you know. I can’t put it down to this reason, I can’t put it down to that reason, it wasn’t my fault, it was, you know – if you had your own personal God you’d say it was God’s will or it was nature or I don’t know but I had to accept that that’s, you know, that’s what happened” (8/202-212).*

For most mothers this journey to acceptance was very challenging as many of the certainties in their lives seemed to collapse. The common notion, especially in Western countries, that people get what they deserve made these mothers wonder why this tragedy had happened specifically to them (Janoff-Bulman, 1992). Laura wondered why she couldn’t have what most people are able to have, a child; people that often abuse their bodies and babies while pregnant:

Laura: *“Everybody has babies, people take drugs and they have babies and that’s what really got me mad. You have people drink, you see them in pubs really heavily pregnant drinking and they have babies and they’re fine and I*

couldn't understand why it just went like that. I mean, I was a bit stressed but I was making sure that I wasn't that stressed so I can't even blame that. You know, it still gets me mad now when I see people drinking in pubs [...] my mum said that, she said people go to refuges and stuff, people are in like real bad times like people in Africa and things and living in the desert and they don't, you know, it shouldn't – it's not really a good reason [...] I know because nothing ever happened really in our family, we just plod along, you know, I think it was a big shock to everyone” (12/243-53).

While Regina wondered why her, who would have been a good mother was deprived of her baby:

Regina: *“Um and so I did think why, why my baby, when I would have been a good mum and there's people that clearly can't look after themselves let alone, you know, which is why I waited till I was older, you know” (19/458-460).*

Lorna was trying to comprehend why she had to suffer such an uncommon type of loss:

Lorna: *“I felt, you know, I felt it was unfair and I felt it was, you know, I – I – I looked at the numbers and, you know, it's like one in two hundred and all the rest of it and – I know – I mean, I felt it was very unfair, I mean, I felt it – it shouldn't have happened to me but then that – that's sort of natural, I imagine...” (6/104-7).*

The loss of their healthy and much awaited babies was a rude awakening from the positive illusions people hold (Janoff-Bulman, 1992). For them the meaningful world that is characterized by justice and control was shattered.

Wilma: *“I remember thinking “why us?” a lot and then my husband said well if a rapist could win the Lottery why anybody?” (16/382-83).*

The process for the realization of both the loss of their child and the loss of their positive illusions appeared to involve many hours of cognitive and emotional processing.

Patricia describes the process she went through:

Patricia: *“all it was - was like kind of marking off time on the calendar, [...] just getting through and looking after each other that first year [...] I could say I remember literally ticking off a calendar, being up at all kinds of hours in the night and, you know” (11/287-306).[...] “I had to, I had to (accept the baby's*

death). It was very very hard and, like I say, I'd read things in magazines and was that the reason, you know, or, you know, and – but I had to find something, I had to find it within myself to accept that because I couldn't move on, I couldn't do anything. [...] And then, er, and I, you know, you just think oh if it was an ideal world, then anybody who has babies, whether they reported that there was a problem beforehand or whether it was their first baby, if they could be monitored the whole way through I wouldn't have lost him but that's not how it works, that's not how it works. So sometimes I get a little bit, you know, oh he would still be alive because they would have picked up on his growth not being as good maybe and, you know, but that wasn't, you know, I suppose, you know. I sometimes have a struggle with it, that's part of grieving, isn't it, you know, sometimes. Not regrets, I don't have any regrets, I just have questions” (19/502-515).

Patricia talks about her conscious efforts to accept her son's death, and also about her acceptance of the absence of an ideal world, where everybody receives ideal medical care. She admits though that there are moments when she becomes angry and her “why?” questions surface again.

Charlotte had to comprehend that her son might had been alive if she had been offered an additional ultrasound scan:

Charlotte: “After we had the results we went and saw the consultant at the hospital and had a meeting with him and he said, um, in his words that they're not that good at picking up small babies. I thought that's not good isn't it? because if it had been found earlier, which is should have been, then they would have, you know, altered the plan of care really and induced me early or done a C-section when I was thirty eight weeks but not – I wouldn't have gone overdue with it because they wouldn't have let it get that far. So I feel quite angry about that still really because he didn't have to die essentially but then you can't, you know, regret things all the time, blame yourself, because otherwise you'd just go mad, I think, wouldn't you, you know? [laughs]” (6/136-145).

The tensions between injustice, wanting to live in a predictable and fair world and the fantasy that medical care can provide the remedy for all ills were struggles reflected in the discourse of many participants. After searching for

reasons and medical explanations they had to comprehend that there are no explanations and that possibly the world is not a safe and just place.

3.3.3.B Theme B: Oscillating between action and avoidance

While the participants actively struggled to process, comprehend, and cope with the loss of their babies and their personal realizations after the loss some avoidance cognitions, emotions, and behaviours were surfaced in order to help them cope with their anguish, so as not to be completely overwhelmed by the reality of this traumatic loss. These states of avoidance were usually alternated with efforts to actively, emotionally process the traumatic material.

3.3.3.B.a Avoiding the pain

It is not of surprise that some of the participants had to engage in different forms of denial in order to protect themselves from the overwhelming power of their loss. This denial (usually characterized by numbness, removal of material from consciousness and memory, behaviour constriction, and avoidance of reminders of the stressor, cognitive reattributions; Horowitz, 1976, 1979) took various forms and for different participants had different duration and intensity.

Charlotte explains why she chose to go back to work soon after her loss:

Charlotte: "I went back ten weeks afterwards because, um, I had to have some kind of – of routine back and some kind of normality really. I think if – if I hadn't done that I don't think I'd have come so far so quickly really because if you're at home you mope about and think about things and, you know, get more upset than you were in the first place really. So I went back quite quickly and got back into my old routine" (11/256-260).

Charlotte described why she intentionally avoided facing the emptiness the death of her son had brought in her life and in her house; going back in her old routine could possibly help her go back in time and experience a normal life again. She, later in her interview, used a very intense word to describe her true motivation; she was trying to “*get rid*” of what had happened to her:

Charlotte: *“I think I wanted to – what’s the word, not get rid of them but I wanted to get back to me and get back to – well to try and get back to what I was before which obviously wasn’t going to happen because I didn’t have what I’d been expecting for the last nine months. So I think initially I went back to work for to try and get rid of what had happened, I think, initially” (11/ 267-271).*

Like Charlotte, who tried to rewind to what she was before, Wilma, a general practitioner, tried to avoid the emptiness through her profession and hold on to her professional identity. However, the pain was returning when she was not busy with work, especially during weekends where she was at home without her son:

Wilma: *“...and then I went back to work eventually [...] although I hated it my job is, when I’m there it was all consuming, I was full time. So really that – that gave me a role – it gave me back my old role that I’d always had. So you become this doctor person again working full time. I – I think it was at week – it sounds awful, it was at weekends I’d be at an absolute loss [...] I found weekends very difficult, I was (at) an absolute loss what to do and I was very unhappy. I – I used to cry coming home in the car on a Friday, I’d be fine at work...” (9/210-226).*

Julia, during her maternity leave, possibly engaged in some avoidance behaviours as she ended up volunteering to seven different charities at the same time:

Julia: *“I had another five months to do something with, but if I sat at home that wouldn’t have done me any good so I went to the volunteer centre in Exeter and I think I got – I signed myself up for seven different things [laughs]. I did sign up for seven different things but that was a little bit over the top, I had to cut down gradually...” (9/145-8).*

Julia and her partner also engaged in various treatments in order to conceive again three months after their loss (while they both were in their mid-twenties), something that happened a year and a half later. When she finally conceived, her initial feelings were rather ambivalent towards the new baby as she had wished to have a girl again, just like the baby she had lost, but the new baby was a boy.

Julia: “When we found out he was a boy not a girl, um, we were both almost a little bit upset. It’s not that we wanted to be close to her but we still wanted our little girl. So when we found out at the twenty week scan we were both a bit scared. Also guilty because we were so grateful he was well [laughs] and everything. **How do you feel now that he is a boy and not a girl?** He’s who he is, he’s Nicky, you know. He couldn’t be a girl because he’s who he is. **He’s Nicky.** Exactly [laughs]. **Yeah.** That’s fine and I’ve had my little girl. I’d love to have a little girl to bring up but it’s not the way it’s going to be” (25/435-42).

Regardless of her initial ambivalence, she subsequently developed an attachment to her son who was no longer replacing his lost sister.

Wilma as well described her “*obsession*” to become pregnant again soon after her loss. She revealed that it was not her first months of bereavement that was “*a living hell*” (2/44), but her efforts to conceive again. Wilma shared her desperate need to bring “*that*” baby back and be a mother again:

Wilma: “I always said before I got married, well right because we’re older if we never have kids well fair enough we’ve got a nice life and then when I lost him...**You wanted to**...I wanted it, yeah, oh it just became an obsession. So – **How – how do you explain that obsession?** I don’t know whether I was trying to replace Antony...**Hmm mmm**...I sometimes – you know, that is – that trying to get that baby back, um, but it’s also that need to feel you’re a mother [...] you know, you just want that back” (2-3/45-56).

Their rush to conceive again could also suggest their determination to become parents and overcome their loss, the intensity of this need and the way they described their efforts could imply avoidance of the bereaved identity and the reminders of their loss, through the arrival of a much wanted baby and the achievement of mothering a baby.

Laura and Lorna went a step further from the rest of the participants and shared more behavioural evidence of their denial processes, which also had larger duration. Both of these participants felt very uncomfortable when others expressed sympathy for their tragedy towards them, and chose to change jobs, so nobody would know about their loss.

Laura: “I started doing a new job and stuff, I wanted a fresh start and I didn’t tell anyone. Because I went back to my old work and they all just looked at me different, they were just different, awkward and they’d look at me and I thought, you know, I don’t want this so I went somewhere else and got a fresh start and didn’t tell anyone [...] and also I feel like I’m keeping like a big secret because no-one knows but I don’t really – I don’t like people’s reactions when I tell them, you don’t know. I don’t mind telling them but then they’re like oh” (6/118-125).

Lorna: “...and I think, um, I think – I think – and I think that’s what people’s reactions to it. I think that they think you’re going to, you know – [...] Um, they just – well, the pity. I’m not saying they did – they did feel pity on me – well, there’s obviously going to be a small amount of that but, um, the, um, – well the fact that people don’t know how to deal with it. It’s something that’s obviously such a – people don’t expect to happen because people don’t really talk about it” (13-4/238-45).

A sense of emotional numbness for their loss was communicated by few participants when they talked about their loss in a very scientific and distant manner. Lorna, during her interview, repeatedly focused on statistical figures on perinatal mortality and infertility:

Lorna: “I guess I’ve become aware of how – how the whole subject, you know, because I began reading into it and realizing the statistics and everything and at that point I didn’t even know, um, about the high incidence of miscarriage etc. I began to sort of really realize how giving birth, having a child, is such a, you know, a – a – a dicey business [laughs]” (15/265-270).

The focus on statistical numbers in order to accept their loss and naming the childbirth as a “business” is an indicative example of this form of denial. Charlotte though shared how these processes were inhibiting the integration of the traumatic material:

Charlotte: “this will sound really strange but it still feels like it didn’t happen to me. I can read things that I’ve written for papers and things, or like a feature in a – in a magazine about me or something and I’m reading it as though it’s someone else and I still don’t think – half of me is probably still, you know, completely not accepting it but the half, the grounded half, does but

I still kind of read things back and think how awful to go through that [laughs], really I've gone through that" (9/218-223).

The different forms of denial and avoidance were one of the two poles between which mothers were fluctuating while they were trying to work through their loss. To a certain extent this denial states were providing the necessary mental breaks from their overwhelming reality.

3.3.3.B.b Active Cognitive-Emotional Coping Processes

The other pole of avoidance was the active cognitive processing of the traumatic material and their efforts to integrate this material to their worldview. They were engaging in deliberate cognitive processing in order to establish an understanding of their loss and a re-understanding of the world and their place in it.

Many participants reported that they never received a medical explanation for their losses and this appeared to give rise to a lot of self-blaming thoughts. In their efforts to make sense of what had happened to them and their babies, they tried to find explanations through their own behaviors and responsibilities. Self-blame appears to be a cognitive-emotional strategy for them to maintain a sense of safety in the world, in a world that they could still maintain some control over. Self-blame seems to have soothed their anguish by providing them a different perspective for their misfortune, a perspective that was allowing them to perceive themselves as not totally hopeless and helpless in the face of tragedy.

Self-blame was an experience that was reported by many participants concerning the first months of their grieving. They also felt anger towards their intimate others because they needed to blame someone for their loss. They were still trying to cognitively process the traumatic information and their search for a reason was exhaustive.

Regina in her agonizing effort to find an answer for her loss started blaming her partner, or her stepdaughter:

Regina: *"Um, I felt sort of a little bit anger towards him (her partner) 'cause I wanted to blame somebody, I wanted to blame somebody. It was his fault in a*

lot of ways, it was, um, my stepdaughter's fault in other ways. I never told them that... but I felt that.[...] because it was unjustified, it was unjustified totally. [...] and although I needed to blame, I couldn't verbalize it. So internally I was, you know, blaming, but I couldn't then say "Well, I blame you for this and you know, you were this and you were that, and if you'd been more this, then it would have been okay". You know, it was like I wanted to blame so that I could have an answer" (21/500-509).

In order to reason why this had happened to them and their babies, Claudia and Julia blamed themselves over superstitious scenarios.

Claudia felt guilty because initially she wanted a little girl instead of a boy:

Claudia: *"I felt terribly guilty about after Lucas was born, um, and I still feel guilty about it, to be honest is when they told me it was a boy –and I think this was just bravado and me showing off because obviously we knew there was nothing wrong at that stage, um, I was almost cross because I'd wanted a little girl – I thought "God, a bloody boy, I hate boys", you know, I'll have to clean his willy, I wanted a girl, I wanted a daughter, you know, in a joking way I used to say this to everybody –and after he was born I nearly killed myself over that, you know, I felt so bad about – although it was said in joke I thought maybe he knew I'd said those things and – you know all the mad thoughts that go through your head. So that was something I felt very bad about" (4/72-83).*

Julia felt guilty because she followed the routine of the hospital but unfortunately it was during those minutes that her newborn daughter stopped breathing. She blamed herself for not paying the necessary attention to her newborn:

Julia: *"I felt – I blamed myself at first for not being with her when I was sitting there eating away at my toast and there was a lady changing my bed and she'd just come back off holiday and I was chatting to her and that and Angela was lying next to me not breathing and I didn't know that at the time. And that came back to me a lot" (7/117-120).*

Laura and Wilma appeared to struggle particularly with self-blame and guilt, as these feelings were still unresolved at the time of the interview. They mentioned their feelings very early in the interview and many times during it.

Their emotions appeared qualitatively different from the self-blame of other participants. Laura blamed herself for smoking and being stressed throughout her pregnancy, while Wilma, as a doctor, for missing the cues and for her career oriented priorities.

Laura kept talking about the reassurance she got from the doctors that her behaviour had nothing to do with her daughter's death, but each time she completed a phrase, she introduced another reason she could blame herself. *Laura*: “at the time we were having a lot of relationship problems and I was going through a lot of stress in my life but the doctor said that wasn't anything to do with it but I don't know” (1/9-11). [...] “Yeah they just said it's one of them things, it's not really an explanation as such but then I think in a way if they'd ground an explanation and it would have been something I'd done, I don't know what, but then that would probably have been even worse because then – I don't know. Because I kept thinking right, is it something I've done and they're just not telling me but then I thought it's ridiculous because there's nothing they could have done, it just happened. Although I did smoke when I were pregnant” (9/206-212).

Wilma, who worked full time during her pregnancy, felt guilty because as a doctor she “should” had recognised the signs of the baby's distress earlier and not postpone her visit to the hospital after she had completed her shift at the surgery. She also felt guilty for not attending her pregnancy more enthusiastically as she was very busy with her work.

Wilma: “because it's that guilt thing that I – we just said oh he's not as active, oh I've got an anterior placenta and people say oh they're not as active the last month and I beat myself up more because being a doctor you feel you should know better but I even said to people oh he's not that active, not as active, just didn't think that anything was wrong” (4/85-88). [...] “I can't remember paying much attention to foetal movements all the way through, the odd kick probably. I was just so busy, um...[...] you don't think the worst really, um” (5/105-7). [...] “sort of like work – not that it's the be-all-and-end all, I'm not a workaholic, but obviously it occupied a big chunk of my life, and you sort of think what the heck was all that about [laughs]. You pour so much energy into it and maybe not enough energy into myself or my pregnant – you know, my

pregnancy. It was like work took priority. When I was worried about the baby, I rang up in the evening after work and what, how stupid can you get?" (7/159-64).

Whether they had blamed others for their loss or they had at varying degrees blamed themselves the vast majority of participants had to emotionally struggle with those feelings. The lack of information over the causes of death for their children had fired these emotions even more, as they were trying hard to find, or create an explanation for their tragedy.

Furthermore, they performed downward comparisons with other unfortunate individuals. These comparisons involved others that the consequences of their misfortune were perceived as more severe, or others that were coping with their tragedy less effectively.

Wilma thought of a friend who has a disabled child and she wonders if she could have coped if that was her scenario:

Wilma: *"But there is that other side that – I've got a friend from University whose daughter's very severely handicapped and that was a delivery problem and I sometimes feel ashamed but I'm – I'm not sure I could have coped with that. I'm sure you would do because you have to but that would have been very different. So there's two sides to everything, aren't there?" (4/89-92).*

While Lorna compared herself with other women who are unable to conceive a child and they don't even have the chance to experience pregnancy and birth:

Lorna: *"Um, you put – you put it into perspective and at least I could get pregnant again, hopefully, which some people I know have problems with, um, some people can't have a child at all so, I mean, you know, you – you put it into – that's how I dealt with it" (7/115-7).*

Charlotte compared herself with others concerning their coping abilities, where she could find herself stronger:

Charlotte: *"this sounds awful but some people just really sink themselves into it and immerse themselves in their grief and don't try and get out of it and it changes their personality and the person that they are and I think that's a shame really because you're still the same person and you have to try..." (7/175-78).*

These comparisons allowed some participants to reframe their experience and consequently to regulate their emotional reactions to it.

Finally, some participants employed some benefit related cognitions regarding the consequences of their loss.

Regina felt that because she did not have a baby of her own she could give more attention to her stepdaughter:

Regina: *“I don’t know if in my mind I make sense of it in the sense of, if we had had Leon we wouldn’t be able to do this now. If I had had a little boy now I wouldn’t be able to give the attention to Maria that she rightly deserved [...] she would have felt rejected, this would be another issue. If we had had Leon now we would have had a teenager and all of the teenage stuff there” (15-6/365-72).*

While Lorna suggested as a compensation for her loss her turn into another career since her maternity leave:

Lorna: *“and then I sort of used – and then I thought right, um, you know, my life hasn’t quite turned out how it’s meant to do so what – what am I going to do now...and, um, and that’s when I decided to sort of give up my – my – you know, my career – my – my desk – my job on the Newspaper and go freelancing in a different direction...because I – I thought this is an opportunity, I – I’m – I’m – I’m – I’ve got this time off I’m being paid for to have a breathing space to decide what I want to do in life, um, it’s not quite how I planned but, you know, why not use the most – why not make the most of it. So we – so I did and it’s been, um, you know, I – I’ve kind of really – it was a good decision and I’ve kind of, you know, the last eighteen months I’ve had some pretty amazing, you know, experiences around the world and done lots of things that I wouldn’t have been able to if I’ve had a baby. So, I mean, I’m not saying – you know, you sort of – you compensate (7-8/132-144).*

Perceiving as compensation for the death of your child a new career can be considered a cognitive strategy to re-appraise the loss, a strategy motivated by the need to manage and cope with the consequences of the loss.

3.3.3.C Theme C: Religious or Spiritual Coping

For most of the participants, spirituality was not necessarily equivalent to religiosity; however, they all referred to concepts related to religion, like heaven and angels. For some of the participants, spirituality and religion were an aid to make sense of their loss, while for others they helped transform the bond to their dead children.

3.3.3.C.a Sub-theme a: Spirituality preserving an orderly world

For Charlotte, Laura, and Lorna the death of their children could not be understood as just random events in an unsafe and unjust world and they chose to continue to believe in a God that has His Divine Plan. That was an explanation that helped them cope with their pain and anguish.

Charlotte expressed her certainty that since there is no one to blame for her loss, “obviously” her loss was the result of a Divine Plan:

Charlotte: “Um, but I kind of made sense of it from the start really. I mean, I wasn’t sure why he’d gone but I thought well that isn’t anything I’ve done so I can’t blame myself so obviously there’s some high being or something has made it happen so, yeah. I’ve always felt quite, not at peace with it, that’s the wrong word, but I’ve always been able to make sense of it” (7/157-162).

Laura as well accepted the explanation of a Divine Plan and found a lot of comfort in the idea that her daughter is in Heaven:

Laura: “I just felt that, you know, it wasn’t meant to be, you know. Yeah I think the best thing is, you know, if you’re thinking that they’re took away because they’re special or that they’re chosen or something, that’s a nice thought but, you know, like I said, when they say they believe in God a bit more it has me. I believe in stuff like that, yeah. If I didn’t think she was in heaven I couldn’t go on” (4/65-71).

For Lorna after the inconclusive answers she got from the post-mortem examination she could exclude the possibility that she had done something wrong and she resorted in the explanation of God’s Will:

*Lorna: “it was sort of inconclusive (**the post-mortem examination**), um, there was – which I felt sort of good and bad about that there wasn’t, um – well, I – I*

just felt it was an act of God rather than something that I could have done myself to avoid in some ways...” (5/89-91).

3.3.4.C.b Sub-theme b: Spirituality preserving an Ongoing Bond

Nearly all participants talked about the spiritual existence of their children. This existence, that does not require their physical presence, allows these mothers to maintain an ongoing bond with their beloved children that they will hopefully meet again in another form of life. They need to feel that their children exist at least spiritually, that they can still feel their love, that somebody is looking after them, and that they will meet again one day.

Claudia was still in an effort to reach her conclusions about after life but definitely she appeared to believe that her son’s spirit is not lost and that they will meet again one day:

Claudia: *“I don’t know the answer, Olga, I don’t know. I pray that there is a God, because then I know that my son’s being looked after, and I pray in a way”* (26/699-700). [...] *“whether you believe in God or in heaven or what, I think anybody will agree that nothing’s ever lost, nobody is ever lost. I think even if you’re not religious you can believe in a spiritual – not exactly afterlife but – well people live on in other people, don’t they?”* (32-3/891-4). [...] *“what keeps me going in life is the belief that I will see him again one day”* (34/925-6).

Regina as well hopes that she will meet her boy one day and that an afterlife exists for him and her lost relatives:

Regina: *“I think the gift really of having a child because although he’s not here and I’m not religious, I do feel like somewhere or maybe in the future I will see my little boy, I don’t know if that’s how I was brought up, I don’t know, I just feel that”* (18/429-31). [...] *“I think of him, um, growing up somewhere whether heaven is there or not, with, you know, my lost relatives, grandparents, things like that, I think of him in, being looked after. Not that I’m necessarily religious, I don’t attend a church, I just treat people how I feel I would want to be treated”* (7/177-180).

Julia and Wilma both use similar words to describe their hopes for their dead babies, that they are there “somewhere” still being able to feel the love of their parents:

Julia: “I called myself an atheist but I didn’t think about it too much really. After Angela it was important to me what happened to her and I do feel she’s out there somewhere, I sort of feel spiritual not religious about it” (14/240-2).

Wilma: “I’m not religious, don’t go to church, I suppose you just feel why would God do such a thing so it’s more anger there, um [...] But you definitely think – you actually think he’s there somewhere. [laughs] Absolutely bizarre, that’s why, you know, you do – you like to – you keep things, photographs, and you do like to think that he’s around somewhere or you like to think he knew he was loved and I – I sometimes look back and think I didn’t pay enough attention to him that’s why it went wrong, um, but I’d like to think he knew us where we’re up to [laughs]” (16/392-98).

Participants shared their fantasies of the spiritual existence of their baby and their hopes to reunite some day. The spiritual existence of their babies’ preserved them, at least in a spiritual form, but also preserved the ongoing maternal relationship and love of the participants towards their babies.

3.3.3.D Theme D: Quality of Social Support as a Catalyst

The quality of social support participants received appears to have functioned as a catalyst for reaching an outcome at the end of the initial processing of their traumatic loss. The ways that important others, such as partners, family and friends but also their social contexts, like community and occupational environment, reacted to their loss and grief, resulted in either supporting these women or derailing them from their personal pathway to resolution and growth.

What participants experienced as supportive was acknowledgement of the existence and death of their babies, and provision of space for them to share their thoughts and emotions.

Patricia, and Julia described how they had shared with their partners their efforts to cope, by looking after each other and talk through things:

Patricia: “all it was - was like kind of marking off time on the calendar, um, and just looking after each other really, you know, and just, um, yeah, just getting through really – just getting through and looking after each other that first year” (11/287-290).

Julia: “I grieved certainly and I got very upset but I never felt really low and isolated, or anything like that. And having Vicky (**their therapist**) to talk to and David (her husband) to talk to, we did talk through things a lot and we made time to talk” (20/350-53).

While Claudia described how she has appreciated that they both accept their son’s presence in their life:

Claudia: “what I do appreciate Paul...because he doesn’t deny his existence. He will say, for example – I mean, even – last night we were having, not an argument, a discussion about the progress of this house, you know, and I said well thank God my son’s not here because he wouldn’t be very impressed would he, or something like that. I said look what you’ve done to his house and he said if your son was here right now he’d be sleeping, he’d be quite happy so shut up. Yeah, even – he will bring – we talk about him a lot as if he’s still here. I don’t think there’s anything wrong with that, um” (33/905-12).

Members of the immediate family who had chosen to acknowledge and remember the babies provided the warmth of acceptance and sharing to these bereaved mothers.

Wilma described an incident with her dad, when he acknowledged the absence of his grandson:

Wilma: “Because we had a – my parents had their 50th wedding anniversary and my dad – my dad said oh it would have been nice if he could have been here but it wasn’t with tears or anything, it was just to me” (15/370-2).

Claudia also described an incident with her dad that assured her that her baby is missed from other members of the family as well:

Claudia: “I tell you what makes me feel happy is when other people remember him. I went – I’ve been away on holiday this summer to France for two weeks and I’d asked my dad to go and water it (the little garden on the baby’s grave) for me and when I came back from holiday I went down there and I found this. My dad’s a cricket fanatic and I found that on his grave with a little card, To

Lucas, Happy Bowling love Grandpa, and that really – it’s just nice to know what other people feel” (41/1110-1118).

Regina talked on how shared her loss felt with her family:

Regina: *“My family were fantastic; it was their loss, um, as well. With my mum probably just as much as mine, I’m, I’ve got to say, I, you know, ‘cause she lost her first grandchild, um, so she was in bits. My sister as well, we’re very close, so I felt that it was shared, it wasn’t just this singular burden” (20-1/491-94).*

Friends too, helped these mothers carry some of the burden of their pain. Both Laura and Wilma talk about the precious presence of their friends in their lives:

Laura: *“I found a couple of friends, you know, that really stuck by me and I was surprised, you know, how close they were but only a few [laughs]” (6/129-30).*

Wilma: *“there were two friends in particular that, you know, we would meet up regularly and they would say well how’s it going and, you know, it must be hard. They’d just talk about it whereas most people wouldn’t or they’d avoid you a little bit. And I remember one good friend, she hasn’t got any children, she’s adopted so maybe she has different views, about a year afterwards she sent an email saying I wish things could be different for you and I know you must be – it’s at hard time, in fact the anniversary, and she’d remembered and I just – I’ve still got the email, um. People like her I’m far closer to, we still meet up a lot when we can. They were a tower of strength.” (12-3/289-96).*

As Wilma said, the support of friends was a tower of strength for those women. This strength was given to them through the containment and the acknowledgement of people around them, even if these people were children as Claudia narrated:

Claudia: *“another of my best friends, her son who’s – Nathan’s seven now so he was six at the time and he was really upset because he was so excited about the baby coming and he’s a Sikh. I don’t know, they have these bangles called a Kara within the Sikh religion and a baby is given a Kara when they’re born to keep them safe. [...]Nathan was crying so I gave Nathan a cuddle and he wanted to see his picture and he wanted to know his name, all these lovely*

things that children do. You'd love adults to do but adults can't do it, you know, and then Nathan said 'I bought a present for Lucas, Claudia', I said 'did you?', 'Nathan, that's lovely what did you bring?'. And, Olga, what he did then, it made me cry, it was so lovely, he said 'I bought him my baby Kara because it's to keep him safe and I don't need it anymore and it will keep him safe'. And I was going [crying noise] [laughs] and he said 'but I've made you sad' and I said 'no you haven't, you've made me really happy, Nathan', and that's just – children have an honesty, don't they?' (35/959-72).

Most of the participants came in some kind of contact with SANDS (use of web-site information, web-site forum, or fundraising), Julia and Claudia describe their experiences with SANDS support groups.

Julia: *“in that support group I like to be able to help other people. It's the same for the charity work, in the support group you can go and you can compare all the little different details of what happened to you...and if someone's feeling something you're like yeah, I felt that too and I feel this. I mean, you don't know what people – how to deal with this sort of thing and it's nice that other people have been through these things and also the woman that runs it, she was bereaved twelve years ago...so – and you can see where people in the future have got to and you think I'm going to get there one day” (20-1/358-66).*

Claudia: *“But that play really helped (a theatrical play from a member of her SANDS support group), [...] I remember at one point we were watching it and his wife would continually go and sit in the baby's room rocking saying I want my son, I want my son. It was really well done and Paul just sat there going yeah that's you [laughs] and I think it helped him to realize that actually I wasn't completely crazy and anybody would go through these emotions, you know, um. Yeah, that's you all over isn't it, um [laughs]. And that was – that was funny but it really helped, um, yeah” (39/1068-76).*

Support groups provided to these women and their partners a containing context, where they could find people who understood and shared their emotions and experiences. There, they reported that they could feel accepted and not irrational; overreacting to a death of baby they 'barely knew'.

Moreover, they could get courage by interacting with other bereaved parents further down in their journey of bereavement.

Many of the participants had a few sessions of counselling after their loss but soon they had aborted it as they reported feeling that it was not helpful. Only Julia, who had therapy for a year after her loss, described it as a positive experience:

***Julia:** “But if anything I was getting stuck in my head, I had Vicky, my counsellor, to chat to. She was really easy to talk to, she just let me talk, helped me see my way through things. I think I said things I didn’t necessarily realize I was thinking. She never put words in my head, she didn’t talk much at all really, um, but she helped me to talk through what I was feeling so it didn’t – I didn’t get bogged down with it” (19/337-41).*

On the other hand, the vast majority of the participants reported some strong negative experiences, arising from the reactions of others to their loss and bereavement. Very few of them talked about problems they had with their immediate families, either because they grieved in different ways, or just because they were not allowing the space to the mothers to express their grief.

Wilma shared the difficulties in her relationship with her husband that arose soon after the loss, since he was away for work on weekdays and he was not very willing to talk about it:

***Wilma:** “I think there was a lot of stress between me and my husband. Which is sad, you’d like to imagine that it would bring you closer, the loss of a child, but I think it caused a lot of stress or maybe more trying again caused a lot of stress between us and upset. I’d get very upset if he wasn’t around or if he didn’t understand [...] So I think already after the first few weeks he went back to work so I think that struck me that oh he’s feeling strong enough, [...] Not, never sort of grieving, he’d say to me I wish things were different and I’m upset too but it was almost like you had to push him to get any response. So – so he appeared to be moving on and coping just because he seemed to get on with life really” (11-2/254-74).*

Laura felt restrained to talk about her feelings with her family as their emotional reactions felt overwhelming to her:

Laura: “Well none of them really want to talk about it. My mum, she’s alright talking about it but she gets upset and I don’t like upsetting other people. I know it sounds stupid but I don’t know. I’d never seen my mum cry until that happened, I don’t know, it was a bit strange” (5/89-91).

Sadly, the vast majority of the participants shared many times during their interviews that their friends, community, and workplace environments had caused them an additional emotional burden, a feeling of isolation and stigmatization. Participants talked about the subtle ways others had discouraged them to talk about their traumatic loss and the deafening silence that was imposed on them.

Laura talked about people avoiding her on the street, or how people were avoiding conversations about her baby:

Laura: “and people used to cross the road and stuff rather than talk to us at the time” (6/115).[...] No-one stops you from talking about it but you do get shut off very quickly if you try and talk about it with people if they don’t want to talk about it” (8/161-3).

Patricia used a very vivid metaphor in order to describe how others avoided her:

Patricia: “You were like – you were like the leper of – of every social circle, every – every scenario that you’d previously been part of you were the leper, you were the person that wasn’t talked to. And I know they did talk to people because they asked Mark (**her husband**) how – how’s Patricia, how’s things going, how are you, but they never...encountered me personally, never acknowledged my loss, um. So that was very hard to deal with because I had never imagined that would be the scenario I’d face after going back having the baby...” (10/250-257).

Claudia also talked on how others were avoiding the conversations for her baby but also suggested an explanation for their behaviour:

Claudia: “Oh some people are quite blatant about it. I remember when I first went back to work people would say I’m really sorry to hear what happened but obviously you don’t want to talk about that so let’s talk about this, you know. I think they have a problem with it more than me. I think they don’t know

how to approach the subject or talk about it. It's their own fears I suspect, um" (36-7/1005-1011).

Claudia suggested that the personal fears of people keep them away from bereaved individuals. As if bereaved mothers carry a contaminating grief, as if grief is leprosy as Patricia pointed out:

Patricia: *"I had been in a place where you feel like a leper, you know, that nobody wants to talk, nobody wants to – it's almost like they don't want you to, um, what's the right word, touch you with your sadness, don't make me – don't make me sad as well, don't make me...not dirty with it but I couldn't cope if you cried, oh God what would I do if you cried, I don't want to upset you and all this type of thing, and I remember thinking it's not about you, it's not about you being upset and you not being able to cope, it's about me, you know"* (15/390-97).

Being a leper carries a social stigma with many facets and the metaphor seems to convey the potency of the experience. Grieving mothers were seen as patients suffering a disease from which they should recover, patients that their mental status had been affected, and sometimes they were viewed as responsible for their misfortune.

The issue of a quick recovery is clearly described by Julia:

Julia: *"Everyone was great...but at first everybody is really alright then after a while people kind of – they don't expect you to be over it but I think they do subconsciously. A knowing smile there [laughs]. That first Christmas everyone – we just wanted to be on our own and that but by the next year you're supposed to move on and get on with it. It happened, you know, get on with life. People aren't like that outwardly, no-one says it to you, but you get that feeling of people and you get over sensitive about it"* (13/227-33).

While Patricia and Claudia described how they were perceived as irrationally angry and resentful:

Patricia: *"there was a scenario at work [...] a real big argument with my manager, [...] It was six – six to eight months after – after Marko was born, [...] it was like oh she's angry, you know, and upset, she lost her baby in December and all that. I thought I am being upset because you're giving me work that I don't want to do, nothing to do with that, you know."*

It was like people want to put you in this [...] they want to put the label on you and that defines you, you know [...] That was Patricia, yeah, that would be Patricia's identity because she lost the baby. That's why she's bitter and twisted, that's why she's angry. No it's not, you know, I lost the baby but I can still be angry about something else [laughs], I can still be upset about something else, you know" (17-8/459-76).

Claudia: *"And the reason I'm telling you that is this is to do with people's reactions. (a story about a neighbour and his pregnant wife) he expressed his condolences and all the rest of it and I said how's Helen, that's his wife, and he said well she's fine but she's not coming out of the house, she'll keep out of your way because she doesn't think you should see her. I said "Steve, she can't stay in the house for the rest of her life", I said tell her I don't want her baby [laughs], you know" (15/409-15).*

The sense of the unspoken blame, for things that the mother could or should have done that would have saved her baby, was often perceived, as Wilma describes:

Wilma: *"another friend, she got pregnant – as I lost him in the August, early August, she got pregnant the following year and she did ring me up and say I want you to know because of what you've been through but she said things like well my baby's meant to be and yours isn't and I was just like fair enough, I was very upset but let it go and then she rang me up when she was quite late into pregnancy and it was before the first year was up and she was sort of saying like oh I'm giving up work early, I'd hate anything to go wrong and she was asking my advice and I thought this isn't really very sensitive and I knew she knew another doctor and I couldn't – who'd had a baby successfully so I couldn't understand why she didn't ring her, um. I remember when I put the phone down just going absolutely hysterical, my husband said that's it, you – you're having nothing more to do with her" (13/296-306).*

Some, but not all, of these women had adequate support from their immediate environment, and nearly all reported being isolated or stigmatised to varying degrees while grieving their babies. To make a bad story worse, some of these women suffered problems with their employment, while their loss was dismissed even from medical professionals.

Shortly after their traumatic losses, women were encouraged by doctors to immediately proceed to another pregnancy. This stance gave rise to either feelings of aggravation, as it was considered indicative of the failure of others to understand their experience, or feelings of crushing guilt because of fear that the dead child would be forgotten or simply replaced:

Laura: “when I first lost her I didn’t think I’d want another baby because when I went to the doctors the first thing he said was oh you can have another one, that’s what he said about a week after and I thought no.[...] it felt like betrayal almost, and the memories were very fresh [...] it I just didn’t seem right, you know, not to give her enough time, you know, because it’s like you’ve forgotten her, isn’t it, if you don’t, you know, if you don’t wait a little while at least” (7/138-44).

Claudia: “one of my GPs who I went to see shortly afterwards, not my regular GP, said oh yes you should get on and have another baby, have another baby, and I was horrified and appalled by the idea because I felt that was replacing him and I didn’t want to do that at all ever” (49/1303-6).

For another participant, the medical professionals failed to inform her adequately about the causes of death and protect her from unnecessary emotional turmoil. Because of her medical identity, that mother had tried to come to terms with her guilt for not reacting faster to the baby’s distress, only to find out accidentally one and a half years later that her baby had died from such an acute event that nothing could have saved him:

Wilma: “when I was expecting my second, the one I’ve got, George, I had a nuchal scan and, er, the woman, I explained to her my history and she got my records because she worked at the same hospital and she was the one who said, she rang me up and she said oh you had a massive bleed, there must have been – it was a massive loss of blood. But nobody tells you anything at the time that might have made it easier” (4/76-80).

Stories of mistreatment in their professional contexts emerged from a small but not negligible number of participants. Three of them lost their job after their maternity leave, something that they experienced as an additional trauma. A world that made sense and was fair had already collapsed once with

the unexplained death of their healthy babies, and now this was happening once more soon after their loss.

Patricia: *“they behaved appallingly to me [starts crying] and I was treated very badly which really really hurt me because, um, I thought, you know I thought I was a senior and valued member of my employer where I worked and it just wasn’t like that. So that was a rude awakening, um” (she eventually lost her job); (9-10/243-246).*

Regina: *“I went back to work in the February, um, only to be told that my job, job had been relocated to Manchester. Um, so that was like the rug being pulled out again, I’d been there seven years. So I had options of leaving or doing a really sort of, um, a job I’d done when I was sort of eighteen and an admin role, this was the alternative” (11/265-69).*

Julia: *“before I had Angela I worked as a Research Scientist at the XXX (name omitted) and I really didn’t get on with my boss and when I was pregnant he re-graded my job and because it was a new grade he advertised it so I had to apply for my own job and the guy I’d been training up ended up getting it instead of me and I was told when I went back that I had to finish training him up on my job and presumably I’d be working under him then possibly. I don’t know, I was – I was screwed over basically and various people told me I should have taken him to various Courts because you’re not allowed to do that to mat – pregnant women, you know, really mess around with their jobs but I didn’t really care after Angela, that sort of thing didn’t matter to me” (16-7/287-96).*

Most of the participants had at least few people from their immediate environments to acknowledge their loss and share their grief. However, the vast majority of people around them made them feel disrespected, isolated and stigmatized. People from their communities and friends imposed a deafening silence about their loss on them, they avoided them, avoided conversations about the loss, they kept their babies away from them and assumed that as soon as they had another baby, everything would be great again. These women that had lost a much awaited baby with no warnings, and were struggling to process, cope with and adjust to their loss had to face the additional burden of a threatening social environment.

3.3.4 Introduction of Super-Ordinate Theme 4: Trauma Resolution and Growth

The fourth and last super-ordinate theme to be presented involves the way participants had managed to resolve their trauma. At the time of the interview different amounts of time had elapsed since the loss experienced by each participant; the time varied from 18 months to nearly 8 years, with an average of about 3 years. Additionally, through the preceding themes one could recognize that each participant was carrying different personal characteristics and circumstances. Consequently, participants were at different stages of their journey to resolution and growth. However, although for some of them the resolution of their grief was not yet reached, and might never be reached, the resolution of the trauma that a perinatal death encompasses had taken place, and that resolution had given rise to growth for all the participants.

3.3.4.A Theme A: The fountains of growth

The meaning that each of the participants had assigned to her loss affected their motivating energy towards change and transformation. Whether their loss was mostly painful because they lost a much awaited baby, or because it taught them in a harsh way that they were vulnerable to misfortune, or because of both, these women were motivated to understand and experience the positive changes occasioned by this traumatic loss.

3.3.4.A.a Sub-theme a: Growth as an affirmation of the baby's importance

Some of the participants talked about the long lasting differences in their personality brought about by maternity. Although their babies did not exist in this world, their love for them was ongoing and the changes in their lives were an affirmation of that love.

Charlotte, after the stillbirth of her son Edward, devoted a lot of her time to charity work with the aim of raising the public's awareness on perinatal death. She talked about her efforts to use her maternal love in order to offer this love to other people around her:

Charlotte: *“I think half of it was what I’d kind of done myself, how I felt in myself, the other half was what he gave us, I think, and what kind of people that he’d made us into. I know for certain now that I’m a much nicer person than I was two years ago [...] because of Edward I think I’ve changed completely 360° really in terms of the kind of person I am now and it –it’s enabled me to help other people now which I’d never have done, to be honest with you, two years ago, never have done” (8-9/199-206). [...] “I think because, yeah, I’ve become softer from that, I have softened actually because of the way I feel about Edward and obviously now with Phillip (**the baby she had since her loss**) as well. I’m even more amazed how you can love two people, you know, that much and still have room, you know, for more love. It’s lovely” (13/303-6).*

Similarly Patricia, a year after the death of her son, pursued studies in counselling. She talked about her conscious decision and effort to transform her pain and love into creativity and skill:

Patricia: *“I didn’t erase the whole experience, couldn’t have done that, you know, couldn’t have done it because that wouldn’t acknowledge the life, his life” (19/517-9). [...] Yeah and so many good things came my way because I – I altered the mindset...completely opposite. [...] and I had two babies on the course [laughs] and everybody thought I was – how do you cope, how do you do it, how are you doing a dissertation, how are you doing - and you just do it because I wanted to do it because it was my witness to my son, this is what it was all about and that was the – that was the driving force because I would have given up on it” (13/343-55).*

Julia talked with acceptance for the pain she still feels for her lost daughter, and the motivating power of this pain again expressed in her new devotion to charity work:

Julia: *“Things sort of keep me going, to see the positive side of everything. It’s great that so much positivity can come out of Angela’s life. I don’t want to just grieve, I just...I want – I want her to be for a reason, to – it’s just nice that she’s brought good. I can’t find the words for it [cries]” (12/217-20). [...] “there’s just times when it suddenly hits you, it sort of hurts in your chest. Early on I used to call it my Angela ache, or something,*

because it was really tight in your chest and you'd feel it and it rarely happened like that but it can do. But I have moved on a lot but it's always there. And I'm glad the way she's changed me" (16/278-82).

3.3.4.A.b Sub-theme b: Growth stemming from the awareness of personal vulnerability

The women who shared their stories encountered death when they expected it the least, at birth. For those that they experienced stillbirth, their own life was in danger while in labour. This trauma happened to them with no warning. After the phase of rumination and disillusionment they reached a what might be described as a sad but more 'realistic' understanding of a world in which they now lived knowing that they were vulnerable to misfortune.

Charlotte described her attitudes towards life before the death of her son, that she took everything for granted, now she had realized her personal vulnerability and this changes in attitudes towards life affected her attitudes towards other people as well:

Charlotte: "I would say before Edward I was probably, what's the word, I took things for granted probably, I didn't think things would happen to me. Even though I was aware there was a risk of things happening I never thought I would be that one percent of people and probably quite intolerant, probably very impatient and not very compassionate and now I think those things have gone completely the other way round so I think I'm the opposite of all of those things now" (9/207-12).

Charlotte realized that tragedy can strike everybody's life, including herself, as Wilma did, who also realized the limited control humans have over misfortune:

Wilma: "I think with time that's come through, is that these things happen, terrible things happen, horrible things happen and often it's just a random chance, it's nothing I did or, um, you know, it could have – I don't know what it is, is it one in a hundred [...] that's how I've come to terms with it really, it's just random acts, one of those things" (16/383-89).

For Regina and Lorna, the death of their babies made them realize their own mortality and the fragility of human life. This was not a threatening realization, but a realization that liberated them:

Regina: *“it made me grow in the sense that I realized how precious life was, because prior to that, I completely took it for granted. Completely. So that, that’s a personal growth” (11/260-2).*

Lorna: *“I’ve gone through stuff – I’ve gone through bad things now and I – you know, life – life is, um, life’s short. I – I guess there’s a sense of my – with that sort of world view changing I feel there’s a real sense of my mortality that I began to feel, um...and sort of life ticking away and that’s why I thought I’ve got to make the most of my life opportunities [...], before I’d just been sort of drifting along [...]. So, no, I guess I just – I’m just a bit more realistic about things and, er, and it – and need to try and change things within my power and although I know that not everything is within my power which I learnt – [...] you obviously (**learn that**)” (12/214-24).[...] “I guess the morality, I just became aware that, you know, I – I – I could have – I could have died in the process or I – I, um, you know, or I was thinking about the fact that people do die in the circumstances, um, and actually I hadn’t so I’ve got to make the most of the fact that I was still, you know, I was still alive...” (15/271-3).*

3.3.4.B Theme B: The Ripples of Growth

All participants experienced growth in many different areas of their lives. There were quantitative differences with regards to how many positive changes they could recognize. However, there were qualitative differences in their growth as well. Any positive change experienced by them had an undeniable impact on their lives; though some of these changes were transformative. The change towards growth was initially realized in their sense of self, and personal life choices and attitudes, while later it was reflected in their social self as well.

3.3.4.B.a Sub-theme a: Transformations in self perception: self-efficacy and self-worth

Since their loss, participants had survived the most painful and demanding time of their lives until then. They had coped with far more than

they thought they could, and now they were experiencing an increased sense of self-efficacy. This journey had brought them a deeper understanding of their inner selves and had helped realize personal qualities that they were not aware of until that time.

Patricia shared her process of personal transformation, a process that involved a deeper understanding and acknowledgement of her inner self and how this process led her later choices:

Patricia: *“It was like that person was gone, that person before. **You before?** Yeah me before and it sounds very dramatic that, doesn’t it, but, um, um, yeah, I just – I couldn’t be doing with any more falseness, any more bullshit, any more playing games, um, I think it just really clarified what was important to me and then identifying that that wasn’t important to me, these things that I had in my life, and shedding all that, you know, and going forward without those things and it meant friends and it meant, you know, many many different situations. What I carried forward was weird, your own inner self, that’s what I carried forward from it, it’s like the shedding of a skin.[...] I mean, I think it was a choice as well, I think I could have not done that (16/430-42).[...] I’d been through such a traumatic thing nobody could hurt me again in that way, you know,[...] it was like, um, you know, let’s give it a go, let’s just put ourselves out there and what’s the worst that could happen, well it’s already happened so [laughs], you know” (13/342-45).*

Regina’s sense of personal transformation could be summarized in the following quote:

Regina: *“I’ve become softer which has made me stronger weirdly” (18/428).*

As Regina was a very young and healthy woman, who had never encountered loss and tragedy in her life, the stillbirth of her son marked her passage to adulthood, and as an adult woman she felt strong and assertive:

Regina: *“(talking about the job she found after her loss) it was like, hang on, I wouldn’t have gone for, I don’t think I would have gone for that before because I didn’t have... well, I just thought “I’m okay here” you know “I’ll just plod along with work” and then I thought “If you don’t try you’ll never know” and it gave me more backbone, I thought, “God, if I can do that, I can do*

anything". If someone had said to me, "Right, Regina, we need you to get into this rocket and send you to the moon". I'd have gone, "Okay, strap me in". "I can do this" because I feel it made me feel like "Look, if I can do that, I can do anything" (11/273-81). [...] "I'm just stronger in the sense so if you say with relationships I'm, I might say previously have let somebody speak to me badly, whereas now I sort of say "Well I don't really feel that I deserve to be spoken to like that" ... whereas, you know, there's like an inner strength" (14/325-29).

For Laura and Claudia, who maybe had not been able to reach a sense of personal transformation, the sense of enhanced self-efficacy and the realization of their inner strength was present:

***Laura:** "I'm stronger now, a lot stronger. I think I surprised myself because you don't really get a choice when it happens. People say to me oh I don't know how you coped or aren't you brave and it's like well you don't really, you know, once it happens there's not much of a choice there is there, you've either got to get on with it or you can't but it certainly made me stronger" (5/97-101).*

***Claudia:** "maybe I realized that what you were actually talking about was survivors and maybe by that stage I realized that I had survived what had happened, um. I don't like the word recovered or, you know, or got over. I hate people who say you've got to move on. No I don't, he's still my son, you know. You don't have to move on but you can survive and I think I feel – I do feel a stronger person than I was before it happened" (43/1156-61).*

3.3.4.B.b Sub-theme b: Transformations in Perception and Attitude:

Appreciation of life and changed priorities

Their changed sense of self and their struggle with loss also altered what these women considered important in their lives. Patricia gave an indicative summary of those changes:

***Patricia:** "it changes your whole perspective on life, um. In many – in many kind(s) of spheres about the way we operate and things, in my own personal way..." (9/241-3).*

Wilma described how now she could appreciate the simple things in life:

***Wilma:** "but better to appreciate things more, appreciate – you appreciate – you know, when things are going well you don't appreciate it, do you? It's like*

the old thing, when you haven't got back pain you don't realize what back pain is until you've got it and then you moan about it all the time. We don't appreciate what we've got" (20/494-97).

As Wilma said attention was drawn onto the things they had in their life. Wilma as well talked about her different priorities and the appreciation she felt for the things she has in life:

Wilma: *"I'm not a materialistic person anyway but it's the old thing, isn't it, you know, money – money can't make you happy. You know, a lot of people think things, possessions will make them happy but they won't. [...] So it changed me from that point of view definitely, definitely (19/466-70). [...] "But I don't think things ruffle me as much like I say at work and things like that [...] ...not worry about things as much, yeah. And I enjoy being a family...and I probably enjoy it – I appreciate it more than I would have done if I hadn't been through what I've been through" (21/512-18).*

Also their scale of what is important and tragic was changed once and for all. Claudia talked about the difference in threshold of what can be upsetting or not and the appreciation she felt for things she has in her life:

Claudia: *"If some arsey Judge (**she works in the legal system**) wants to give me a hard time and have an argument about it I do not take them on any more, I just say whatever [laughs]. Um, I don't get anxious and worked up about money in the way I used to. I have less money now than I did then but I know it's not worth having a nervous breakdown about whether they're going to repossess the house or not because what's going to happen is going to happen and there are more important things in life and even if I haven't got my son here then I must look after other people who are close to me. Um, I think it's taught me that thing can – tragic things can and do happen every day to all sorts of different people and I could or you could be knocked down by a bus tomorrow, you know, so we must live for – we must appreciate what we've got. You're brought up to believe that but I think it drives it home" (46/1219-29).*

For Julia this shift in priorities was also evident in her career choices:

Julia: *"I now work in a completely different job with people I like and, career wise, I'm not going to go anywhere because I haven't particularly got any qualifications in IT where I now work...but I'm happy.[...]I work with people I*

like and that's important to me now (more) than a career. It's just not important, you just need to be happy" (17/302-9).

Regina had realized that maybe life is not the fairytale that she had dreamed of but she still had a lot in her life that have a great value, like her partner:

Regina: *"Well it's just such a, sometimes such a cruel world, it's not a fair world". We, you know, we have these fairy tales of; and they all lived happily ever after. [...] all these big parties, the chandeliers and you know, which sometimes, you know, you can go to a nice party with chandeliers, but that's not life is it, you know. My Richard hasn't got a horse as much as ... you know, as much as I'd like him to have one. But he, er, is, he is supportive and, you know, I think you've just got to try and make the best out of a bad situation really because otherwise all you do is make yourself worse" (23/561-69).*

Their families and the children they were able to have after their loss possessed a very different meaning for them, as they no longer appeared to them for granted. Laura, Wilma, and Julia talked about their children and their special position in the family:

Laura: *"Pamela is very special as well, well she seems extra special [laughs] because of what happened really, you know" (7/150-1).*

Wilma: *"The simple things. I mean, it – it's the silly things like I can sit there and watch George non-stop and I'm sure lots of people do that but maybe – maybe not to the same extent that I do or what I see in it. [...] I look at him in the bath and he's playing around for ages and I might just think, you know, Antony might cross through my mind and it's – and I do appreciate that chance I've had, you know, it's – cause it is – it – it gives you – well they're both special but one's here and one isn't, um" (20/499-505).*

Julia: *"And Nickolas in a way. I wouldn't have had him when I had him necessarily...and it wouldn't have been the same. And I wouldn't have- I might have taken him for granted more. I don't think I would have done, I have always wanted a little girl and a little boy and that's what I've got...but, you know, I do treasure every moment, or however you say it, with him because I know how lucky I am to have him..." (18/320-26).*

3.3.4.B.c Sub-theme c: Transformations in Relationships: Empathy and Companionship

Participants described the way that they relate to others had changed on many levels. During their struggle with their traumatic loss they realized who were the people that actually cared for them, and their bond with these people became even stronger. But the way they related to people outside their immediate environments also changed fundamentally. Each participant with her unique way of charting her personal pathway to growth described numerous occasions, where these changes were apparent.

Wilma, Regina, and Lorna shared the way their intimate relationships had changed for the better.

Lorna: "I feel like all my relationships have strength as a result of what happened with my family, with my partner, with my friends, um" (13/226-8).

Wilma spoke both for the friends who were there for her but also for the ones that did not exist in her life anymore:

Wilma: "it did make you look at your relationships with people differently, um. [...]The few (friends) that I've got...the few that were there for me definitely, definitely, yes, yeah definitely. Um, they were an absolute godsend. They could totally relate which I know now from myself it's not easy to do, um, but no I am closer to them. And some I've lost but maybe that wasn't a bad thing, you know, maybe they were just baggage or using me because – but, you know, it – it's a bit sad in a way that people didn't bother but, um" (13/307-13).

While Regina shared how her relationship with her stepdaughter, who has lost her biological mother, has changed:

*Regina: "like for example Maria (**her stepdaughter**), who I mentioned to you... lives with us, has lost her mother and she would some days she'd just look very down and [pause] and I never knew what to say. Now at that point I was able afterwards I was able to understand her more, understand her that she needed a hug, understand that there aren't any words, understand, because I've, understand that emotion" (10-1/249-53).*

Wilma and Patricia shared how they used their encounter with trauma and death in their professional contexts. Wilma, as general practitioner,

described now being a more empathetic doctor that would not anymore avoid death and tragedy:

Wilma: *“there’s so much negative about it that never goes away...but in work definitely, um, I found it much easier obviously to relate to people who’d had difficult times, especially death. I’m not frightened of it anymore, I mean, I don’t want to die but it doesn’t scare me as much, um, I suppose maybe because Antony went through it, he’s been through it so why should, why should it frighten me as much” (6/134-8). [...] “and you’re also able to bring the subject up and talk about it whereas before you couldn’t. It’s a taboo, isn’t it? The number of people that – you know, like I said, a number of patients would say to me that they’d lost a child and it might be many many years ago and they obviously wanted to share that which is – I felt privileged about that” (14-5/346-50).*

Wilma, after the death of her son, no longer perceived death as a taboo, as a subject hard to mention and this has made her offer the space to her patients to share their own pains and sorrows. Wilma also tried to undo her old “mistakes”:

Wilma: *“And I think it sounds morbid but with things like cancer I’m much better able to bring the subject up. I think before I did find it difficult talking about their news or dropping hints that there might be something amiss, um, and I’m very ashamed to say that once there was a little boy who died and he’d been ill for a while and I just – I – I avoided going round to the house because I just didn’t know what to say. I actually apologised – since I’ve lost Antony I’ve actually apologised to mum saying I felt awful that I never did but I just – But I felt I owed it to her because her son’s at the same cemetery as Antony and you suddenly realize that okay I was feeling awkward but she was going through all this time and I should have, however hard I found it I should have done something. But I since have apologised to her and said I did let you down there and that was my mistake, um, but I couldn’t have done that – I was just thinking of myself rather than thinking of her” (8-9/186-97).*

Patricia, a year after the death of her son, decided to go back to university and change her career. She decided to become a counsellor, here she explains why:

Patricia: “and then my mind moved to counselling and whether that would be something for me and especially about the experiences that I’d had that it might be something which would, er, as well as being able to offer something it might be something that I would get a lot out of” (12/323-26). [...] “I found that way of – of using what I’ve experienced in a – in a way that will help people. That sounds kind of really – I always think it sounds naff about counselling” (15-6/418-20).

Contrary to what one would expect she did not wish to specialize on bereavement but on trauma. Below she describes her approach to a female client she had who was abused and was self-harming:

Patricia: “So I could completely empathise with this woman, a whole different set of circumstances, a whole different – I didn’t know how she really felt or what her scenario was but I could – I could see that there was kind of [...] the emotion that was going with her so I thought, you know, that’s what’s, you know, and that’s a positive, I’m not afraid to go to these places that some people are at, you know, and to be there with them, not for them to be lonely in where they are, you know” (14-5/396-404). [...] “I always say to myself just be led by that person, whatever it seems that that person wants you to do. [...] But just to be there, just for another human being to acknowledge. [...] acknowledge that they’re real and what’s going on for them is real and genuine, you know, and not – even if it’s silence, silence doesn’t matter [...] you don’t have to follow silence with inappropriate words” (20/539-45).

Patricia was transformed via her struggle with loss and found a new career through which she will be able to help other people in turmoil:

Patricia: “So that’s the major positive really, isn’t it, that it’s altered – [coughs] -well altered my whole path of life really and I will now go and find a job or find some way to help people, you know” (16/427-29).

Charlotte, Regina, and Julia shared how their experience had changed their reactions to people who suffer from many different kinds of misfortune. Their different attitude was expressed to people in their immediate environments but also to strangers through charity work.

Charlotte, explained how her experience, becoming a mother of a stillborn boy, has affected her interactions with others:

Charlotte: *“probably quite intolerant, probably very impatient and not very compassionate and now I think those things have gone completely the other way round so I think I’m the opposite of all of those things now. [...] I mean, I’ve, um, obviously helped people who have been through what I’ve been through but just – even my friends at work and things, I’m more understanding of their situations and things and can empathise more really. Before I was like whatever, just get on with it, you know, but now I kind of understand people. [...] I think I’ve mellowed, even more now with Phillip, I’m very mushy [laughs]” (9/209-17).*

Charlotte became very involved with SANDS, she organized fundraising events, presented her story in conferences, and actively participated in the SANDS forum. Charlotte also proceeded with a formal complain directed at the hospital in relation to the treatment both she and her baby had.

Charlotte: *“They have changed it now, the procedures have changed because we made a complaint about it and I’ve worked, um well, the hospital to make them better so hopefully it won’t ever happen again. I hope so for everyone else. [...] I just thought it’s not fair that someone else has to go through that, you know. [...] and I thought if I can change something then it’s worth it. So hopefully they won’t ever go that way again but that really held us back a long time, I think” (5/122-8).*

Julia subsequently became involved in charity work. She worked not only for charities related to perinatal loss but also to children and animals and she has organized many fundraising events.

Julia: *“Oh, and some of the money went to the Neo Natal Maternity Unit as well...[...]. They didn’t have everything to hand (resuscitation equipment) so they spent our money on a Bristol trolley or something. Yeah, it’s a trolley that has all the GIFT kit in it and since then, when we went back in, um, because our counsellor thought it would be good for us just to look around and say goodbye to the place before it closed down...um, they showed us the trolley and they told us that one woman, at least one baby, was saved by it. So that’s great. So we just bought a trolley but it had helped. [...] and if any babies or mothers*

collapse we've got the Unit ready. So – I mean, if Angela had been caught an extra minute earlier, if they've got her to the resuscitation unit it wouldn't have mattered so I haven't got any – I'm not cross" (10-1/176-196).

While Regina talked about how different she felt in her everyday interactions as a result of her personal transformation and growth.

Regina: *"So that was a growth on that level, it was a growth of my understanding of, um, grief and loss and personal loss so that I could almost identify with other people that had [pause] lost a relative or someone very close to them..." (10/246-8).*

For Regina this experience was transformative in many levels, she emerged from this experience as a strong woman able to offer support to others:

Regina: *"there's times when I've said, you know, "Look, bad things happen, you know, if you need a hand or you need to talk to anyone, let me know, you know where I am". And other times where I can just see someone's face and give 'em a hug, you know. And, and I don't know if I would, if I could do that before. Yeah, I don't know if it does make you more whole or whether you just know yourself a bit better" (14/330-5).*

She, like many of the other participants, reported becoming more sensitive and empathetic towards the suffering of other people, regardless of the reason for their pain:

Regina: *"I think I'm the person that people ring if they needed to talk or – and often people have said to me, "Oh it's nothing compared to what you've been through". And I say "Don't be so silly, look, this is relative to you". [...] you can't measure it like you can't measure your pain, it's not, it's not a pint of milk" (12/291-6).*

The way these women related with others was not just changed to the better but was transformed. They could now realize their strengths and vulnerabilities and could offer their empathy and support to others undergoing difficult times, feeling deeply connected not only with those that remained around them during their struggle, but also with strangers going through their own personal tragedies.

Chapter 4: Discussion

4.1 Chapter Overview

This chapter aims to critically present the findings of the present research in relation and comparison to existing theoretical and empirical literature for each super-ordinate theme presented in the preceding results section. Furthermore, the researcher will present a suggested model of growth after a perinatal loss by emphasizing the subthemes that appeared to be essential for participants to experience growth. Additionally, the possible applications of the knowledge gained through this research on the practice of counselling psychology and psychotherapy will be presented. Finally, the strengths and weaknesses of the present research will be evaluated and suggestions for further research will be outlined.

4.2 Discussion of Super-Ordinate Theme 1: The Experience of Perinatal Loss as a Trauma

The first super-ordinate theme presents the experiences of participants around the time of their loss unraveling the traumatic characteristics of perinatal bereavement and can help the reader to become familiarized with the experiences and procedures associated mainly with stillbirth, since this experience remains largely unknown to the public. The participants talked in great detail about the days around the death of their baby although only the first icebreaking question of the interview schedule concerned this time period (see Appendix D).

4.2.1.A Discussion of Theme: Maternal Determination and Investment.

The first two themes described participants' determination to become parents, and their investment in their pregnancies. All participants were expecting their first child. All pregnancies were welcomed, and it can be noted that for some participants this pregnancy had come after reproductive treatments, operations, or miscarriages. During their pregnancies, participants

had provided the space both psychologically and physically to the expected new member of their families; and the vast majority of participants had followed all the routines that could safeguard a healthy baby such as medical examinations, diet, quitting smoking and alcohol etc. As Patricia very vividly described after all the treatments she had she was finally expecting a baby and her pregnancy became the period in which her and her partner adjusted into their new role as parents. The words of Patricia can help us understand the process of this life adjustment: **Patricia:** *“we were just kind of making lots of plans and sorting out – I think sorting out mentally as well as anything else, just prepare for the baby as you do, you know, you change from this couple into these people that are expecting a baby and almost, er, well you’ve almost become a family then, haven’t you, I always thought” (1/10-14).[...]“we had adjusted to being this family and all that was missing was the baby being born, you know. We’d done his nursery, we’d decorated, his cot was ready for him, er, you know, we’d made these adjustments” (19/520-523).*

4.2.1.B Discussion of Theme: The absence of predictability: Experiencing perfect pregnancies and babies.

The process of the psychological investment was enhanced from their uncomplicated pregnancies and the total absence of any information about the possibility of death. As Charlotte said they were assured that their babies were healthy and their pregnancies were progressing normally, but in the end they had to leave the hospital without a baby: **Charlotte:** *“especially after my last scan, you know the one they do at twenty two weeks and I’d checked and after that it didn’t even occur to me that anything could go wrong, we bought the whole nursery, we bought the pram, all the clothes, nappies and things, all laid out just like Phillip’s (**her living child after the stillbirth**) is really and, you know, you don’t get told, as you say, that something could happen, you’ll be overdue and you won’t bring the baby home” (2-3/46-50).*

It should be noted also that nearly none of the participants belonged to a high risk for stillbirth group as they were young, healthy, not obese, and not in poverty (Flenady, et al., 2011). On the contrary, most of the participants had

high educational and socioeconomic status, placing them in a low-risk group. Their smooth experience of pregnancy and the lack of any alarming medical information had as a consequence that they were completely unprepared to face the loss of their baby. Among the most prominent characteristics of traumatic events, are that they are beyond individual control and that they are unpredictable (March, 1993).

4.2.1.C Discussion of Theme: “No heartbeat”: The moment when the world collapses.

The third theme describes the moment when the mothers realized their babies had died. The vividness of their recollections years after their loss is indicative of the traumatic quality of those moments (Joseph, Williams, & Yule, 1997). For example, they remembered their movements and thoughts, but also sensations (e.g. gel on abdomen) or sounds (e.g. crisps). The narration of Patricia, eight years after her loss and after having three healthy babies, can help us feel the tragedy of those moments: *Patricia*: “*I know it was – it was bizarre as well because that was the first night that we were meant to be starting Parent-craft classes at the hospital [...] the midwife came and she did the basic, er, you know, jelly – jelly on the tummy and couldn’t get a heartbeat. [...] you didn’t know what she was looking for and no alarm goes off, does it. [...] when the penny did start to drop she said look we’re going to take you in now [...] I want the doctor to come and we’re going to get an ultrasound scan [...] the three minutes that he (the doctor) was looking – he obviously knew what he was looking for and it wasn’t there and he had to then impart the information to us, you know, and, er, and it was just horrendous, absolutely horrendous. It was like – it was like the whole world fell in [starts crying], it was absolutely awful, absolutely awful. [...] they don’t use words like death to you, do they, they just said your baby’s passed away, we can’t find a heartbeat and I just went to – Mark was absolutely devastated, you know, and we just – obviously you get very emotional and you kind of fall, you know, you literally fall on the floor [...]. You can’t possibly take in, you know, you can’t – you can’t understand what they’re saying, you know, but what do you mean, I don’t understand what you’re saying” (3-4/68-92).*

Participants unexpectedly were informed of the death of their healthy baby, and, in cases of stillbirth, they were confronted with the possibility of physical threat to themselves. These two characteristics of the event meet two more criteria for traumatic events, as set by the latest edition of the Diagnostic and Statistical Manual (DSM-IV-TR).

4.2.1.D Discussion of Theme: Having a silent birth: The entrance to a lonesome motherhood.

The subsequent themes present the experiences of participants while in hospital, the process of labour and delivery, their meetings with their babies, and their overall care while hospitalized. The quality of care that health professionals provide to a woman who loses a baby perinatally is considered crucial for her long-term well-being (Condon, 1987; Hughes, Turton, Hopper, & Evans, 2002; Rådestad, Steineck, Nordin, & Sjögren, 1996; Trulsson, & Rådestad, 2004). Despite improvements made in the last two decades in the management of such cases, it is noteworthy that still 3 years after a stillbirth, women experience twice the risk of frequent anxiety-related symptoms compared to women who gave birth to a living child (Rådestad, Sjögren, Nordin, & Steineck, 1997; Rådestad, Steineck, Nordin, & Sjögren, 1996). It has also been reported that while 0-7% of women after childbirth fulfill the criteria for PTSD diagnosis, the percentage rises up to 26% for women after a stillbirth (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008). The way the mother will experience labour and the meeting with her dead baby is considered critical for her future mental well-being (Condon, 1987; Rådestad, Steineck, Nordin, & Sjögren, 1996; Trulsson, & Rådestad, 2004). The recently published guidelines of the Royal College of Obstetricians and Gynaecologists (RCOG; Guideline No. 55, 2010) clearly note that vaginal birth is the recommended mode of delivery for women who experience an intrauterine death because it allows immediate recovery and has fewer negative implications for future childbearing. Nevertheless, because many women can find this experience very distressing “a careful and sensitive discussion and joint decision taking” should be followed by obstetricians (p.12). During the

interviews participants did not describe such a joint decision taking between them and their obstetric team, rather that the vaginal birth was imposed on them as mandatory. What Claudia remembered is indicative of the choices they were given: *Claudia*: “and she (a midwife) was explaining I have to come back in in two days to go through labour and all the rest of it and I was saying – I said but why, I don’t understand, they were going to do a caesarean (it was already agreed with the physician during her pregnancy), why can’t you do that and she said it doesn’t work like that, my darling, which was really patronising” (10/241-4).

The participants initially felt appalled by the plan of vaginal delivery, a reaction that has been also reported in a qualitative study conducted in Norway (Trulsson, & Rådestad, 2004). However, in both the present study and the study by Trulsson and Rådestad (2004) mothers felt fortified by vaginal delivery. Labour offered them a sense of achievement, since their bodies had managed to accomplish childbirth, and that came in sharp contrast to the feelings of failure engendered by not having been able to give birth to a living child. Similar feelings of incompleteness and personal failure because of the death of their babies in utero have been expressed also by participants in a qualitative study in Taiwan (Hsu, Tseng, Banks, & Kuo, 2004). In the present research project the participants accentuated another function of vaginal delivery, its contribution to the achievement of maternal identity. By giving birth, participants had achieved another milestone of maternal identity, childbirth. For these women, after about nine months of pregnancy, labour was the next and last act of motherhood that they were entitled to perform.

4.2.1.E Discussion of Theme: Death in the face of one’s baby: The first and last meeting with the baby.

Overwhelming evidence (an early randomized trial, observational studies, narratives) shows the beneficial effect of a relaxed meeting between parents and the dead baby (Cacciatore, Rådestad, & Frøen, 2008; Forest, Standish, Baum, 1982; Fox, Pillai, Porter, & Gill, 1997; Janssen, Cuisinier, Hoogduin, & de Graauw, 1996; Lovell, 1983; Malacrida, 1997; Rådestad, Steineck, Nordin, & Sjögren, 1996; Rand, Kellner, Revak-Lutz, & Massey,

1998; Samuelsson, Rådestad, & Segesten, 2001; Trulsson, & Rådestad, 2004; Welch, & Bergen, 1999-2000; Xiaoqin Lin, & Lasker, 1996). For example, Rådestad and colleagues (1996) found that the anxiety three to four years after a stillbirth was reduced if the woman had the option to spend as much time as she wanted with her dead child after the delivery, and if she had a token of remembrance of the child. Also Cacciatore, Rådestad and Frøen (2008) in an internet survey of 2.292 women who had experienced a stillbirth (1748 of them in the preceding three years), revealed that anxiety and depression were significantly lower for those who had seen and had held their baby as opposed to those who had not.

Nevertheless two important points should be stressed here according to Trulsson and Rådestad (2004); first, prior to meeting her dead baby, the mother should be prepared by her obstetric team who can provide her information about the status of her baby, and second, the mother should be encouraged but not forced to see or touch the baby, in case she is not willing or ready to do so. All of the participants in the present study were given the choice to see and hold their babies but were not given the choice of when to see their baby. They were all 'supposed' to see their baby immediately after birth.

In line with earlier findings (Condon, 1987; Lovell, 1983), they reported that their fantasies about the condition of their baby were much worse than reality. As Claudia remembered "*I had this awful fear because I knew nothing about stillbirth and nobody had told me any details or given me any information, I thought my baby was going to look horrible and deformed. I thought he'd be rotten with mug – you know, you think of a dead body and I thought he'd be all emaciated and rotten and, I was disgusted by it actually and that was what was actually really really making me scared*"(12/317-22). Unfortunately, for the vast majority of participants these fantasies were discounted by reality and not by information given to them by their obstetric team before meeting the baby. However, all of the participants agreed that seeing and holding their baby was a painful but good decision, since this was their only chance to meet their long awaited baby, feelings that have been reported in earlier studies as well (Lovell 1983; Rådestad, Nordin, Steineck, & Sjögren, 1996; Trulsson, & Rådestad, 2004).

The present findings contradict those of one study comparing the experience of 65 women who had a stillbirth to that of 60 control women who had given birth to a living child (Hughes, Turton, Hopper, & Evans, 2002). That study assessed depression, anxiety, and PTSD symptoms during the next pregnancy after a stillbirth and one year after birth for 65 women, and 60 women who had no experience of a stillbirth and were pregnant. They concluded that the women who had held their babies were more likely to be depressed than women who had only seen their baby, and the women who had only seen their baby were more likely to be depressed than the women who hadn't seen their baby. The same pattern of results was also observed for symptoms of anxiety and PTSD. This study, although it contradicts numerous other studies and regardless of the small numbers of both sample groups, apparently has been very influential as it is the only study given as a framework on this matter in RCOG guidelines (2010) that do not encourage a meeting with the baby.

4.2.1.F Discussion of Theme: Iatrogenic Psychological Trauma

The last theme, iatrogenic psychological trauma, presents the experiences of participants that resulted in additional pain and anguish for them. It became apparent that health professionals can improve the long-term well-being of a woman after stillbirth, first by avoiding to exacerbate her psychological trauma due to the loss of her child, and second, by empowering her to cope with the loss. Sadly, nearly all participants had experiences of health professionals that failed to protect them from additional trauma. In a meta-analytic research of 68 studies on trauma and PTSD symptomatology of adults, it was revealed that negative peritraumatic emotional responses had a significant correlation with PTSD symptomatology occurrence. The negative peritraumatic emotions explored were fear, helplessness, horror, guilt, and shame (Ozer, Best, Lipsey, & Weiss, 2003). When participants had just been informed of their children's death, they were under extreme psychological stress (and they were sent home with minimum information for two days on the average); when labour started for these women they were also in a state of

physiological stress; these two conditions left them vulnerable to additional trauma caused by the way health professionals managed the situation.

The existing literature, coming mainly from Sweden and Norway, clearly underlines the standardized necessary steps for the management of a stillbirth (Condon, 1987; Rådestad, Nordin, Steineck, & Sjögren, 1996; Saflund, Sjögren, & Wredling, 2004; Trulsson, & Rådestad, 2004) that apparently had not been implemented in the United Kingdom comprehensively at the time participants gave birth, since guidelines in the UK were only created in 2010 (RCOG, 2010). An old qualitative study that was conducted in four London hospitals had reported extremely negative experiences during the hospitalization of 22 bereaved mothers from perinatal loss, and especially for those that had experienced a stillbirth (Lovell, 1983). Lovell (1983) reported on the attitude the medical personnel exhibited towards these mothers and their babies; they had negated to acknowledge the maternal identity of the mothers and the human identity of the babies. In addition, the qualitative study by McCreight in Northern Ireland (2008) reported various insensitive hospital practices during the labour, and the meeting with the baby, but also regarding the available baby keepsakes. Half of the participants of the present research project endured less harsh hospital practices, but still half of them reported many negative experiences during their hospitalization, experiences that have been proven to be traumatizing in the limited existing literature.

Four of the seven participants that suffered a stillbirth, after the diagnosis of their baby's death were sent home with no information about labour and delivery and their appointment for delivery was scheduled for two or three days later. Saflund and colleagues (2004) interviewed twice 31 couples that had suffered a stillbirth in Sweden. Their research suggested that when parents are informed of the death of their baby they are subjected to severe psychological stress and "need support in their state of chaos" (p.136). The time between diagnosis and delivery is described as critical, and during this time information should be given to the parents about vaginal delivery and its rituals in a sensitive and considerate way.

In another nationwide population based study by Rådestad, Steineck and colleagues (1996) which used epidemiological methods in Sweden on 380

women who had stillbirth and 379 who had a live birth it was found that when delivery of the dead infant was delayed more than 24 hours, due to care routines, the risk of long-term anxiety-related symptoms increased fivefold compared with women who gave birth to their stillborn infant within 6 hours from the diagnosis. These findings were also confirmed by a qualitative study conducted in Norway by Trulsson and Rådestad (2004). One explanation offered for the strong association between long-term anxiety related symptoms and the time since diagnosis and delivery is that the state of carrying a dead baby entails a psychological trauma in itself, a trauma that increases with the duration. Another explanation is that longer duration increases the probability that events evoking a psychological trauma occur (Trulsson, & Rådestad, 2004). Finally, two medical implications of delayed labour should be taken into consideration as well; first, that the value of the postmortem may be reduced and second, that the appearance of the baby may deteriorate (RCOG, 2010).

The recommended way of handling stillbirths (RCOG, 2010) is after the diagnosis of death, to give to the mother as much information as she can absorb at that moment and then give her the choice of either going home or staying at the hospital for the hours until her labour is induced, and these hours should not be fewer than six and more than 24. This time range has been found to be the optimum in order for the family to comprehend what has happened and prepare for labour, but also to avoid further traumatization from the psychological stress caused by the prolonged apprehension exacerbated by the lack of information and control (Saflund, Sjögren, & Wredling, 2004). Unfortunately, only for two of the participants labour was induced within hours of the diagnosis, while the remaining were sent home for days without any information about the delivery, causing them additional psychological trauma.

Regarding the time of delivery, research (Saflund, Sjögren, & Wredling, 2004; Trulsson, & Rådestad, 2004) has stressed the importance of calm, dependable caregivers, who have time to give to the mother clear information, advice, and support about every step of the labour process. It has been claimed that the sense of lack of control during delivery, due to alienation from medical procedures followed, or to bodily weakness, may be psychologically traumatic

and pose a risk for posttraumatic stress disorder after birth (Trulsson, & Rådestad, 2004).

With two of the participants (Laura and Claudia) having extremely negative experiences from their caregivers and others narrating a number of lesser complaints (Charlotte, Patricia) it appears that the medical personnel in some hospitals have not been trained to handle stillbirths, thus causing additional trauma to these women. When midwives are crying over the mothers' beds, or women are left to give birth on their own, there is no doubt that they did not receive the care described in any guideline. What Laura remembered of her midwife was indicative: *Laura: "Um, they didn't really know how to deal with it, I don't think. Some of them were quite upset and they were crying and things" (2/16-7).[...]"and the midwife that were there she were dead upset and she were crying and it were horrendous..."(10/218-9).* However, the present research is not the first to report these kinds of experiences. In survey of 769 mothers in the US, who had experienced a stillbirth within the last 18 months (Cacciatore, Schnebly, & Frøen, 2008) physicians were the least commonly reported source of support, with one third of the sample reporting no support from the obstetric team. From a nursing perspective, DeMontigny and colleagues (DeMontigny, Beaudet, & Dumas, 1999) conducted a study in Canada, using open ended questionnaires with a sample of 20 bereaved parents after a perinatal loss which had taken place the previous 6 years. In that study parents also felt that health care professionals were uncomfortable dealing with them, avoided them, left alone while giving birth, and had rushed them to decisions about their baby's body.

It is a standard practice to take pictures, foot and hand prints, and a lock of hair from the stillborn babies (Rådestad, Nordin, Steineck, & Sjögren, 1996; RCOG, 2010). In a nationwide study in Sweden (Rådestad, Steineck, Nordin, & Sjögren, 1996) it was found that possessing no tokens from the baby resulted in a fourfold increase in maternal anxiety three years after the baby's death, when compared with mothers possessing two or more tokens. It is recommended that the pictures should be clear, and the dead baby washed, dressed and in clean clothing (no signs of blood) taken before major postmortal changes (Rådestad, Nordin, Steineck, & Sjögren, 1996). In the present sample

all mothers had at least one photo of their baby, although two of them had problems with the quality of the photos and had a single picture from a Polaroid camera. It has been suggested that these rituals of holding and caring for the dead body of a loved one is a way of realizing and coping with a loss; a way that has been used by humans throughout history and across cultures. These rituals can function as an antidote to helplessness, transforming and mediating grief, while facilitating a symbolic connection to the deceased (Beder, 2002; Boss, 1990; Miller, 1999; Romanoff, & Terenzio, 1998). If after a perinatal death bereaved parents are discouraged to hold their baby and they are not offered pictures and other reminiscences, then they will be deprived of the healing functions of rituals.

Regarding the aftercare that participants received, hospitals are supposed to provide to the parents as much information as possible about the causes of death, a referral for counselling and support, and mainly the time and space to recover before leaving the hospital (Rädestad, Nordin, Steineck, & Sjögren, 1996; RCOG, 2010). The vast majority of participants were given these options. One last remark of possible interest though is the amount of time these women spend in hospital after labour. Five of the seven participants who experienced a stillbirth were sent home within six hours after delivery. There are no official reports in the UK about the average time of discharge after a vaginal delivery; the researcher through a personal contact with a senior registrar of the NHS was informed that six hours are considered the minimum time after a vaginal delivery of a live baby, while 24 hours are considered the standard practice (personal communication, Makris, 2011). It is of interest that in the qualitative study conducted in 1983 from Lovell in four London hospitals she had also underlined the rushed discharge of women from the hospitals after a perinatal loss; but also Thearle and Gregory (1992) from Australia in their review article reported that this is a common practice after a perinatal loss.

Health services in the UK are under increasing pressure to be cost-effective. Since the implementation of changes in the care of mothers experiencing stillbirth in Sweden, severe long-term psychological morbidity after stillbirth decreased plunging from approximately 30 percent to nearly zero

(Janssen, Cuisinier, Hoogduin, de Graauw, 1996). This proves that the implementation of a more humane and structured management of stillbirth in the UK as well might be a very cost-effective improvement in health care; by eliminating the iatrogenic psychological trauma that usually accompanies stillbirth. The Royal College of obstetricians and gynaecologists published the first guidelines regarding the optimal care for women experiencing a stillbirth only in 2010 (guideline No. 55, Late Intrauterine Fetal Death and Stillbirth; RCOG) and we have to wait and see in the future the extent of their implementation and their impact.

4.3. Discussion of Super-Ordinate Theme 2: The Ripples of Loss

In the second super-ordinate theme participants talked about their love for their babies, the void death left in their lives, the sense of a lost shared future and sense of maternal identity and the threat over their reproductive ability. One should take into consideration that adverse psychological states after a perinatal loss become even more complicated because of the complex physiological effects that both pregnancy and childbirth, have on women who may find themselves vulnerable to depression, suicidal ideation, mood disorders, PTSD, and dramatic biochemical changes (Affonso, & Arimendi, 1986; Ayers, et al, 2008; Ballard, Stanley, & Brockington, 1995; Beech, & Robinson, 1985; Cacciatore, Schnebly, & Frøen, 2008; Hendrick, Altshuler, & Suri, 1998; O'Hara, 1995; Silver, 2007; Slade, 2006).

4.3.2.A Discussion of Theme: The amputated object relationship

The present results provide additional evidence for the theories supporting that attachment between a mother and her infant begins to develop early in the perinatal period and is already formed by the time of birth (Klaus, & Kennell, 1976; Rubin, 1975). Based on Bowlby's (1980) attachment theory, adult attachment has been differently conceptualized as a state-based syndrome and a trait-based tendency (Berman, & Sperling, 1994; as cited in Uren and Wastell, 2002). From the state-based syndrome perspective, grief is seen as a form of separation anxiety elicited by the disruption of an attachment bond.

Winnicott's (1958) seminal contribution to our understanding of the mother-baby attachment, suggested the term *primary maternal preoccupation* to describe the state of a mother shortly before and after birth when all her psychological and physical energy is focused on her baby and his/her needs. Perinatal loss disrupts this natural process of attachment, with the object of maternal fixation no longer being available physically.

Robinson, Baker, and Nackerud (1999) were among the first to suggest that the attachment perspective could enhance our understanding of perinatal bereavement. Uren and Wastell (2002), who tested empirically this hypothesis were able to confirm it. The 109 female participants (two to 207 months after their loss) reported all the feelings associated with a state-based syndrome such as yearning, disorganization and despair. The present findings also come to agree with Uren's and Wastell's (2002) results and add further support to the claim that a mother-infant bond is present prenatally. Participants spoke about the despair and emptiness experienced in their lives at the present but also looking into the future, leaving them disoriented as to what to do to fill this void. Wilma very vividly described this stage of her bereavement: **Wilma:** *"I remember lying in bed when I got home, um, after I'd had him thinking what's the point. Not that I was suic – I wasn't suicidal or anything like that, but I remember thinking what is the point, what's the point in getting up, there isn't, if I disappeared tomorrow it wouldn't matter. And that – that was sad but that is how I felt about it, is that, you know"* (7/155-58).[...] *"because I'd been excepted to be a mother and be a parent and time taken up so I'd really – in a way maybe not so much the meaning of life but I had to find myself again and that took me quite a long time"* (10/225-7).

It is of interest that the mothers, who spoke more about their sense of emptiness and lost future, were the same mothers that had also stressed their determination to become mothers, happily making any necessary adjustments during their pregnancy. This finding is in agreement with previous research (Bennett et al., 2005; Moulder, 1994; Robinson, Baker, & Nackerud, 1999) which has suggested that maternal attachment consists of a complex set of events, including not only tangible events, such as fetal movement, but also events such as preparation and adjustment to the pregnancy. It is argued that it

might not be just the gestational age or time spent with a baby that defines the strength of the attachment, but also the maternal investment in the pregnancy and the unborn child. The participants' reports of the love they were experiencing for the first time in their lives resonated Condon's (1993) suggestion that the core experience of attachment is love.

4.3.2.B Discussion of Theme: A socially unrecognized maternal identity

A perinatal loss involves not only the bereavement of a baby but also the woman's bereavement of herself as a mother. Mead (1934) argued that identity is developed and maintained in relation to others, while Rubin (1984) argued specifically for the maternal identity that is developed in relation to the child. It is through identifying the child that the mother identifies herself.

A first pregnancy has been perceived to be qualitatively different from subsequent pregnancies since it marks the passage from childlessness to parenthood and is a time of emotional and psychological upheaval (Gerber-Epstein, Leichtentritt, & Benyamini, 2009). During this major developmental transition, participants had to face death and their newly found maternal identity was expelled to a limbo state. The maternal role attainment was not completed, since they never had time with their babies although the maternal-infant attachment had progressed greatly. Participants made it clear that their bond with their children was ongoing, and thus their identities as mothers were continuing. This stability of maternal identity has been reported by many studies of bereaved parents following perinatal death (Uren, & Wastell, 2002), death of an only child (Talbot, 2002) and other types of parental bereavement (Rubin, 1984).

The apparent difficulty of feeling a mother without a child to mother was not the major difficulty that participants reported. It was rather the lack of recognition of that maternal identity by society that they found most painfully difficult. The absence of a socially visible child to mourn, and the lack of memories of shared life experiences exacerbated the lack of recognition by relatives and friends regarding the significance of the loss (Keefe-Cooperman, 2004-5). A perinatal loss is not considered by society as a significant loss. It is usually placed in comparison to the loss of an older child or an adult loved one

and the predominant media messages convey the impression that such losses can be avoided with good medical care and good health habits (Smith, & Borgers, 1988-9).

The difficulty of society to recognize those women's maternal identity is very much related to the society's difficulty to recognize the "person" identity of unborn children, resulting in the discouragement of open grieving for this type of losses (Cacciatore, & Bushfield, 2008; Keefe-Cooperman, 2004-5; Layne, 2003; Uren, & Wastell, 2002). The definitions of life and death are mainly dependent on social and cultural criteria (Kovit, 1978). Life and death is intimately related to social existence and non-existence. Stillborn babies do not have time for a social birth as this is preceded by their death (Peelen, 2009). The social status of a fetus is central to public and scientific debates on abortion, genetic research, in-vitro fertilization methodologies, and the legal status of an unborn child, when issues of abortion or protection from drug and alcohol abusive mothers are raised (Heriot, 1996; Layne, 2003; Morgan, 2002). However, in the present sample even Julia, whose daughter died neonatally, received the same reactions from society as the rest of the participants. As Julia said: *Julia: "Yeah, it was difficult with the whole being a mother but you're not a mother thing, that was very hard because she was my first. If you've already got a child I guess they distract you and you're already a mother but if it's your first you know you're a mother but because you've got no child no-one sees you as a mother"* (13/221-24).

It appears that in perinatal loss the experience of parents and the different perspectives of their social networks result in mutual incomprehension. Since the dead baby lacks the identity of a real person, the woman who gives birth to this baby lacks the identity of a mother.

4.3.2.C Discussion of Theme: The threatened reproductive ability

Historically, motherhood has always been considered to be a woman's natural destiny and mothers enjoy an idealized status in societies. Perinatal loss inhibits women to achieve this special status at the very last moment and evokes strong feelings of failure (Letherby, 1993; Zucker, 1999). As Layne

(2003) put it, society loves pregnant women, but only when the pregnancy is successful. The combination of the glorification of a happy, healthy pregnancy and the societal indifference towards this type of loss leaves women deprived of their babies, of the social status of a mother, and of their feminine identity.

Participants expressed their sense of biological failure. Because motherhood is almost synonymous with femininity, childless women (if loss happens in 1st pregnancy) are deprived of the most central element of their gender identity and, hence, personal integrity (Whiteford, & Gonzalez, 1995). Baruch and colleagues (1983) had pointed out that women are socialized to view their self-worth and femininity as linked to their reproductive potential (as cited in Holt, & Slade, 2003).

The present findings agree with past research on pregnancy loss (Borg, & Lasker, 1989; Gerber-Epstein, Leichtentritt, & Benyamini, 2009) reporting that a woman who has failed to successfully reproduce feels that her body has let her down, and perceives herself as disabled or defective. As Wilma described her feelings: **Wilma**: “Everybody said oh you’ll be fine next time but you-you don’t trust your body” (6/122). Consequently, the participants reported fear of greater loss and failure, experiencing the threat of infertility. Losing their children at that stage of their pregnancy or immediately after birth made women question their ability to bear a child and give birth to a healthy baby. This belief was expressed by the participants although nearly all of them had been reassured by medical professionals that their reproductive system had not sustained any permanent damage. This fear of infertility has been reported also by women that had experienced a miscarriage in a qualitative study conducted by Gerber-Epstein and her colleagues (2009). This last finding also relates to the theory of White-Van Mourik and colleagues (1992) about the grief factors specific to perinatal loss. One of the areas of loss according to this theory is the loss of biological self-esteem. Women experiencing a perinatal loss may feel physically inadequate, feeling responsible for their reproductive failure and thus losing their self-esteem regarding their biological abilities. When this loss occurs they possibly don’t trust and value their body as being any more capable to reproduce successfully.

Janoff- Bulman (1992), in her very influential book on trauma recovery, had claimed that traumatic events shatter an individual's fundamental assumptions; one of the three assumptions is that the self is worthy. Self-worth involves "a global evaluation of the self, and, in general, we perceive ourselves as good, capable, and moral individuals" (p. 11). The way participants judged their biological competence to successfully give birth and raise a healthy child, their competence to exert control over their environment so as to prevent a tragedy, coupled with the lack of societal validation of their maternal status and right to grieve possibly led to the shattering of their positive sense of self-worth.

4.4. Discussion of Super-Ordinate Theme 3: Working through the loss

The association of bereavement with "work" can be traced to the phrase "the work of mourning" coined by Freud (1917/1957, p. 166) to describe the painful process of grief. Although many of the aspects of the grief theory of Freud have been questioned and abandoned (Bonanno, & Kaltman, 1999; Stroebe, 1992; Stroebe, & Stroebe, 1991; Wortman, & Silver, 1989) the metaphor of mourning as a work that requires effortful cognitive and emotional investment still presents itself as very accurate. The experience of a perinatal loss leaves mothers having to deal with not only the impact of that loss in their lives (e.g. missing the child's presence) but also a loss of faith in beliefs, values, assumptions, and norms they once held about the way the world should be.

4.4.3.A Discussion of Theme: Rumination and Disillusionment

According to classical *social psychology theories of attributions* (Heider, 1958; Kelley, 1971) people should be motivated to believe that the world is controllable and predictable. When individuals experience traumatic unanticipated events, they try to explain why the event took place, what may have caused it, or who is responsible for the event (Downey, Silver, & Wortman, 1990).

Bereavement strikes mothers at a deep level, a level on which their whole existence is based (Braun, & Berg, 1994). The beliefs, assumptions, and expectations for past and future life events have been called *mental schemas* (Horowitz, 1986), *fundamental assumptions* (Janoff-Bulman, 1992), or *inner assumptive world* (Parkes, 1975, 1988). For the purposes of this research these terms are used interchangeably as they describe the same concept. Many *cognitive processing theories of trauma adaptation* (Horowitz, 1986; Creamer, Burgess, & Pattison, 1992; Foa, Steketee, & Rothbaum, 1989; Janoff-Bulman, 1992) suggest that traumatic events present a challenge to one's perception of the world and self. Consequently, adaptive coping is seen as the individuals' ability to integrate the new information inherent in the traumatic experience into their world and self views, either by assimilating the event into their existing worldview, or shifting their worldview to accommodate the new, event-related challenging information. The theory on *posttraumatic growth* by Joseph and Linley (*Organismic Valuing Theory of Growth*, 2005) has incorporated and elaborated this perspective about *assimilation* and *accommodation* of trauma-related information. Recent research has supported the applicability of such models to bereavement adjustment especially in cases of traumatic bereavement (Bower, Kemeny, Taylor, & Fahey, 1998; Michael, & Snyder, 2005; Stein, Folkman, Trabasso, & Richards, 1997; Wheeler, 2001).

On the first theme under this super-ordinate theme of "working through the loss" the efforts of participants to comprehend the loss through rumination are presented. *Rumination* has been defined in different ways by various theorists. The main distinction is that for some theorists the term rumination is used to denote exclusively negative, automatic, and intrusive thinking of an event, its causes, and consequences (Lyubomirsky, & Nolen-Hoeksema, 1995; Nolen-Hoeksema, & Morrow, 1993; Morrow, & Nolen-Hoeksema, 1990), while for others the term *rumination* entails event related recurrent thinking that includes making sense, problem solving, and reminiscence, whilst it is perceived as an essential step for the individual to take in order to process and integrate the traumatic material (Janoff-Bulman, 1992; Calhoun, Tedeschi, Fulmer, & Harlan, 2000; Martin, & Tesser, 1996). In both perspectives though rumination entails recurrent thinking, and due to this characteristic it applied to

this theme, without necessarily the judgement of whether it is a positive or a negative process. Calhoun and Tedeschi (2004, 2006) in their theory of posttraumatic growth have accepted and incorporated both definitions of rumination, assuming that they can coexist, considering that the engagement in the more deliberate and reflective type of rumination is predictive of posttraumatic growth.

The participants engaged in rumination in order to make sense of their traumatic loss. What happened to them and their children was seriously violating their pre-trauma fundamental assumptions. Participants struggled to answer “why?” and “why me?” questions about their loss. Initially they searched for medical explanations, through the post-mortem examinations; they wondered whether their emotional state during the pregnancy or the procedure of amniocentesis had harmed the baby. They were also wondering why other women who engage in high-risk behaviours during their pregnancies, such as substance use, have healthy babies or how come it had happened to them who were going to be good and devoted parents. The pattern among these thoughts is that participants were trying to understand their loss through their existing fundamental assumptions, which state that the world is a just, controllable, and meaningful place where misfortune is not arbitrary and haphazard.

The *person-outcome* and the *action-outcome contingencies* presented in the theory of Janoff-Bulman (1992) reflect popularly accepted conceptions of justice and control also found in the present sample. The *person-outcome contingency* implies the principle of personal deservingness, that people deserve what they get in life based on their character. An instance of this type of reasoning was when Regina said: **Regina:** “Um and so I did think why, why my baby, when I would have been a good mum and there’s people that clearly can’t look after themselves let alone, you know, which is why I waited till I was older, you know” (19/458-460). The *action-outcome contingency* expresses the assumption that we can directly control what happens to us through our behaviour, so when the behaviour is not appropriate then misfortune can result. When Laura was mentioning cases where the behaviour of people should led to misfortune the action-outcome contingency assumption was expressed: **Laura:** “Everybody has babies, people take drugs and they have babies and that’s

what really got me mad. You have people drink, you see them in pubs really heavily pregnant drinking and they have babies and they're fine and I couldn't understand why it just went like that. I mean, I was a bit stressed but I was making sure that I wasn't that stressed so I can't even blame that". (12/243-47).

This process of initially examining the traumatic material based on one's existing fundamental assumptions has been named *meaning-as-comprehensibility* (Janoff-Bulman, & Frantz, 1997), *sense-making* (Davis, Nolen-Hoeksema, & Larson, 1998; Gillies, & Neimeyer, 2006) and *situational meaning* (Park, & Folkman, 1997) with all these terms reflecting the efforts exerted to fit the new material within a system of rules and theories. The surfacing of the why questions after a trauma or a traumatic loss have repeatedly been reported in the existing theoretical and empirical literature (Davis, Nolen-Hoeksema, & Larson, 1998; Gillies, & Neimeyer, 2006; Holland, Currier, & Neimeyer, 2006; Taku, Calhoun, Cann, & Tedeschi, 2008; Taylor, 1983; Wong, & Weiner, 1981), especially in relationship to bereaved parents (Braun, & Berg, 1994; Calhoun, Tedeschi, Fulner, & Harlan, 2000; Murphy, Johnson, & Lohan, 2003; Wheeler, 2001; Winje, 1998).

Regarding the theoretical debate whether *ruminatio*n is a negative or a positive process, the present data suggest that it is more of a natural and essential process after a traumatic loss that does not necessarily require a qualifier. However, the quality of the ruminative thoughts presented by participants is more related to the type of rumination described as negative, intrusive automatic thinking by Nolen-Hoeksema and colleagues (Lyubomirsky, & Nolen-Hoeksema, 1995; Nolen-Hoeksema, & Morrow, 1993; Morrow, & Nolen-Hoeksema, 1990).

In the theme "rumination and disillusionment" the first conclusions of rumination are also presented. Some participants bitterly realized that their existing mental schemas could not explain their traumatic experience and that possibly the world is random and unjust. They started to realize that a rapist could win the lottery regardless of his bad character and actions, that medical care cannot provide them the means to control the course of events, and that this world is far from ideal. Participants also spoke about their mixed feelings

towards this realization and fluctuated between anger and acceptance even at the time of the interview. This however is in agreement with the literature which claims that parental bereavement is a life-long process (Gerrish, Steed, & Neimeyer, 2010). The fluctuation between acceptance and anger was described from Patricia as well as her realization that an ideal world does not exist: *Patricia: And then, er, and I, you know, you just think oh if it was an ideal world, then anybody who has babies, whether they reported that there was a problem beforehand or whether it was their first baby, if they could be monitored the whole way through I wouldn't have lost him but that's not how it works, that's not how it works. So sometimes I get a little bit, you know, oh he would still be alive because they would have picked up on his growth not being as good maybe and, you know, but that wasn't, you know, I suppose, you know. I sometimes have a struggle with it, that's part of grieving, isn't it, you know, sometimes. Not regrets, I don't have any regrets, I just have questions"* (19/502-515).

This realization has been described as the shattering of assumptions or disillusionment, as the previously held positive illusions about life become seriously challenged (Calhoun, & Tedeschi, 2004, 2006; Janoff-Bulman, 1992).

4.4.3.B Discussion of Theme: Oscillating between Action and Avoidance.

When cherished old assumptions were seriously challenged participants were in disequilibrium and terror, since on top of their bereavement their past understanding of the world had collapsed but no new understanding had emerged that was not either totally threatening or uncontrollable. The second theme presents all the processes involved in the integration of the traumatic material in their mental schemas. Participants' cognitive and emotional activity was oscillating between approaching and avoiding the threatening traumatic material.

The approach-avoidance distinction is not new; it has its historical roots in Freud's psychoanalytic theories on defence mechanisms and working through (Freud, 1915/1957). In the recent decades many different theorists of the cognitive tradition have suggested different approach-avoidance coping formulations (Carver, & Scheier, 1994; Folkman, & Lazarus, 1985; Horowitz,

1976, 1979; Mullen, & Suls, 1982) which were also integrated in theories of trauma adaptation (Foa, Steketee, & Rothbaum, 1989; Janoff-Bulman, 1992). After the phase of the initial rumination over their loss new threatening material had emerged which needed to be processed and integrated into their mental schemas, but this is not considered a very easy process. Incomprehensible traumatic material is prevented from being completely processed and remains in active memory exercising a constant pressure towards processing (Horowitz, 1976, 1979). Denial is believed to be motivated “*by the need to protect the ego from the overwhelming power of the stressor*” (Roth, & Cohen, 1986, p. 814). The terms *denial* or *avoidance* in all *information processing coping theories* connote emotional, cognitive and behavioral reactions of numbness, removal of material from consciousness and from memory, behavioral constriction, and avoidance of reminders of the stressor (Creamer, Burgess, & Pattison, 1992; Horowitz, 1976, 1979; Roth, & Cohen, 1986)

Some of the participants created very rational explanations about why soon after their loss went back to work or other activities maintaining old routines and identities (e.g. childless full-time employee, doctor). During the interviews, women revealed that the motive behind those choices was either an effort to get rid of what had happened, or to hold on to their existing identities and find meaning and purpose in life through them. As Charlotte reflected on her initial choice to go back to work: **Charlotte:** “*I think I wanted to – what’s the word, not get rid of them but I wanted to get back to me and get back to – well to try and get back to what I was before which obviously wasn’t going to happen because I didn’t have what I’d been expecting for the last nine months. So I think initially I went back to work for to try and get rid of what had happened, I think, initially*” (11/ 267-271).

In cases where another pregnancy was attempted very soon after their loss and very early in their bereavement they expressed their realization that these attempts were possibly stemming from their desperate need to get their lost baby and maternal identity back. One participant mentioned her initial ambivalent feelings towards her subsequent child because he was not the same gender as the dead baby. Literature has indicated that after a perinatal loss, the

mother develops lower levels of prenatal attachment during the next pregnancy (Armstrong, & Hutti, 1998), and in case this happens soon after the loss (next baby born 12 to 19 months after the loss) there are significantly higher incidences of *disorganized attachment* of the subsequent child to the mother (Heller, & Zeanah, 1999; Hughes, Turton, Hopper, McGauley, & Fonagy, 2001). The story of the above mentioned participant can confirm only Armstrong and Hutti (1998) since eventually, after the pregnancy was successfully completed, she accepted and valued her new baby and that possibly affected positively the baby's attachment (who was 4 months old at the time of the interview).

For two of the participants the engagement in avoidance behaviours appeared to be prolonged. Those two women (Laura and Lorna) were avoiding acknowledging the pain and loss both in the external realities but also in their emotional worlds. When this pain and loss was acknowledged by others, then they felt extremely uncomfortable and they perceived their reactions as pity. In their efforts to avoid their recent history and the reactions of others they preferred to change professional environments. In *stress and coping theories* the function of *denial* as a coping strategy is controversial (Carver, Scheier, & Weintraub, 1989). For some theorists denial is perceived as useful because it can minimize the distress and thereby facilitate coping (Cohen, & Lazarus, 1973; Wilson, 1981). For others *denial* can only serve this function only at the early stages of a stressful encounter because later or excessive use of *denial* can impede coping (Levine, Warrenburg, Kerns, Schwartz, Delaney, Fontana, Gradman, Smith, Allen, & Cascione, 1987; Mullen, & Suls, 1982; Suls, & Fletcher, 1985). Closer to the later view of denial is the term *avoidant emotional coping* (Folkman, & Lazarus, 1985) that has been considered a maladaptive coping strategy that has been found to be a significant and substantial predictor of both *Complicated Grief* (Holahan, & Moos, 1987; Prigerson, et al., 1995; Prigerson, et al., 1997) and *Posttraumatic Stress Disorder* (Schnider, Elhai, & Gray, 2007; Steward, 1999).

Whether *denial or avoidant emotional coping* is adaptive can be answered at least partially by the last quote of this subtheme. This participant who had exercised various avoidant strategies shared with the researcher that

still at the time of the interview, two years after her loss and with a ten-week-old son, was still in disbelief about the death of her firstborn child. Disbelief is considered an emotional reaction of the very early stages of bereavement (Rubin, 1984-5; Tedeschi, & Calhoun, 2004a) and in this case can be considered as indication of an incomplete assimilation of the traumatic material. However, this quote could also reflect a fluctuation between denial and acceptance that continues long after bereavement, especially among bereaved parents (Cordell, & Thomas, 1997). However, most of the participants did engage only initially in some form of avoidance or denial; providing to themselves the necessary mental breaks from their harsh reality. Only very few of them, one could say, actually engaged in avoidant emotional coping where periods of avoidance were very much prolonged and expressed in different spheres of their lives.

In the second sub-theme “cognitive-emotional coping mechanisms” such as self-blame, downward comparisons, and benefit-reminding are presented. The cognitive-emotional coping mechanisms presented in this theme reflect the women’s engaged efforts to rebuild their shattered assumptions. The initial path towards this goal was reinterpretation of the traumatic information. The engagement of participants in these coping strategies was alternated with periods of avoidance. When observing these cognitive strategies it is very useful for a researcher to have in mind what Janoff-Bulman (1992) underlined regarding this process of reinterpretation, pointing out that “survivors are motivated by recovery, not accuracy in attributions” (p. 123).

According to *attribution theory* (Heider, 1958; Kelley, 1971) after a traumatic and uncontrollable event, individuals make *causal attributions* that facilitate adaptation by helping them feel as if they are in control of their environment (Kelley, 1967; Wong, & Weiner, 1981) and their own reactions (Taylor, 1983). For these participants their initial efforts to attribute their babies’ death to medical reasons had failed. Since they could not find an explanation through the facts they were provided with, a process of cognitive reappraisal of the traumatic experience was facilitated.

According to the *defensive attribution hypothesis* (Shaver, 1970; Tennen, Affleck, & Gershman, 1986; Walster, 1966), self-protective motives

mediate people's perceptions of tragic events. Traumatic events can create the need to believe that the event could have been averted and thus could be avoided in the future. *Self-blame* can serve as a *defensive attribution* because it defends against the conclusion that traumatic events are random and uncontrollable; it restores a belief in an orderly, controllable world, and thus allows the individual to feel that a tragedy could be avoided in the future (Janoff-Bulman, 1992; Tennen, Affleck, & Gershman, 1986). This last aspect of the benefits of self-blame, the sense of control for future tragedy, was especially relevant to these participants; they had just lost their first baby and they were hoping to give birth in the future to other children. In order for some of the participants to build a new understanding of the world they needed to re-appraise what had happened in a way that would allow them at least to restore their belief in a controllable world. Julia whose daughter died neonatally of a lethal metabolic condition blamed herself for having breakfast instead of being next to her daughter: **Julia:** *"I felt – I blamed myself at first for not being with her when I was sitting there eating away at my toast and there was a lady changing my bed and she'd just come back off holiday and I was chatting to her and that and Angela was lying next to me not breathing and I didn't know that at the time. And that came back to me a lot"* (7/117-120).

A high incidence of *self-blame* has been reported in previous research studies of parents of acutely ill or handicapped newborns (Affleck, Allen, McGrade, & McQueeney, 1982; Affleck, McGrade, Allen, & McQueeney, 1985; Tennen, Affleck, & Gershman, 1986), of chronically ill children (Affleck, Allen, Tennen, McGrade, & Ratzan, 1985), and bereaved parents after a SIDS death, miscarriage, or perinatal loss (Downey, Silver, & Wortman, 1990; Jind, 2003; Madden, 1988). Jind (2003) surveyed twice during the first year of their bereavement 71 parents, who had lost a baby from the 15th week of pregnancy to two years after birth, Measures on trauma symptomatology and attributions were used. Regardless of the very lenient inclusion criteria, and the confounding effects of gender differences (gender differences were evident in the analysis), and other methodological limitations (e.g., the groups created for the purposes of the statistical analysis), Jind (2003) reported that 61% of the participants had wondered frequently or all the time "Why me?" or "Why my

baby?'. Furthermore 25% of the parents, 1-14 months after their loss, had considered themselves responsible to the death of their baby, while 43.6% sometimes considered themselves responsible. There was a significant decrease of these percentages in the measurement that took place 15-61 months post-loss, with 12.2% still considering themselves responsible, and 26.1% sometimes considering themselves as responsible. Finally, it was reported that self-blame tends to significantly decline with time.

This last conclusion was also supported by Downey and colleagues (Downey, Silver, & Wortman, 1990), who conducting research with 124 bereaved parents after SIDS death, found that attributional concern tended to decline with time. At least for some of the participants this explanation appears plausible, their self-blame being a strategy used in order to cope with their loss and restore their belief in a controllable world that faced away with time.

However, two participants appeared to be battling with self-blame, so that this could not be considered as an adaptive coping strategy. The intensity of their self-blame evoked persistent feelings of guilt. Guilt has been previously reported as a problematic feeling related to maternal mourning, especially after a perinatal loss (Barr, 2004; Barr, & Cacciato, 2007-8; Brice, 1991; Hazzard, Weston, & Gutterres, 1992; Tedeschi, & Calhoun, 2004b; Wheeler, 2001). The two mothers who reported feelings of guilt were very different from each other. One, being a doctor herself, had unrealistic expectations about her ability to control and prevent this tragedy. Her sense of personal control was seriously undermined from her loss and this fired guilt related to her investment to her medical identity in general. The other participant was struggling with guilt because she believed that she had failed to provide an ideal prenatal environment to her child due to her relationship issues at that period. Although she was reassured from the doctors that her actions had not caused her baby's death, the lack of any other medical explanation exacerbated her guilt. A characteristic common to these two participants that will be presented in a following sub-theme, is the complete absence or poor quality of social support which possibly diminished their ability to work through their emotional anguish.

The other two cognitive-emotional strategies employed by participants, *downward comparisons* and *benefit-reminding*, also involve processes of reinterpretation of the traumatic material. One of the most well known and widely accepted theories in psychology is the *social comparison theory* by Festinger (1954); this theory expresses the notion that individuals evaluate their outcomes by comparing them with that of others. These comparisons are usually serving: (a) *self-evaluation*, where comparisons are made for the individual to receive diagnostic information especially about his or her own abilities; (b) *self-improvement*, where comparisons are made in order for the individual to obtain information on how to perform better; but also (c) *self-enhancement*, where the individual performs comparisons with others who are not necessarily similar to him or her and are less “successful” in order to feel better about herself or himself (Janoff-Bulman, 1992). When individuals are experiencing negative emotions and feel threatened, social comparisons serve an emotionally palliative function, and are named *downward comparisons* (Wills, 1981). Two theorists of trauma adaptation, Shelley Taylor and Ronnie Janoff-Bulman with their colleagues, described and incorporated in their theories the concept of *downward comparisons* (Brickman, & (Janoff-) Bulman, 1977; Janoff-Bulman, 1992; Taylor, 1983; Taylor, & Brown, 1988; Taylor, Wood, & Lichtman, 1983).

Following traumatic events, the pervasiveness of *downward comparisons* has been demonstrated among survivors of various types of trauma and perinatal loss; these comparisons allows them to feel better about themselves and usually revolve around the themes “it could have been worse” and “I am coping well compared to him or her” (Janoff-Bulman, 1992; Taylor, Wood, & Lichtman, 1983; Uren, & Wastell, 2002). The comparisons performed by the mothers participating in the present research were echoing these earlier findings. The present participants compared themselves with mothers of seriously handicapped children, with women that because of a reproductive loss they lost their ability to reproduce forever, or with others that apparently were coping less effectively than they did. According to Janoff-Bulman (1992) these comparisons are important means of minimizing the threat and malevolence of one’s victimization. The comparisons serve as re-appraisals of

the event that now can feel as less catastrophic and hostile and the world can again be seen as less malevolent and random.

The last coping strategy included in this third theme is *benefit-reminding*. As already presented in the introduction section, whether finding benefits is an illusory coping strategy or a positive outcome after a traumatic event, it has received intensive scholarly interest and has been explored in various theories (Affleck, & Tennen, 1996; Davis, Nolen-Hoeksema, & Larson, 1998; Janoff-Bulman, 1992; Park, & Folkman, 1997; Taylor, 1983; Calhoun, & Tedeschi, 2006). Despite the continuous production of scientific overlapping nomenclatures on *benefit finding/reminding* and *growth* that has not fostered a deeper understanding of when growth is an illusory coping strategy and when it can be considered an outcome.

The present results suggest that both phenomena are true for bereaved mothers. In support of the theories, developed by Affleck and Tennen (1996), Park and Folkman (1997), Gillies and Neimeyer (2006), Davis and colleagues (1998), the participants did engage in benefit-related cognitions on positive consequences of “side effects” of their loss in order to cope, a coping strategy that has been named *benefit-reminding*. However, the thoughts of participants presented in this theme lack a transformative quality and can be perceived as merely intellectual reflections missing strong affective components. Lorna’s thoughts on her change of career is indicative: **Lorna:** “*and then I sort of used – and then I thought right, um, you know, my life hasn’t quite turned out how it’s meant to do so what – what am I going to do now...and, um, and that’s when I decided to sort of give up my – my – you know, my career – my – my desk – my job on the Newspaper and go freelancing in a different direction...because I – I thought this is an opportunity, I – I’m – I’m – I’m – I’ve got this time off I’m being paid for to have a breathing space to decide what I want to do in life, um, it’s not quite how I planned but, you know, why not use the most – why not make the most of it. So we – so I did and it’s been, um, you know, I – I’ve kind of really – it was a good decision and I’ve kind of, you know, the last eighteen months I’ve had some pretty amazing, you know, experiences around the world and done lots of things that I wouldn’t have been*”

able to if I've had a baby. So, I mean, I'm not saying – you know, you sort of – you compensate (7-8/132-144).

According to Calhoun and Tedeschi (2004) the transformative quality and the affective components of these reflections are essential in order for positive changes (or perceived benefits) to be perceived as *growth*. Affleck and Tennen (1996) defined *benefit-reminding* or benefit-related cognitions as coping strategies during difficult times, while Park and Folkman (1997) claimed that any benefit related cognitions, possess an established situational meaning and do not reflect a revision of core beliefs, a revised global meaning, and should be viewed only as a coping strategy. The qualitative difference of these reports of benefit from the ones presented in the fourth super-ordinate theme highlight the actual existence of this distinction between growth as a coping strategy (or benefit finding/reminding) and growth as an outcome.

4.4.3.D Discussion of Theme: Religious or Spiritual Coping

On the fourth theme religious and spiritual coping processes are presented. Generally in research these two terms are used interchangeably (Becker, et al., 2007); however, one could distinguish the two terms based on their focus, where *religion* connotes an organized group and their shared beliefs while *spirituality* connotes individual beliefs of transcendent reality (Tedeschi, & Calhoun, 2006). The relationship between religion/spirituality and bereavement is apparent, since throughout human history people engage with religion when facing death. Many aspects of culture such as art, literature, and religious literature have repeatedly exemplified the link between religion and facing death (Wortman, & Park, 2008). Schuchter and Zisook (1993) have suggested that one of the most frequently used and effective ways of coping with death is through religion as it facilitates meaning-making. Bereaved individuals usually turn to religion/spirituality seeking comfort, coping resources, and a meaning framework (Pargament, Koenig, & Perez, 2000; Wortman, & Park, 2008).

The role of religion to an individual's adjustment including to traumatic events has been well documented (Calhoun, Tedeschi, Cann, & Hanks, 2010; Matthews, & Marwit, 2006; McIntosh, Silver, & Wortman, 1993; Overcash,

Calhoun, Cann, & Tedeschi, 1996; Pargament, 1990; Tedeschi, & Calhoun, 2006). Furthermore, *religious/spiritual coping* has been considered a predictor of *posttraumatic growth* (Calhoun, Cann, Tedeschi, & McMillan, 2000; Calhoun, Tedeschi, Cann, & Hanks, 2010; Shaw, Joseph, & Linley, 2005; Tedeschi, & Calhoun, 2006; Znoj, 2006). Two of the functions of *religious coping* are very relevant to bereaved parents; first, that religion can help bereaved individuals to find meaning or an explanation to an otherwise inconceivable event, and second, religion can offer comfort and solace through its claims about after-life (McIntosh, Silver, & Wortman, 1993; Tedeschi, & Calhoun, 2006).

In the present research the death of the healthy babies of participants seriously challenged the mothers' fundamental assumptions about the meaningfulness, malevolence, and justice of the world. However, core religious beliefs (God has His Divine Plan) can be resilient to empirical disconfirmation and still provide to the bereaved a framework for understanding and accepting death (Overcash, Calhoun, Cann, & Tedeschi, 1996). The present results do replicate previous findings on bereaved individuals and parents, suggesting that religious views can help a bereaved parent assimilate the traumatic material into existing schemas, rather than accommodate the traumatic material and create new revised schemas. This means that bereaved parents can make sense of their loss through the acceptance of God's plan and thus find solace in the idea that the world is not random but follows His Divine Plan that they are just too small to understand (Braun, & Berg, 1994; Joseph, & Linley, 2005, 2008; McIntosh, Silver, & Wortman, 1993; Murphy, Johnson, & Lohan, 2003; Overcash, Calhoun, Cann, & Tedeschi, 1996; Park, & Folkman, 1997; Tedeschi, & Calhoun, 2006). Remembering Laura's words can help us understand this process: **Laura**: *"I just felt that, you know, it wasn't meant to be, you know. Yeah I think the best thing is, you know, if you're thinking that they're took away because they're special or that they're chosen or something, that's a nice thought but, you know, like I said, when they say they believe in God a bit more it has me. I believe in stuff like that, yeah. If I didn't think she was in heaven I couldn't go on"* (4/65-71).

However, most of the participants had not reported any religious affiliation in the demographic information questionnaire and this was reflected in the way they used religious coping that should be actually seen in this case as spiritual coping. As suggested by Tedeschi and Calhoun (2006) a person without a religious perspective or a spiritual awareness before a loss may reconsider his/her beliefs after a loss and begin to experience something beyond the strictly observable and material, through the experience of a continuing bond with the deceased. The issue of *continuing bonds* with deceased loved ones has been controversial in the bereavement literature for very long (Boerner, & Heckhausen, 2003; Bonanno, & Kaltman, 1999; Field, 2006; Klass, 1993, 1997; Stroebe, & Schut, 2005). However, the current view of most bereavement theorists is that *continuing bonds* can provide solace, comfort, support, and ease the transitions from an individual's past to his or her future (Klass, Silverman, & Nickman, 1996). Shuchter and Zisook (1993) explained the adaptive value of *continuing bonds* in very simple terms; since relationships with alive individuals function at several levels of actual, symbolic, internalized, and imagined relatedness, when a loved one dies only the actual (living and breathing) relationship is lost but the rest of the levels remain and can even develop in more elaborate forms. The *continuing bonds*, according to the *integrative theory of bereavement* by Bonanno and Kaltman (1999) can provide a sense of meaning and continuity of identity for the bereaved individuals.

The vast majority of the bereaved mothers participating in the present research did share their sense of a *continuing bond* with their dead babies and their hopes that their children have a spiritual existence. What appeared to give them particular solace from the spiritual existence of their babies was the hope that one day they will meet again. As Regina explained her sense of her son's existence and their hoped future meeting: **Regina:** "*although he's not here and I'm not religious, I do feel like he is somewhere or maybe in the future I will see my little boy, I don't know if that's how I was brought up, I don't know, I just feel that*" (18/430-31).

The way they described their understanding of their babies' existence appeared far from pathological as the early bereaved theorists would claim

(Bowlby, 1961; Freud, 1917/1957; Lindermann, 1944). Their perception of their babies' spiritual existence was not preventing them to form attachment to the living people in their lives; rather it was providing them with some comfort in order to accept the death of their firstborns. The present findings do replicate the findings of other qualitative studies with bereaved parents presented in the introduction section (Arnold, & Gemma, 2008; Braun, & Berg, 1994; Murphy, Johnson, & Lohan, 2003; Wheeler, 2001).

A theoretical question though rises at this point, whether these enhanced religious and spiritual beliefs could be named as *posttraumatic growth*, as suggested by Tedeschi and Calhoun (2006), or as coping processes. One of the areas of posttraumatic growth includes existential elements and it can also reflect spiritual and religious elements (Calhoun, Tedeschi, Cann, & Hanks, 2010). From the present findings, and especially as these unfolded in the fourth theme on "trauma resolution and growth", it appears that growth in the existential domain is better echoed when the bereaved individual engages with fundamental existential questions (Calhoun, & Tedeschi, 2004) and this is reflected in changed priorities and views in life. However, the findings reported in this subtheme do support what Znoj (2006) suggested; that *spiritual coping* is among the top predictors of *posttraumatic growth* among bereaved parents. It was evident from the participants' narrations that religious/spiritual coping was an essential part of their mourning process that allowed them to find meaning, solace, and hope.

4.4.3.E Discussion of Theme: Quality of Social Support as a Catalyst.

The last theme of the "working through" phase reflects the catalytic effects of the social context, both proximal and distal, on *grief* resolution and growth. As already mentioned a central theme in cognitive processing theories is that first, traumatic experiences cause psychological distress by challenging people's core, optimistic assumptions about the self and the world and second, that recovery requires activation of the traumatic memories so they can be integrated into schematic representations (Creamer, Burgess, & Pattison, 1990; Epstein, 1985; Foa, Steketee, & Rothbaum, 1989; Horowitz, 1986; Janoff-Bulman, 1992; Parkes, 1975; Wilson, 1989). Any attempts to integrate

traumatic experiences appear to activate two fundamental processes. One of them is essentially intrapsychic; it involves the processes presented under previous themes such as rumination, religious coping, cognitive reappraisal and others. The other process, which may actually be a strategy to facilitate the first one, is to talk with others about the experience (Lepore, Silver, Wortman, & Wayment, 1996; Guay, Billette, & Marchand, 2006).

There are two main theories that have attempted to explain why disclosure after a traumatic event can facilitate resolution. Joseph, Williams and Yule (1997; Williams, & Joseph, 1999) have proposed that social support is an environmental variable that may either lower or exacerbate stress levels after a traumatic experience. They identified three ways in which social support affects adjustment to trauma; first, other people's point of views can influence the victim's interpretation of events, positively or negatively; second, others may have an impact on the victim's emotional state, causing panic, guilt or shame; and third, others may affect the coping strategies the victim will need to activate (e.g. denial or active emotional coping).

Lepore and his colleagues (Lepore, 2001; Lepore, Ragan, & Jones, 2000; Lepore, Silver, Wortman, & Wayment, 1996) have suggested that there are at least two ways that expressive tasks and disclosure might influence adjustment processes. The first way serves the integration of the traumatic material and has been named the *integration/ completion hypothesis*. Because communication is creative and involves problem solving, dialogue is thought to foster the mental processing of trauma and make the experience more understandable to the person describing it (Clark, 1993; Pennebaker, 1985, 1995). Thus talking about the traumatic event facilitates cognitive restructuring and potentially assists the process of finding or making meaning of the experience. However, the emotional benefits of disclosure are dependent upon the reactions of others. The second way in which disclosure might facilitate resolution is through the *desensitization or habituation processes*. Disclosure facilitates the active confrontation of trauma related cognitions and this may assist emotional adjustment either by extinguishing negative emotional responses, or by creating more benign emotional associations with memories and reminders of the trauma. The cognitive processing theories that consider

disclosure and social support as a key coping and adjustment factor have received support from numerous empirical studies that have identified a relationship between unconstrained disclosure and improved physical and mental health, decreased psychological distress and PTSD symptomatology (Cacciatore, Schnebly, & Frøen, 2008; Guay, Billette, & Marchand, 2006; Ozer, Best, Lipsey, & Weiss, 2003).

Calhoun and Tedeschi's (2006) theory of posttraumatic growth has acknowledged the fact that individuals do not face the aftermath of a traumatic event as socially isolated and disconnected persons, but rather that their experience unfolds within the diverse influences of their reference groups. In their theory, social support plays just as central a role over the development of posttraumatic growth as it does in other theories of trauma adaptation (Janoff-Bulman, 1992). Also in the theory of Joseph and Linley (2005, 2008) the social environment is presented as the key prerequisite for growth, satisfying some basic psychological needs of the individuals so that they can fulfil their inner-directed journey to growth. The availability of and satisfaction with social support has been consistently identified as an important predictor of PTG in many groups of traumatized individuals (Prati, & Pietrantonio, 2009; Taku, Tedeschi, Cann, & Calhoun, 2009) including bereaved parents (Polatinsky, & Esprey, 2000).

What the participants of the present research named as supportive and helpful in their grief with respect to their social networks, had an astonishing resemblance to the reports of other bereaved parents found in earlier empirical studies. Participants talked about their need for others to acknowledge their babies life and death, to allow them to mourn their lost child, to allow them to talk over their memories and feelings, and to stay around and spend time with them. Studies of bereaved parents after a perinatal loss (Brabant, Forsyth, & McFarland, 1995; Braun, & Berg, 1994; DeFrain, 1991; Dyregrov, 2003-4; Laakso, & Paunonen-Ilmonen, 2002; DeMontigny, Beaudet, & Dumas, 1999; Rajan, & Oakley, 1993; Smith, & Borgers, 1988-9) and bereaved parents after other types of child loss (Bath, 2009; Brabant, Forsyth, & McFarland, 1995; Davidowitz, & Myrick, 1984; Dyregrov, 2003-4; Lehman, Ellard, & Wortman,

1986) have highlighted exactly the same themes as being important in supportive social interactions.

The benefits from participation in support groups after a perinatal loss has been repeatedly illustrated (Cacciatore, 2007; Cordell, & Thomas, 1997; McCreight, 2007; Reilly-Smorawski, Armstrong, & Catlin, 2002; Schwab, 1995-6; Wheeler, 1993-4). Two of the participants who attended support groups organized by SANDS described those support groups as a place where they could share their grief with other individuals, a place where the intensity and breadth of their emotions was normalized, a place where they could receive and offer help to other individuals. These functions of support groups have been repeatedly reported in literature (Cacciatore, 2007). An additional benefit, not reported earlier in the literature, at least to the knowledge of the researcher, was mentioned by one participant. She referred to the inspiration of hope and endurance that the older members of these groups provided for the newly bereaved. That participant talked about the inspiration and courage she had received witnessing the adjustment achieved by members of the group who had lost their babies many years earlier. This effect could be related to what Calhoun and Tedeschi (2006) had suggested, that when there are models of people with posttraumatic growth in the social environment of an individual, this might encourage the him or her to find a personal pathway to growth.

Regarding psychotherapy, three participants had attended only the very limited number of sessions offered by the hospitals they gave birth (two, four and six sessions depending on the hospital), while only one, along with her partner continued for a year. However, this last participant had a history of depression and she was under treatment with antidepressant drugs many years before her loss and throughout her pregnancy. This long struggle with depression was the possible reason why she chose to seek professional help for her loss. The remaining four participants never sought help from a mental health professional while few of them were never offered this option. The participants who had few sessions did not even mention those sessions during their interviews. It is possible that this reflects the null effects these few sessions had on their adjustment.

Nevertheless, participants in the present study did talk more about the lack of social support or the additional burden they faced because of the reactions of others. The absence of support and the unsupportive, unreceptive and critical responses of proximal and distal societal contexts have been reported repeatedly and consistently by empirical research; towards bereaved and traumatized individuals (Bath, 2009; Davidowitz, & Myrick, 1984; Lehman, Ellard, & Wortman, 1986; Paul, et al., 2010; Tennen, Affleck, & Gershman, 1986; Ullman, & Filipas, 2001), towards bereaved parents (Brabant, Forsyth, & McFarlain, 1995; Dyregrov, 2003-4; Laakso, & Paunonen-Ilmonen, 2002; Lepore, Silver, Wortman, & Wayment, 1996), and towards bereaved parents after a perinatal loss (Cacciatore, Schnebly, & Frøen, 2008; DeFrain, 1991; DeMontigny, Beaudet, & Dumas, 1999; Rajan, & Oakley, 1993; Smith, & Borgers, 1988-9; Sukran, Rådestad, Cnattingius, Steineck, & Dickman, 2009).

Despite of the common occurrence of perinatal loss in the UK (17 babies die every day) current society and the media promote the message that good maternal health, proper prenatal care, and modern medical science ensure perfect babies. A perinatal death is often an isolating, marginalizing experience for women and there exists a social discrepancy in the degree to which grief after the death of a stillborn or a newborn child is legitimate, as opposed to the death of an older child (Cacciatore, Schnebly, & Frøen, 2008). This may intensify and complicate grief or even prolong grief for some. The term that Doka (1989, p.4) introduced, *disenfranchised grief*, is the grief that “persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported” this definition definitely captures the experience of the vast majority of participants. In the case on a perinatal loss both the relationship of the mother with the dead baby is disenfranchised, as is not usually perceived from society as a “real” mother and the death is disenfranchised, as society fails or is unwilling to acknowledge this death as the death of a real person (Corr, 1998-9; Doka, 1989).

The themes that emerged from the participants’ narrations were reflecting their stigmatization and marginalization both from family and friends and their wider communities. Participants described how disclosure about their

loss was inhibited from those around them, how others avoided any contact with them, how others had failed to acknowledge their loss, how they perceived a subtle blame for their loss and for their mental status and how others expected them to recover soon after their traumatic loss. The resemblance of these themes with those of other qualitative and quantitative studies with mothers who had lost a child perinatally is impressive (Cacciatore, Schnebly, & Frøen, 2008; DeFrain, 1991; Hazen, 2003; DeMontigny, Beaudet, & Dumas, 1999; Rajan, & Oakley, 1993; Smith, & Borgers, 1988-9; Sukran, Rådestad, Cnattingius, Steineck, & Dickman, 2009).

Patricia when describing her isolation and stigmatization referred to the metaphor of the “leper: *Patricia*: “*I had been in a place where you feel like a leper, you know, that nobody wants to talk, nobody wants to – it’s almost like they don’t want you to, um, what’s the right word, touch you with your sadness, don’t make me –don’t make me sad as well, don’t make me...not dirty with it but I couldn’t cope if you cried, oh God what would I do if you cried, I don’t want to upset you and all this type of thing, and I remember thinking it’s not about you, it’s not about you being upset and you not being able to cope, it’s about me, you know*” (15/390-97); a metaphor that has been also reported by DeFrain who has been conducting clinical work and research in this area for more than 30 years (DeFrain, 1991, p. 219).

DeMontigny and colleagues (1999) interviewed 20 parents who had lost a child perinatally, for a maximum of six years prior to the interview. Parents described how their family and friends had avoided talking about their dead baby, either by circumventing the subject or by pretending that they had not heard what was said, making comments that diminished the intensity of the loss, and expecting them to be “normal” again very quickly after the death. These reactions had led many of the participants to withdraw from social interactions and sometimes even abandon some or most of their social networks. Rajan and Oakley (1993) noted that it is remarkable how often for bereaved parents suffering perinatal loss, social support is not only lacking, but is replaced by antagonistic, insensitive, and generally negative attitudes. Among other negative reactions referred to in their survey of 509 women, participating in a randomized study on social support after a pregnancy loss,

bereaved mothers reported that they had been ignored and avoided by their social networks (Rajan, & Oakley, 1993).

One would expect that individuals who engage professionally with vulnerable groups would have known better than to offer the unhelpful and hurtful comments participants mentioned that they received from health professionals. This kind of comments have been repeatedly reported by empirical findings as being totally unhelpful and possibly damaging. In the DeMontigny and colleagues (1999) qualitative study parents reported that health care professionals should not tell them what to do, in terms of having a baby or waiting, because this was definitely beyond their scope of interest, responsibility and knowledge. In the survey by Cacciatore and colleagues (2008) the least reported source of support was women's physicians.

In addition to their loss, three participants faced occupational problems upon their return from maternity leave. Hazen (2003) had reported in her qualitative studies issues of disenfranchisement of grief in the workplace where colleagues failed to acknowledge the loss and offer support, but to the researcher's knowledge, similar results have not been previously reported.

What is worth considering though is the impact of these unhelpful attitudes and behaviours on mothers' grief resolution and growth. Cacciatore and colleagues (2008) in a survey of 769 women, who had experienced a stillbirth within the past 18 months, reported that dissatisfaction from the support of family members was associated with notably higher levels of both anxiety and depression. However, the empirical evidence on the effects of absence of, or dissatisfaction with social support to bereaved mothers is scarce. Still, the notion that behaviour inhibition (being inhibited to share their thoughts and feelings with others, being inhibited to mourn their child) can exacerbate emotional disturbance after a traumatic event can be traced as early as in the writings of Freud (1917/1957). One should consider the aforementioned benefits of social support to infer the consequences of social isolation. When individuals cannot talk to others they may be inclined to inhibit discussion of their experiences and therefore have fewer possibilities to process the traumatic material. The social constraint itself can be also stressful per se, thus increasing the individual's level of arousal, and through this arousal

interfere with the cognitive processing of the experience (Lepore, Silver, Wortman, & Wayment, 1996). Some theorists have suggested that people who do not discuss a traumatic experience may be less likely to find meaning in it (Tait, & Silver, 1989) or gain insight into how to resolve it (Clark, 1993), than people who do discuss it.

Nevertheless, the experiences described by the participants of the present research do suggest that the harm caused by negative social reactions was not just inhibition of disclosure and the consequent decreased opportunities for trauma assimilation, but rather an additional grief and trauma. Losing people from their lives either because others avoided them, or because they chose it themselves in order to be protected from hurtful comments, meant that those women had to suffer additional losses compounding their loss, additional “deaths” that they had to mourn as well.

Some insights on the effects of negative social reactions can be gained through the findings of Ullman and Filipas (2001) who conducted a quantitative study in a sample of 323 sexual assault victims. Their basic measures were on social support and PTSD symptomatology and although the traumatic experiences of their participants were very different from the experience of the participants in the present research, the societal reactions they had endured were very similar. They concluded that a range of negative social reactions, including treating the victim differently, egocentric reactions (e.g. I cannot handle you being upset), victim blame, and controlling responses (e.g. you shouldn't react like that) were related to greater PTSD symptom severity. Specifically, being treated differently (stigmatizing responses) was most predictive of PTSD symptom severity.

Furthermore, it was suggested that stigmatizing responses from others may further contribute to the violation of positive assumptions about the self, which as Janoff-Bulman (1992) argues are characteristically disrupted by traumatic events. Those positive illusions about the self usually revolve around issues of self-worth, that when others stigmatize and marginalize individuals this personal sense of self-worth can be severely affected. In addition to Ullman's and Filipa's suggestions, one could further argue that other positive assumptions such as the benevolence and meaningfulness of the world (Janoff-

Bulman, 1992) are also affected. As participants said, being treated that way by their social context was a rude awakening for them, which made them realize on a deep affective level again that not all individuals are good, that this world can be hostile and that things happening do not always make sense. The reactions of family members, friends, acquaintances, doctors, and colleagues were in many instances shaking again their schemas of the world and the self while participants were actively struggling to make sense and effectively cope with their loss.

The plethora of literature (Bath, 2009; Brabant, Forsyth, & McFarlain, 1995; Cacciatore, Schnebly, & Frøen, 2008; Davidowitz, & Myrick, 1984; DeFrain, 1991; Dyregrov, 2003-4; Guay, Billette, & Marchand, 2006; Laakso, & Paunonen-Ilmonen, 2002; Lehman, Ellard, & Wortman, 1986; Lepore, Silver, Wortman, & Wayment, 1996; DeMontigny, Beaudet, & Dumas, 1999; Ozer, Best, Lipsey, & Weiss, 2003; Paul, et al., 2010; Rajan, & Oakley, 1993; Smith, & Borgers, 1988-9; Sukran, Rådestad, Cnattingius, Steineck, & Dickman, 2009; Tennen, Affleck, & Gershman, 1986; Ullman, & Filipas, 2001) concluding that social support is not offered to traumatized individuals, regardless of the type of trauma suffered suggests that proximal and distal societal contexts are affected not only by the type of trauma and the attitudes they hold for that type of trauma, but also by other more psychological factors. With the exception of the immediate family, where support may not be offered because all members have been affected from the loss and they are possibly unable rather than unwilling to offer support, researchers and theorists have speculated on the reasons why social support is not offered. The participants of the present research appeared to have been equally puzzled about the reasons others hesitated or felt uncomfortable in their social interactions with them.

Sukran and colleagues (2009), who surveyed 314 women within three years after their perinatal loss, proposed five reasons: (a) others may consider the loss a private matter in which they should not intrude; (b) they are afraid of not knowing what to say; (c) they might blame the woman for the baby's death; (d) they might believe that by avoiding any conversation they are protecting the mother; and finally (e) the mothers themselves often see themselves as

caregivers, and the needs of others take precedence over their own and thus they might avoid any conversation in order not to upset others.

In another quantitative study of 171 bereaved mothers after a SIDS death (Lepore, Silver, Wortman, & Wayment, 1996) researchers suggested that social networks may abandon or avoid a person in need because they feel helpless since either they cannot undo the trauma the person is facing or because psychological defence mechanisms of their own might be activated. These defences are triggered because the bereaved individual is perceived as a reminder that tragedy can strike everyone and in order to reduce their feelings of personal vulnerability, they avoid the victim or blame her for her loss. This latter explanation for the absence of social support is affirmed by the *defensive attribution hypothesis* as well. According to Walster (1966) and Shaver (1970) a tragic event creates a need for the observers to believe that the event could have been averted and consequently could not happen to them. When a tragic event has occurred, others not only blame victims, but also attribute more causal responsibility to them. The more devastating an event is the more unpleasant it becomes to others to acknowledge that something like that could happen to them.

Janoff-Bulman (1992) placed a central role in the quality and consistency of social support in her theory of trauma recovery. She states “At a time when survivors are struggling to understand and reconstruct their basic beliefs about themselves and the world, the reaction of others, as in infancy, are fundamentally important” (p. 146-7). She also claims that other peoples’ negative reactions should not be surprising if we take into consideration other people’s investment in maintaining their own fundamental assumptions about benevolence, meaning, and self-worth. A confrontation with victimization and misfortune might be very threatening to other people. Janoff-Bulman (1992) named *victim stigmatization* and *blame* as the two most common defensive strategies of others and suggested that this rejection can be a second injury to victims. However these explanations accounting for the motivations of the individuals who chose to be unsupportive towards bereaved mothers and other traumatized individuals are only tentative since no study, to the researcher’s

knowledge, has been undertaken in order to explore their actual thoughts and motivations.

In addition, regardless of the personal motivations and attitudes, one should also consider the cultural attitudes towards different traumatic events, such as perinatal death, considering traumatized individuals within their social contexts. Since perinatal death is a largely overlooked issue by scientists, the media, and social dialogue (Cousens, Blencowe, Stanton, Ahmed, Steinhardt, et al., 2001; Frøen, Cacciatore, McClure, Kuti, Jokhio, et al., 2011; Smith, & Borgers, 1988-9) the reactions of the social environments of bereaved parents might just be congruent with the general silence and disenfranchisement of this type of death.

4.5. Discussion of Super-Ordinate Theme 4: Trauma Resolution and Growth

The term *growth*, during its relatively short existence in academic literature, has received many different definitions and has been alternatively reported as either a process or an outcome of struggling with trauma, as either related or unrelated to psychological distress, and as either real or illusory (Calhoun, & Tedeschi, 2004; Davis, 2008). The plethora of definitions and debates as well as the strong reliance on quantitative studies have barely enlightened or led to a deeper understanding of the phenomenon, although they have multiplied the publications in this area of research. Driven by theories on bereavement (Gillies, & Neimeyer, 2006) it is widely accepted today that the term *recovery* appears inappropriate for parental grief, since parents do not appear to return to their pre-loss state of being. The question posed is whether in this new post-loss state of being bereaved parents can experience some positive changes as well, or in other terms, *growth*.

While the initial definition of *growth* by Tedeschi and Calhoun (1995, p.81) was “growth is change in schemas”, and later “growth refers to positive psychological change experienced as a result of the struggles with highly challenging life events” (Tedeschi, & Calhoun, 2004a, p.1) the latest definition

provided is that “growth is an indication that persons who experience it are living life in ways that, at least from their point of view, are fuller, richer, and perhaps more meaningful” (Calhoun, & Tedeschi, 2006, p.7). The areas of *growth* that have been described are: *increased appreciation of life, closer, more meaningful relationships, increased personal strength, realization of new possibilities, and spiritual/ existential growth* (Tedeschi, & Calhoun, 2004a). However, all of these definitions are abstract enough to make room for criticisms on whether growth is an actual phenomenon or a defensive illusion (Frazier, et al., 2009; Smith, & Cook, 2004).

Davis (2008) attempted to integrate theories (Tedeschi, and Calhoun, 1995; Neimeyer, 2006; Janoff-Bulman, 1992, 2004; Taylor, 1983; Wortman, 2004, Davis, Wohl, & Verberg, 2007; Nerken, 1993) and suggested the following criteria for distinguishing growth from benefit finding. *Benefit-finding* realizations are the common but relatively transient and incidental by-products of experiencing adversity, and thus are conceived as part of a coping process. For these positive changes to be considered *growth* three criteria need to met: (a) changes should be reflected in an individual’s actions and not be just intellectual reflections and need to be significant and sustained; (b) active processing of the meaning of trauma must have occurred followed by revised life goals and directions; (c) growth should be reflected in how one understands one-self, the sense of identity, life narrative, and self-awareness.

The findings of the present research although informed and enriched from the existing theories do not adhere to the predictions made by any of them. The ways bereaved mothers participating in this research described what they experienced as growth after the death of their babies do not neatly fit into the predefined categories of quantitative instruments and do not appear to be illusory.

4.5.4.A Discussion of Theme: The fountains of Growth

The first theme, “fountains of growth”, presents how childbirth and confrontation with existential dilemmas facilitated the positive changes experienced in many spheres of the women’s lives. Childbirth and the continuing bond with the dead babies established a maternal identity that was

experienced and expressed through the need to honour the memory of the child. The majority of participants transformed the love they felt for their babies in altruistic acts towards others, statements like “*because it was my witness to my son*” (Patricia, x/x) and “*I want her to be for a reason, to – it’s just nice that she’s brought good*” (Julia, x/x) are very indicative that the positive changes that followed were considered as an affirmation of their babies’ importance.

Theorists and empirical studies have reported on what could be called as *developmental growth*. Aldwin and Levenson (2004) suggested that profound experiences like childbirth have the potential to promote growth in a dramatic way. The birth of a child can change the identity, values and priorities, can increase the emotional ties to others, and open up new life paths (Aldwin, & Levenson, 2004). Tedeschi and Calhoun (2004a) have also suggested that peak experiences, or life-altering events can have effects on schemas that are similar to that of traumas and thus might result in some of the positive changes reported by trauma survivors. From a psychodynamic developmental perspective pregnancy and childbirth, especially when it marks the entrance to parenthood, is a critical process of maturation (Benedek, 1959; Bibring, 1959; Deutsch, 1944; as cited in Dragona, 1999). Talbot (1996-7), a bereaved mother herself, in an empirical study of 80 bereaved mothers, who had lost their only child, suggested that motherhood is integrated in the self in order for the mother to survive the dual loss, child and identity. A bereaved mother can find meaningful ways to continue “mothering” as part of a new, integrated identity which acknowledges the child’s death but also preserves the child’s memory and her internalized maternal identity. Thus, the maternal identity of the participants might be responsible for the positive changes they experienced after their loss.

However, in the literature on posttraumatic growth and bereavement there are repeated reports on the need of bereaved parents to preserve the memory of their children and this need is expressed in positive ways. Tedeschi and Calhoun (2004b) who have done extensive clinical work with bereaved parents reached the same conclusion in their book for clinicians working with bereaved parents. They suggested that one of the most important and meaningful aspects of life after the death of a child is to protect and nurture the

memory of the child, not just to themselves (with continuing bonds), but especially to others. This need encourages parents to do things that end up carrying additional meanings, for example by various altruistic acts, all in the memory of their children. Wheeler (2001) in her qualitative study described how bereaved parents were trying to keep their child's memory alive by concentrating on the significance the life and death of that child had on other people's lives. Similarly, Parappully and colleagues (Parappully, Rosenbaum, Daele, & Nzewi, 2002) reported that the 16 bereaved parents of murdered children who participated in their qualitative study were especially concerned with the positive impact their child's death could have had on society.

The second area of transformation that appeared to have had a great impact on the positive changes participants experienced was existential awareness. The death of their child had shaken their fundamental assumptions to the core. In their search for meaning and their struggle to cope with their multiple losses, bereaved mothers had to confront major existential dilemmas. Participants realized their own personal mortality and their vulnerability to misfortune. Like Regina said: **Regina:** *"it made me grow in the sense that I realized how precious life was, because prior to that, I completely took it for granted. Completely. So that, that's a personal growth"* (11/260-2).

This deep realization could have been an intellectual reflection before the loss of their child, but as the stories of the participants unfolded during the interviews, it became apparent that sometime after the death of their child this realization was not a mere product of their intellect, but had a transformative impact on many spheres of their lives. Finally, their reflections on this realization could not be considered as depressiogenic, like in the case of negative accommodations described by the *organismic valuing theory* (Joseph, & Linley, 2005).

In the Calhoun and Tedeschi model (Calhoun, Tedeschi, Cann, & Hanks, 2010) on growth and grief, one of the areas of growth includes existential elements and appears to be related to the findings of the present research. Although what participants described here lacks the religious elements described as present in this area of growth, the existential element suggested in the model is clearly present. Yalom and Lieberman (1991) pointed out the

possibility of heightened existential awareness after bereavement together with the positive and significant relationship of that awareness to growth. Balk (1999) and Rosenblatt (2000) have theorized on spiritual change following bereavement, while empirical studies of bereaved parents have highlighted this change. Again, the participants of Wheeler's (2001) study had shared their deeper spiritual understanding and their new understanding and appreciation of life. Polatinsky and Esprey (2000) in their quantitative study of 67 bereaved parents, employing the Posttraumatic Growth Inventory, reported high scores on the subscale of spiritual change.

4.5.4.B Discussion of Theme: The Ripples of Growth

The “ripples of growth” theme presents all these positive changes experienced by participants. As with the ripples in a lake, where the ripples start from the centre and expand towards outer layers this appeared to be true of the positive changes the participants experienced. The experienced changes in the self, determined the changes in their attitude to life and their interaction with their social world. As Nerken (1993) had pointed out “Grief work is self work, of the most profound and intense kind” (p. 1). Thus, the participants, who had worked through their traumatic loss, had inevitably not only restructured their fundamental assumptions about the world, but had also restructured their sense of self. The *constructivist theory of grief* (Gillies, & Neimeyer, 2006; Neimeyer, 2006) has also suggested that *identity change* is the final goal for meaning reconstruction after bereavement, where the bereaved reconstructs his or her own self.

The vast majority of participants perceived themselves as stronger because they had managed to survive the death of their babies and described how this changed self-perception had affected their life choices. Feeling that they had survived the worse that could happen to them, they were convinced that they were capable of handling the most demanding life situations and claiming whatever they felt they deserved in life. Regina for example for whom the stillbirth of her son was her first encounter with adversity realized her strength as an individual while coping with her loss: **Regina**: “[...] it gave me more backbone, I thought, “God, if I can do that, I can do anything”. If

someone had said to me, “Right, Regina, we need you to get into this rocket and send you to the moon”. I’d have gone, “Okay, strap me in”. “I can do this” because I feel it made me feel like “Look, if I can do that, I can do anything” (11/277-81)

The participant that pursued further studies in counselling, Patricia, possibly because of her enhanced ability to express her inner-reflections verbally, described this process of self reconstruction very eloquently as a shedding of skin, through which her inner self had emerged; that inner self was convinced that could handle life challenges and was ready to engage in behaviors needed to actualize the new self understanding. **Patricia:** *“It was like that person was gone, that person before. **You before?** Yeah me before and it sounds very dramatic that, doesn’t it, but, um, um, yeah, I just – I couldn’t be doing with any more falseness, any more bullshit, any more playing games, um, I think it just really clarified what was important to me and then identifying that that wasn’t important to me, these things that I had in my life, and shedding all that, you know, and going forward without those things and it meant friends and it meant, you know, many many different situations. What I carried forward was weird, your own inner self, that’s what I carried forward from it, it’s like the shedding of a skin.[...] I mean, I think it was a choice as well, I think I could have not done that (16/430-42).[...] I’d been through such a traumatic thing nobody could hurt me again in that way, you know,[...] it was like, um, you know, let’s give it a go, let’s just put ourselves out there and what’s the worst that could happen, well it’s already happened so [laughs], you know” (13/342-45).*

Tedeschi and Calhoun (1995; 2004a) consider these changes in self-concept as one of the five areas of PTG. The similarity of reported statements among persons studied earlier (Calhoun, & Tedeschi, 2008; Calhoun, Tedeschi, Cann, & Hanks, 2010; Tedeschi, & Calhoun, 2004a) and the present participants allows for the conclusion that bereaved mothers after a perinatal loss do indeed experience growth in this area.

However, according to the stricter criteria that Davis (2008) suggested for the distinction between growth and benefits one could argue that for two of the participants, Laura and Claudia, this self-perception regarding personal

strength is not really growth. Two of the participants described their changed perception of self, but did not describe how this sense had affected their behavior and life choices. The lack of behavioral evidence could make someone consider these reports as positive reappraisals of the traumatic material with high coping value (Janoff-Bulman, 1992, Neimeyer, 2008). Empirical studies with bereaved parents after many different types of child death (illness, accident, perinatal) employing various methodologies have repeatedly reported this aspect of positive change in bereaved mothers' self-perception (Arnold, & Gemma, 2008; Arnold, Gemma, & Cushman, 2005; Engelkemeyer, & Marwit, 2008; Milo, 1997; Uren, & Wastell, 2002; Wheeler, 2001). Uren and Wastell (2002) in their mixed design study of 109 mothers bereaved after a perinatal loss reported that 87% of the participants experienced changes in their identity with their qualitative results suggesting that these positive changes were mainly concerning self-perception of personal strength.

The second area of growth came as an outcome of their increased existential awareness and affected their perception and attitudes towards life choices and relationships. Their changed perspective in life meant that they came to appreciate more the things they had, mostly relationships, they were worried less for matters like money and career, and as one could expect they appreciated the chance they got to have more children after their traumatic loss. What participants described as a renewed appreciation of life and the consequent difference in life priorities has been repeatedly reported in trauma and bereavement literature. As Claudia narrated: ***Claudia:** "Um, I think it's taught me that thing can – tragic things can and do happen every day to all sorts of different people and I could or you could be knocked down by a bus tomorrow, you know, so we must live for – we must appreciate what we've got. You're brought up to believe that but I think it drives it home"* (46/1226-29).

Janoff- Bulman (1992) has pointed out that this new found appreciation of life occurs because the psychological annihilation the trauma has caused strips life to its essentials and thus can function as a turning point for the survivor, who turns from the superficial to the profound. Since participants could not take life for granted anymore they turned to what could make their life meaningful, and that was reflected in changed life priorities. What is

described in this subtheme strongly resembles one of the five areas of growth in the Tedeschi and Calhoun (2004a) model as well. Nearly all the empirical studies on bereaved parents that have been located and reviewed in the present research have reported that parents do experience the sense of changed appreciation of life and life priorities (Braun, & Berg, 1994; Wheeler, 2001; Murphy, Johnson, & Lohan, 2003; Büchi et al, 2007; Polatinsky, & Esprey, 2000; Miles, & Crandall, 1983; Milo, 1997). When Büchi and colleagues (2007) assessed posttraumatic growth in parents bereaved after a perinatal loss, the highest scores on the Posttraumatic Growth Inventory (Tedeschi, & Calhoun, 1996) were obtained on the new priorities subscale with 78% of the mothers reporting growth on this area.

The last subtheme presenting the growth of participants on a relational level was among the richest of the present analysis. The attitudes and behaviors included in this subtheme were the outcomes of the positive changes in all the areas presented previously. Participants had integrated their maternal identity and had made a commitment to honour the memory of their children. They had gone through an existential crisis, recognising their personal vulnerability and mortality, and that had led to the revision of their life priorities. Surviving their child's death had altered their self-perception and now they were experiencing themselves as very strong and resilient, able to face life's future challenges. In this last subtheme participants described how these realizations and changes had affected their relationships with others.

Although in the course of their bereavement many participants lost some people from their lives, those people who choose not to share their grief, the ones that remained in their lives and the new friends they had found were now in closer, more meaningful and intimate relationships with the bereaved mothers. Participants were now aware of life's randomness and could not avoid, as many others had done to them, individuals facing loss and adversity. Through their struggle with their loss they had deeply understood pain and anguish and they had realized their personal strength, so now they could empathize with people in pain, and offer their containment and support, as strong and generous individuals. Two of the participants, Wilma and Patricia, chose to express their ability to support others and offer them the space to

suffer through their professions, one being a doctor and the other becoming a counselor. Other participants expressed the ability to empathize in their social relationships. Like Regina said, now she could empathize with people without getting into unnecessary comparisons: **Regina:** *“I think I’m the person that people ring if they needed to talk or – and often people have said to me, “Oh it’s nothing compared to what you’ve been through”. And I say “Don’t be so silly, look, this is relative to you”. [...] you can’t measure it like you can’t measure your pain, it’s not, it’s not a pint of milk” (12/291-6).* In all of the cases though, the sharing of difficult and painful emotions enhanced the creation of more intimate and meaningful relationships. Their deeper connectedness with others was also expressed through charity as well. Some mothers actively engaged in charitable acts in order to help other individuals to avoid the pain they had gone through, or other types of misfortune. Charlotte who worked hard for the change of some hospital policies shared: **Charlotte:** *and I thought if I can change something then it’s worth it. So hopefully they won’t ever go that way again but that really held us back a long time, I think” (5/122-8).*

Empathy and closer social relationships are typically reported in research on trauma and bereavement. Tedeschi and Calhoun (2004a) have included this type of positive change in their model of posttraumatic growth. Janoff-Bulman (1992) has suggested that transforming the trauma into altruistic acts can provide the survivor some basis for meaning and value in her/his life. Thus, allowing them an at least partial restoration of their beliefs on meaningfulness and benevolence in the world. It has also been reported that helping others increases self-efficacy (Midlarsky, 1991), and self-efficacy could be perceived as highly related to the *self-worth* concept of Janoff-Bulman (1992). For the mothers who had already altered their perception of self, as being stronger and more capable, helping others was possibly reinforcing this new self-perception and consequently increasing their motivation for altruistic acts.

Becoming caring and helpful towards others after a traumatic experience and suffering has been named as *altruism born of suffering* (ABS; Staub, 2003). In their award winning article Staub and Vollhardt (2008) suggested that promoting others’ welfare through altruistic actions may be a way to fulfill

basic psychological needs such as feelings of security, feelings of connection to others, the belief in human ability to influence events, sense of autonomy and choice, need to comprehend reality, that were frustrated by the trauma and the subsequent suffering. In this same model altruistic acts are also examined as coping strategies, adding to the existing literature the suggestion that these acts, might be an avenue to healing through personal or societal change.

The ABS model though, did not present altruism only merely as a coping strategy. It was argued that after a traumatic experience certain psychological changes may have occurred for the survivor, and these are the changes that encourage and reinforce altruism. The changes they named were (a) greater salience and awareness of suffering, meaning that people who have suffered may become more easily aware of the suffering of other people; (b) increased perspective-taking, empathy, and sympathy, meaning that one's own suffering can lead to a greater ability to understand how people who suffer might feel; (c) perceived similarity and identification with other victims, meaning that people who have suffered might be better able to acknowledge the common fate of humans and/or identify with others who suffer; (d) greater sense of responsibility for others' suffering, meaning that people who have survived successfully a traumatic experience may feel more responsibility to alleviate or prevent others' suffering. All these four processes require that the survivor has achieved at least some level of recovery or adjustment.

This theory appears to capture the experiences shared by the present participants. Indeed, one could consider their increased connectedness with other humans and their altruism as coping strategies. However, these changes appeared to be persistent over time and were followed by various and repeated altruistic acts. As a result, they could be considered more of an outcome and less of a coping strategy. The participants' abilities to become aware of others' suffering were enhanced, their empathy and compassion was enhanced and they could identify with others in pain regardless of their personal situations. Participants described a strong motivation to help others in need of support and their belief that they could actually help to alleviate someone's pain or prevent his/her suffering. However, one could argue that this strong need was a result of the fact that when they were suffering the quality of the social support they

got was really poor and that motivated them to try and prevent the social isolation they had suffered to happen to other suffering individuals. It appears that some of their altruistic behaviors were motivated by their need to cause change in the society and the societal attitudes towards suffering and death.

Empirical research on bereaved parents has repeatedly identified the theme on closer and more meaningful social relationships and increased empathy (Arnold, & Gemma, 2008; Arnold, Gemma, & Cushman, 2005; Buchi et al, 2007; Miles, & Crandall, 1983; Milo, 1997; Murphy, Johnson, & Lohan, 2003; Parappully et al, 2002; Polatinsky, & Esprey, 2000; Talbot, 1998-99; Talbot, 1996-97; Uren, & Wastell, 2002; Wheeler, 2001). In Talbot's studies (1996-97; 1998-99) many of the mothers who had lost their only child engaged in volunteer work or turned to helping professions. Talbot's explanation of this phenomenon was twofold. First, mothers had integrated in their identity the maternal identity without having a child to mother anymore, and through this identity they were preserving their sense of self but also their child's memory. These mothers used these new roles to continue "mothering" by offering their nurturance and compassion to others in need. Second, these new roles they took came as an affirmation of their strengthened existential awareness and they turned to meaningful and fulfilling activities rather than superficial and repetitive ones. The explanation offered by Talbot could be enlightening for the present sample as well. As the participants had just lost their newly established maternal identities they fulfilled their need to "mother" through helping and supporting others socially or professionally. However, the vast majority of the participants in the present research did have other children after their loss, and nevertheless their commitment in more meaningful relationships and their compassion did not diminish after that. Thus, their changed relationships and increased empathy could be better interpreted as outcomes of their struggle with pain and loss rather than as means to overcome their loss.

4.6. General Discussion: Conclusions from the present findings

Within the Positive Psychology paradigm and its emerging subfield of Psychology of Loss, the present research aimed at exploring and presenting

how mothers after a perinatal loss experience personal growth from the perspective of counselling psychology. The interview schedule was designed in order to capture the essence of this type of bereavement, by identifying the major processes that were activated after this loss and the ways they affected the personal pathway of each woman, and by allowing the women to express what they experienced as growth explaining the qualities and characteristics of that growth. Super-ordinate themes one and two mainly presented the traumatic quality of this type of bereavement and the multiple losses involved. Super-ordinate theme three presented all the coping mechanisms that were activated by participants in order to work through their loss; while super-ordinate theme four presented the positive changes that came as a consequence of the women's experience and struggle to psychologically survive the loss.

All available models on growth have been mainly based on quantitative measures, creating the paradox of attempting to describe a qualitative phenomenon in individual functioning and perception with the restricted richness of inventories and questionnaires. Although models of growth conceptually belong to the paradigm of positive psychology, they do perpetuate the medical doctrines of generalizability and categorization of individuals and psychological phenomena. As one could expect, because of the qualitative nature of the present research, the present findings do not fit neatly to all the predictions of any of the models of growth but do confirm many aspects of some of the theories, as presented earlier in the discussion. The model of growth that could be suggested on the basis of the present findings stresses some key conditions and processes for growth to emerge after a perinatal loss.

The degree of maternal investment and determination in their pregnancies and their shared future lives with their babies, along with the strength of the formation of the attachment to the babies appeared to shape the intensity of later transformation for these women. As investment in the pregnancy is essential for the maternal attachment to the baby to be achieved, the presence of a strong maternal attachment to the baby resulted in greater grief reaction. From the perspective of trauma and growth theories this could be explained in the terms that mothers who had developed a stronger attachment relationship with their babies experienced the death of their child as

a stronger challenging event for all their prior schemas and their sense of coherence and meaning in life. As many theorists have described (Janoff-Bulman, 1992; Tedeschi, & Calhoun, 2004a) for growth to result the traumatic event needs to be seismic for the assumptive world of the survivor.

Furthermore, as Boals and colleagues (Boals, Steward, & Schuettler) have recently suggested, the centrality of the traumatic event to one's identity is a key factor for the experience of growth; the participants for whom maternal role was central to their identity did appear to experience growth in many spheres of their life.

Their experiences around the time of their child's birth and death, appear to affect the intensity of their trauma reactions, their perception of self, and their subsequent pathway to growth. The experience of vaginal delivery and iatrogenic psychological trauma are both factors that seem to stifle growth. The narrations included in the subtheme of iatrogenic trauma reflected emotions of fear, helplessness, horror, guilt, and shame, emotions related with PTSD occurrence and intensity. When participants could not rely on the support and expertise of medical professionals, when they were sent home for days with no information awaiting the birth of their dead baby, or were treated in disrespectful and inconsiderate manner at a time of heightened psychological vulnerability the intensity of their distress and traumatization was unnecessarily exacerbated. The long time interval between the announcement of their babies' death and delivery, as well as the lack of control during the delivery have been previously related with increased risk of PTSD symptomatology. Thus, the participants who were exposed to iatrogenic trauma, had more traumatic material to process and that possibly led to additional challenges in the aftermath of their loss inhibiting growth.

On the contrary, vaginal delivery appeared to have a positive impact on participants' healing and growing process. Successful vaginal delivery appeared to at least partially restore for many of the participants their feelings of defectiveness, failure, disability and wounded biological self-esteem. The feelings of shame and guilt of mothers that have been repeatedly reported in cases of pregnancy complications, perinatal loss and infertility appear to be alleviated by achieving to give birth to their child. This restoration of biological

self-esteem might function as a foundation for the future changes in self perception, and as an enhancement for the women's challenged self-worth.

In the theme presenting the grief work and coping processes of participants, many mechanisms appeared to have a strong influence on the growth outcomes. The distinction between assimilation and accommodation of traumatic material into existing schemas that Joseph and Linley (2005) have suggested appears very relevant for the understanding of the different coping mechanisms. Joseph and Linley (2005), Tedeschi and Calhoun (2004a), Park and Folkman (1997) posit that for growth to occur the existing schemas need to go through crisis and revision, to accommodate the traumatic material, for growth to occur. Indeed, the present findings do appear to underline the need for schema revision for growth to be achieved.

Participants who engaged in rumination, or more accurately stated, deliberate cognitive engagement, and did not resort to denial for prolonged periods of time, appeared to process their traumatic loss more effectively and transform through this coping. Findings of existing literature have suggested that avoidant emotional coping is a significant predictor of *complicated grief*. Thus, the present results could also suggest that *avoidant emotional coping* has detrimental effects on the experience of growth; if one follows the participants who engaged in *avoidant coping strategies* on the theme "ripples of growth" he/she can realize the quantitative and qualitative difference on the growth they experienced compared to other participants. In agreement with growth theories (Joseph, & Linley, 2005; Tedeschi, & Calhoun, 2004a), cognitive engagement into the processing of the traumatic material was essential for growth in the present sample as well.

Certain coping mechanisms such as resorting to religion function towards the preservation of the existing schemas (Joseph, & Linley, 2005); they provide the means to attribute misfortune to one's own inappropriate behavior or the will of God instead of initiating the revision of existing schemas. Mothers who managed to explain the death of their baby through religious beliefs did not have to continue their search for meaning in their experience and they were also the ones experiencing limited growth. This finding however contradicts the finding of a meta-analytic review of benefit-finding and growth (Helgeson,

Reynolds, & Tomich, 2006) which revealed that religiosity to be related to benefit finding and growth. Nevertheless, Park and Folkman (1997) had suggested that religiosity may assist an individual to find only *situational meaning* rendering the revision of *global meaning*, a prerequisite for growth, unnecessary.

However, the mothers by not resorting to religion but managing to establish an internalized, spiritual, continuing bond with their dead child did appear to become transformed through their experience in many areas. It is possible that what is presented under the subtheme on growth as an affirmation of the baby's importance has captured how this continuing bond inspired the transformation of participants. Findings from this study indicate that the ongoing relationship participants had with their deceased child gave purpose and meaning to their lives and was a critical ingredient in their experience of growth. Far from leaving their child behind, or letting go of them, they took their child with them, describing experiences of feeling their child's presence, keeping their child in memory, and reaching out to others or changing their personal path and attitude in life in ways that honoured the child and their loss.

One more finding that does not agree with some of the existing theoretical assumptions concerning *positive reappraisals*, is that *benefit reminding* were not necessarily predictive of *growth*. *Cognitive reappraisal processes* (benefit-reminding, downward comparisons, self-blame) were activated by most of the participants, but there was no evidence to consider these reappraisals as prerequisites for growth. Possibly, as Davis and colleagues (1998) have suggested there are two distinct construals of meaning, independent of each other. Finding benefit or reframing the experience cognitively appears to be an essential part of coping, while growth is an outcome of this struggle to cope.

However, what surfaced as a key factor in the participants' ability and endurance during the most demanding and painful time in their efforts to psychologically survive their loss, was the quality of social support they received. What emerged from their accounts was not only that social support helped them process their trauma, cope with their trauma, and find meaning in their loss, but also that the lack of social support, or the presence of negative

reactions from their social environments impeded their coping, trauma resolution, and growth. The importance of social support has been stressed by many theories of growth. What has not been stressed, at least theoretically, is the harm that negative reactions of the social environments can do on bereaved parents.

Related to that, arises the important question of what constitutes complicated or abnormal grief. If we were to follow the suggestions of DSM, all of the participants in the present research and nearly all of the bereaved parents participating in other empirical studies, suffer from complicated or “abnormal” grief since they suffered intensively for more than two months.

One could also wonder why themes on anger or on becoming a mother again did not appear in the present analysis. Apparently for the women who participated in this research these two issues did not have a causal relationship to their transformations. Only one mother reported strong feelings of anger shortly after her loss while only one other mother expressed strongly her feelings on the healing effects that having another baby had for her. The present sample consisted of women who had or had not other babies after their loss, and the individual stories and areas of transformation did not appear related at all to that. The participants, who had other children since their loss, described that their personal transformation had begun before becoming mothers again although the way they were experiencing parenthood was greatly affected by their loss (for example they felt more grateful).

Regarding the ongoing debate on whether growth reports are reflecting real transformations or are illusory, in the light of the present findings, one could argue that what the participants experienced as growth is not illusory since it is followed by many behavioral changes as well. Moreover, this debate presents little relevance to what is important in this scientific inquiry; although a scholarly matter of concern, whether growth is true or illusory it is irrelevant to what psychology can learn from the experience of these individuals and how this knowledge can be applied to professional counselling and psychotherapy for bereaved parents.

The areas of transformation presented in this research are very similar but not necessarily identical to those suggested by growth theories. Another

main theoretical issue arising from the analysis is whether growth is actually a multidimensional phenomenon, as measured and perceived by all the available inventories, or a unidimensional phenomenon, a single perception of transformative growth overarching different areas of change. The interrelation and co-dependence of the different areas of growth portrayed in the present research could suggest that it is actually a unidimensional phenomenon as Gillies and Neimeyer (2006) has suggested with the term *identity change*. Identity change captures many positive changes such as a changed sense of self (feeling more resilient, confident, independent), undertaking new roles, developing a greater awareness of life's fragility, changes in social relationships, increased capacity for empathy and emotional closeness to others, spiritual or existential growth, and becoming "sadder but wiser" in the process (Gillies, & Neimeyer, 2006).

Moreover, Parkes (1988) in his very influential theory presented bereavement as a *psychosocial transition* that when it is successfully resolved, maturity and self-efficacy are experienced by the bereaved individual; and these two characteristics could be sufficient to give rise to all the positive changes reported by bereaved mothers. Joseph and Linley (2005), influenced by their humanistic background, suggested that all the areas and changes that have been named growth appear to parallel those characteristics that humanistic psychologists have referred to as characteristic of *fully functioning* individuals (Joseph, 2004; Rogers, 1959).

Finally, regarding the commonly used term *recovery from bereavement*, as suggested by theorists and researchers, this term appears inappropriate for mainly three reasons. First, it implies that bereavement is an illness from which when people recover they will go back to their pre-loss state; regardless of the similarities of grief to clinical depression, this does not appear to be the case in the present research project and in many other studies as well. This term also aligns more with the medical doctrine that treats such states as mental disorders rather than a normative, emotionally exhausting universal human experience. Third, it is a term that bereaved individuals usually find irritating and offending while they do not appear to use this term to describe their adaptation to their loss. In the present study, as in many others (e.g., Rosenblatt, 2008),

participants did not use this term. In psychology and psychotherapy it would be best to use words and concepts that are more neutral and permit the representation of a much broader domain of the human experience of grief. In the present research the term resolution was preferred as a more “open” term. Dictionary definitions of the term include “to convert or transform”, “to clear away or dispel”, “to fix or settle on by deliberate choice and will” (Random House College Dictionary, 1975). Furman (1978) offered a very vivid metaphor capturing the experience of grief resolution after parental bereavement. He proposed that although grief is often compared to a wound, which will heal over time, the death of a child is more like an amputation of a limb or the permanent loss of its functioning. The amputee cannot expect the healing of this limb, but can gradually accept and adapt to this painful and irretrievable loss.

4.7 Growth in Counselling Psychology and Psychotherapy

In mainstream schools of psychotherapy, growth is not explicitly addressed as a part or a goal of psychological interventions. Since World War II, psychology had been dominated and absorbed by the medical model of treating illnesses and damage (Seligman, 1999). Clients are commonly referred as patients that seek therapy because they suffer from distressing symptoms, negative emotions, or impaired functionality affecting their interpersonal, social, and professional life. Thus, the focus of their treatment is to alleviate the symptoms so as the person can go back to a “normal” functioning, to return to his/her pre-crisis level of functioning. Two major schools of thought, psychodynamic and cognitive behavioral, until very recently, had not directly addressed spiritual or existential issues of human adjustment and psychological well-being.

However, in the history of psychotherapy theorists of the humanistic-existential schools of thought, like Rogers (1951), Frankl (1969), and Yalom (1980), addressed, although not directly, the phenomenon of growth through closely related phenomena such as finding meaning, transforming through adversity and trauma, or becoming self-actualized. Rollo May (1981) wrote on

the transformative power of trauma “giving up the delusion of false hopes [...] Then and only then can this person begin to rebuilt himself” (p. 236). Since most individuals seek psychotherapy after or while they are going through some sort of crisis, which they feel exceeds their coping capacity, it is reasonable to consider growth as an integral part of psychotherapy. Within the emerging paradigm of Positive Psychology, the third wave of Cognitive Therapies, and recent developments in Psychodynamic Therapies (Zoellner, & Maercker, 2006), growth as a process or outcome of psychotherapy can be introduced to psychotherapists.

Traditional Grief Counselling has been criticized repeatedly both theoretically and empirically as possibly ineffective (Allumbaugh, & Hoyt, 1999; Jordan, & Neimeyer, 2003; Neimeyer, 2000; Neimeyer, & Hogan, 2000), making space for the development of new therapeutic approaches to traumatically bereaved individuals. Theorists on growth like Joseph and Linley (2006; Joseph, 2004; Linley, & Joseph, 2004), Calhoun and Tedeschi (1998; 1999; Calhoun, Tedeschi, Cann, & Hanks, 2010; Tedeschi, & Calhoun, 2004b) have offered advice for the clinical application of their theories in broad lines. Those suggestions however are offered within a frame of caution. Therapists can realize that trauma does not necessarily lead to psychopathology and damaged lives, and be aware of the possibility of growth after the struggle with a traumatic event. However, both of these realizations do not question the psychological distress resulting from trauma, nor do they suggest that all trauma survivors should, or can experience growth. Dismissing the distress of trauma survivors and forcing them to experience growth can only have detrimental effects on their psychological well-being (Calhoun, & Tedeschi, 1999; Joseph, & Linley, 2006; Tennen, & Affleck, 1999).

As the Joseph and Linley model (2005, 2008) is strongly based on the *person-centred* model and Carl Rogers’ (1959) seminal work, their suggestions (Joseph, 2004; Joseph, & Linley, 2006; Linley, & Joseph, 2004) for treating PTSD and helping traumatized individuals not only to recover from trauma, but to achieve growth as well, are within a person-centred theoretical framework. According to Rogers (1959), PTSD can be understood “as representing the normal psychological manifestation of a process that is instigated when the

self-structure comes under threat” (Joseph, 2004, p.105). This conception is not very different from later social cognitive theories like Horowitz’s (1986) and Janoff-Bulman’s (1992). Rogers (1959) suggested that the traumatized individual needs to accurately symbolize in his/her awareness the traumatic experience in order for the reintegration of self and experience to be achieved. Again, this is not far from current conceptualizations of trauma treatment that emphasize exposure (Foa, & Rothbaum, 1998). Posttraumatic growth represents the congruent reintegration of self with experience, where the person goes beyond the pre-trauma levels of functioning and comes closer to becoming a fully functioning person as Rogers (1959) had defined it:

“The fully functioning person is synonymous with optimal psychological adjustment, optimal psychological maturity, complete congruence, and complete openness to experience [...]. Since some of these terms sound somewhat static, as though a person ‘had arrived’ it should be pointed out that all the characteristics of such a person are process characteristics. The fully functioning person would be a person-in-process, a person continually changing” (p.235).

Within a person centred framework, including the well-known conditions of this type of psychotherapy, Joseph (2004; Joseph, & Linley, 2006) suggested the following areas of special concern for traumatized individuals in therapy. Psychotherapists working with traumatized individuals should have knowledge of the trauma literature regarding general reactions to trauma; however, their approach towards each individual client should not be guided or restricted by this theoretical knowledge, keeping the focus on individual treatment while avoiding making any assumptions about individual experiences.

Traumatized clients should not be pressurized or have their reluctance to talk about their trauma early in therapy judged. The disclosure will happen when the client feels accepted and understood by the therapist. For this step to be achieved there should be no specific time frames. When eventually the client starts sharing her/his traumatic experience the therapist should not guide this narrative, but rather try and understand the experience from the client’s perspective and communicate this understanding back to the client; always aiming to achieve and sustain psychological contact with the client during the

therapy sessions. As the client starts to explore the meaning of his/her experience a person centred therapist is supposed to help the client hear his or her meanings so that she or he can reappraise and re-evaluate the experience for him-or herself. During this process, clients usually experience intense negative emotions that the therapist should not make any efforts to remove, but stay instead with his/her client's experience. In accordance with the person-centred model, a therapist providing therapy to a traumatized individual is not supposed to direct the client to exercises or activities, making suggestions, however, without further pressure is acceptable.

According to the *organismic valuing theory of growth* (Joseph, & Linley, 2005, 2008) and the *person-centred* model (Rogers, 1959), traumatized individuals actualize their innate tendency to growth and reach their personal growth when provided the appropriate environment that will facilitate and not impede this process. Thus, the psychotherapist is supposed to provide this social environment for his/her client. Nevertheless, growth is a very gradual and slow process and the therapist needs to respect the personal needs of time for each client. Finally, Joseph (2004) underlined the need for the therapists to understand that, regardless of their personal need to cause change, they should not take the responsibility for recovery away from their clients' hands. In agreement with Calhoun and Tedeschi (1999), therapists can only provide the therapeutic context conducive to PTG, but PTG can be achieved only by the client her/himself. The effectiveness of the suggestions made by Joseph and Linley (2005, 2006; Joseph, 2004; Linley, & Joseph, 2004) have not been tested empirically, but they do present a sound alternative to the wide-spread conceptualization of trauma, the treatment of PTSD and the promotion of growth. For clinicians experienced with this client group, this conceptualization of trauma therapy provides an alternative that is worthy of further exploration and evaluation.

Tedeschi and Calhoun have published extensively in the area of growth and their model and questionnaire have dominated this field of scientific inquiry (Calhoun, & Tedeschi, 1999; Calhoun, & Tedeschi, 2006; Tedeschi, & Calhoun, 1995; Tedeschi, Park, & Calhoun, 1998; Tedeschi, & Calhoun, 2004a; Tedeschi, & Calhoun, 2004b). Throughout their theory and research

development, they have both remained clinicians providing psychotherapy to traumatized individuals and have published chapters in edited books, journal articles and two clinician's guide books (Calhoun, & Tedeschi, 1998; Calhoun, & Tedeschi, 2007; Calhoun, & Tedeschi, 1999; Calhoun, Tedeschi, Cann, & Hanks, 2010; Tedeschi, & Calhoun, 2004b), the latter being specialized in counselling and psychotherapy for bereaved parents.

Tedeschi and Calhoun (2004b) provided a general framework for interventions, and underlined the major difference between bereaved parents and other client groups. Although bereaved parents may appear in therapy to be in a great psychological distress, in most of the cases, they were psychologically healthy individuals before their loss. Consequently, the clinician should be able to trust them to find their own way to grieve and survive, rather than to proceed to various psychological interventions needed in types of psychopathology like mood or anxiety disorders. However, treatment approaches focusing on trauma (Foa, & Rothbaum, 1998; Herman, 1992) might be an integral part of psychotherapy for bereaved parents. Another issue raised by these authors, but also by other specialists on bereavement (Gerrish, Steed, & Neimeyer, 2010), was the very long journey that parental bereavement is and the need for the therapist to accompany them in this long journey of resolution; something that is not always possible because of setting restrictions (managed public care). Short-term therapy that has become increasingly popular may not be appropriate for bereaved parents, and a clinician might at least try to spread out the number of sessions allowed in his/her setting within a longer period of time in order to accommodate the needs of bereaved parents.

The central clinical stance suggested by Tedeschi and Calhoun (2004b) is that of an *expert companion*, downplaying professional clinical expertise, in order to promote safety and trust in individuals who have often felt avoided, isolated, and misunderstood and in great despair for the unnatural loss of their children. As a companion, the therapist can offer to the parents what their social environment has often denied them, and stay with them as they talk about their children's lives and deaths. Moreover, in accordance with the suggested therapeutic stance and the assumption that bereaved parents are psychologically healthy individuals, the therapist should be less directive and

more open to the parents' expectations and suggestions of what is helpful in therapy. Providing very structured sessions according to any specific psychotherapeutic approach might not be the therapy that a bereaved parent needs or finds helpful. The therapist must be eager to learn the special meanings and qualities the life and death of their children hold but also the circumstances surrounding death. Parents can feel safer with a clinician who wants to know about their child and respects his or her memory, so the therapist should encourage the parents to help her/him to know their child by inviting them to share pictures, videos, and stories (Tedeschi, & Calhoun, 2004b).

If we consider bereaved parents after a perinatal loss, it appears that the initial stage of establishing the relationship between client and therapist is very important. Possibly most of the therapists are not aware of the medical procedures involved in a stillbirth and allowing the parents to explain their personal experience will assist the therapist to understand the personal experience of each and every client. An expert companion will allow them the space to talk about their loss and will not fail to acknowledge the importance of their loss, as their social contexts often do, will not end the conversation with uncomfortable silences, or just avoid them. A mother who has lost her baby perinatally being invited to share the pictures of her baby can appreciate this invitation even stronger, as these pictures are the only tangible evidence of her child's existence and other individuals have possibly avoided to look at them. The therapist who comments on the looks of the baby in the pictures, as Tedeschi and Calhoun (2004b) suggest, might offer mothers a chance to feel pride about her beautiful baby, a pride that might help her rebuild her sense of self-worth. Because these bereaved mothers experience a great incongruence between the intensity of their grief and the societal acknowledgment and validation of that grief, the presence of an expert companion will provide the validation needed, allowing them the space to comprehend their loss and work through its traumatic qualities. As seen in the literature discussion and the present results, rumination is essential for grief and trauma resolution, and the therapeutic context can be a facilitating factor for this process.

A therapist working with bereaved parents should become informed on the sociocultural context of the parents and the ways this shapes their grief experience. Tedeschi and Calhoun (2004b) suggested that the clinician should become familiar with the social rules and norms to which the bereaved parents abide, their religious faith and its rituals, and the linguistic idioms on death and mourning used in their cultural milieu. All these are essential forces affecting the parents' course of bereavement and unless the therapist can judiciously accept and learn them she/he cannot follow the client in this journey. All participants in the present research were White British (except one who was White American) and there were limited differences among them regarding the funeral and religious rituals, however in clinical practice, a client might be from a very different cultural background than the therapist. The social norms and rules might affect the availability of social support, chances for disclosure of emotions and what the parent feels he/she is permitted to do as part of a normal grieving process. Linguistic idioms and the need for the therapist to follow them is not an unfamiliar idea for clinicians, however, the sensitivity and vulnerability of the bereaved parents makes this need even more imperative; for example in cases a mother always talks about her baby with his/her name and the therapist continuously refers to the baby anonymously this might make the mother feel that the therapist does not validate the existence of her child and as a result withdraw from the therapeutic relationship.

Tedeschi and Calhoun (2004b) prompted therapists to initially explore and identify the primary groups of reference and support parents have and later to proceed exploring the effects of any change in the parents' perspective and attitudes on these groups. A clinician needs to know who are close to the bereaved parent, to whom she/he can turn to for emotional or material support, and whose opinion and advice does she/he greatly value and for what reasons. This information might be especially valuable because the therapist will become aware of sources of influence, apart from therapy, but also of the direction towards which these sources push the bereaved parents. Encouraging the client to proactively explore the consequences of change on their relationships with important others might also further empower the client to

take the responsibility of his/her change, weigh the consequences and be prepared for them.

In the case of bereaved mothers following a perinatal loss, there can be many examples underlining the need for the above referred to exploration. One of the participants in the present research mentioned her close relationship with a priest, and how her words had affected her grieving process from very early on; if her hypothetical therapist had failed to explore her primary reference groups she/he would have missed this important information. Through therapy, a bereaved mother might become able to realize who can and are willing to support her and who are not, and decide both the actions she wants to take in order to receive the support she needs and how to remove sources of additional distress. Helping bereaved mothers identify their social support group, and encouraging her to reach out and seek the emotional support they needs might be a catalytic step towards growth as the results of this research along with many other studies has revealed (Prati, & Pietrantonio, 2009; Taku, Tedeschi, Cann, & Calhoun, 2009). Regarding social support, Tedeschi and Calhoun (2004b) strongly urge, the clinicians to inform the parents about support groups for bereaved parents; according to their view others who have gone through a similar loss can be great sources of information, guidance, support, and comfort. Indeed, the beneficial effects of support groups on perinatal parental bereavement have been repeatedly documented (Cacciato, 2007; Cordell, & Thomas, 1997; McCreight, 2007; Reilly-Smorawski, Armstrong, & Catlin, 2002; Schwab, 1995-6; Wheeler, 1993-4).

Furthermore, a clinician working with bereaved parents should make an effort to understand their religious and spiritual assumptions (Tedeschi, & Calhoun, 2004b). In order to do so, the therapist must adopt the viewpoint of *pragmatic religious constructivism*, a viewpoint assuming that “it is desirable for the clinician to enter, respectfully, into the client’s religious worldview and help him or her utilize [...] spiritual understanding to recover, grow, and develop” (Calhoun, & Tedeschi, 1999, p. 110). Regardless of his/her own religious views or the absence of them, he/she must explore the parent’s beliefs about after life and the continued existence of the child, possibilities about contacting the child and the general role of God(s). As seen in earlier findings

and presented here, some parents resort to the existence of a Divine Plan and the existence of Heaven, while others believe in the spiritual existence of their children, something that allows them an ongoing connection and a hope to reunite after their death. Both of these views had positive impact on mothers' grief resolution with the latter contributing to their growth.

Regardless of the present results, it is evident from earlier research that religious and spiritual issues are central in parental bereavement and can either enhance the journey to growth or impede it. One example of how religious beliefs can impede grief resolution is the case of the concept of *being in limbo* of the Catholic church. In Catholicism it was believed, until 2007 when Pope Benedict XVI abolished this hypothesis, that children who die perinatally do not go in hell, but they cannot go to heaven either, because they are not baptized, and bearing the Original Sin they stay in limbo for ever (Peelen, 2009). This representation of the unwanted and sinful infants can be very painful for parents and it deprives them the possibility of reunion in the afterlife. Consequently, when working therapeutically with a perinatally bereaved mother of Catholic faith, a clinician should address these religious beliefs and try to alleviate the unnecessary guilt and anguish that a mother may possibly experience.

In addition to *expert companionship*, another part of the clinical stance recommended by Tedeschi and Calhoun (2004b) is the adoption of a growth perspective. The first step in order to take this perspective is for the therapist to be aware of the possibility of growth, growth resulting from the struggle of bereaved parents with their loss. The therapist should be able to notice in the parent's narrative themes related to growth, but not necessarily name them as such, in case that would mean forcing the client to deal with a concept (growth) he or she is not ready. The therapist should use his/her clinical judgment on when it is the right time for parents to acknowledge the positive changes and explore them further. Using respectful language in this process might be a key for the maintenance of a good therapeutic rapport; it is strongly advised to suggest that it was the parents' struggle with the loss that have brought some positive changes and not the loss itself.

When exploring existential issues about the meaning of life with clients, parents may engage consciously in meaning making processes that often lead to benefit finding. In the present research many participants had asked the researcher, on the initial telephone discussion, what she meant by growth and positive changes, being afraid that this kind of phrasing might imply the dismissal of the pain and struggle. In most cases the researcher responded with what one of the participants later repeated in her interview: *Patricia*: “well, I think you said on the phone to me about, um, we can either – for everything that’s happened since I would trade it all for the baby I lost which I think is very very true, you know, you wouldn’t want to have gone through but it happened, you know. So, um, you just – you just feel as though – I don’t know, it changes your whole perspective on life, um” (9/237-241).

Tedeschi and Calhoun (2004b) underline that sometimes the positive changes arising from the struggle with loss can also act as memorials to the dead child; noting that this might be a more intense need for the parents who lose a baby perinatally, as their child did not have the opportunity to live, they need to commit in actions that will create a legacy for those short lives, a legacy that will touch as many peoples’ lives as possible. The accuracy with which this commentary from Tedeschi and Calhoun (2004b) captures what participants shared in the present research is impressive. The subthemes of “growth as an affirmation of the baby’s importance” and many parts of the subtheme on “empathy and companionship” reflect this exact need of bereaved mothers. A therapist can find ways for this need to be fulfilled by suggesting memorials, charities, scholarships or other ways where the name of their child would live.

In accordance with the *expert companionship* attitude, the therapist should focus on listening, as a fully present listener is essential for the parent to feel free to talk about all the horrific details of his/her loss. Although most clinicians feel compelled to intervene and reduce the emotional distress, or to solve the problem, Tedeschi and Calhoun (2004b; Calhoun, & Tedeschi, 2007) suggest that a passivity adopted by therapists is a building block towards growth. Going a step beyond they suggest that “therapists will be most

effective when they listen in a way that allows them to be changed by their clients' experience rather than being intent on promoting certain changes in the client" (Calhoun, & Tedeschi, 2007, p.168). This kind of respect for the bereaved parent is powerful. When the clinician acknowledges his/her limitations and provides her/his full attention, she/he acknowledges how profound this loss is, and how much it takes to endure it; thus, providing recognition to the parents that they are managing such a great struggle. When a therapist is willing to learn and be changed she/he acknowledges the value of this experience and allows the legacy of the dead child to touch her/him as well.

Finally, Calhoun and Tedeschi (2007; Arnold, Calhoun, Tedeschi, & Cann, 2005; Tedeschi, & Calhoun, 2004b) described how this attitude of listening and being changed can lead therapists to *vicarious posttraumatic growth*. In a qualitative study conducted by them and their colleagues (Arnold, Calhoun, Tedeschi, & Cann, 2005) they interviewed 21 psychologists (clinical or counselling), with a mean of 16.9 years of experience in clinical practice, and a 45% of their client load being with traumatized individuals, while 81% of the therapists themselves had experienced a traumatic event in their lives. The interviews were analysed with constant-comparison analysis.

The most frequently reported (90%) positive consequence of the psychologists' work with traumatized individuals was observing and encouraging clients' posttraumatic growth. Another set of positive changes reported from nearly all participants (86%) was enduring changes in the self, mostly concerning increased sensitivity, empathy, compassion, insight and tolerance. Enhanced spirituality and heightened awareness of their good fortunes were also reported by more than half of the participants, while nearly half of them shared how their clients' struggle with trauma had deepened their own appreciation of the strength and resilience of the human spirit. These results, although preliminary, give an indication that working with traumatized individuals is not only hazardous for the therapist, as it has been implied in the past (McCann, & Pearlman, 1990; Pearlman, & Saakvitne, 1995), but it can also be a very valuable experience causing positive changes in the therapist.

The models and suggestions presented in this section do not necessarily have the strong empirical evidence to be considered as treatment manuals, or models that could be adhered to and applied universally. However, they are the only perspectives available for counselling psychologists and psychotherapists to be inspired by and start considering growth as a possible outcome after severe traumatization. Concerning bereaved mothers after a perinatal loss, these suggestions to therapists to adopt a non-intervention approach might enable them to provide the necessary support and companionship for the resolution of the non-validated loss of the mothers.

4.8 Critical evaluation of the research project

4.8.1 Strengths

The present research project attempted to draw attention to the experience of growth after a perinatal loss. Qualitative research on perinatal loss is sparse and usually conducted by scientists from disciplines other than psychology. What this research offers is some initial knowledge on the essence of the experience of growth after a perinatal loss, as growth in relation to perinatal bereavement has only been explored once in a quantitative study by Büchi and his colleagues (2007). This research aimed to explore the experience of growth in mothers who had either experienced a stillbirth or a neonatal death rather than the commonly explored psychopathology resulting from these types of bereavement. As this is a new area of scientific enquiry, the qualitative methodology permitted a deeper understanding of the phenomenon of growth and the processes involved in its achievement. The richness of the information available from the interviews can enlighten researchers and clinicians about the essence of the experience for these participants in a way that scores on questionnaires would not have permitted. The interviews revealed the traumatic nature of this type of bereavement, the caused disequilibrium in the participants' personal identities, the various coping mechanisms that can be activated after this loss, the catalytic role of the presence or absence of social support in this process, the areas of growth and its possible fountains. Within the emerging paradigm of Positive Psychology, the present study is a first

attempt to associate perinatal bereavement with growth from a counselling psychology perspective.

Concerning the research procedures there are certain aspects that contributed to the richness of the participants' accounts (for a detailed description please see chapter 2). The professional identity of the researcher equipped her with the necessary skills for the establishment of a warm, relaxed and trusting atmosphere during the initial contact (through telephone) and the ensuing interviews. The fact that the participants knew that the researcher herself had gone through a similar loss did not appear to have a negative effect on their disclosures, on the contrary it reassured them that she could deeply understand their loss and pain and that the positive changes explored did not imply in any way the insignificance of their loss and anguish.

Regarding the analysis of the interviews, the credibility of interpretations was addressed by the application of various measures (also described in detail in chapter 2), like the presentation of parts of the interviews and their interpretations to the supervisor, other PhD/DPsych students, and an IPA study group. Attention was given to discrepant data in order for the narrative accounts to maintain a balance between what was distinct to individuals and what was common to the group as a whole.

4.8.2 Limitations

This research project is based on the interviews of eight mothers bereaved from a perinatal loss and the generalizability of results is bound with the intrinsic limitations of qualitative methods, including IPA. Qualitative methods can provide depth of knowledge but attract criticisms regarding the generalizability of results. The analysis was specific to these participants, from the specific researcher, at a certain time, and as such, other interpretations of the same material are possible. The researcher acknowledges that her personal identity as a bereaved mother might have affected her interpretations, although many measures were taken in order to avoid misuse and abuse of the interpretative liberty inherent in IPA. If another researcher with another set of participants had followed the same interview schedule, it is always possible

that different results might have occurred. However, most of the themes reported in the present research have been also reported in past bereavement or growth studies. The present results are based on the participants' self-reported and self-perceived growth and not in any standardized measure of growth; consequently one could question the validity of those reports.

Moreover, IPA as a qualitative methodology has some inherent limitations and the results of the present research are unavoidably affected by those. A common criticism of IPA could apply in the present research. The extent to which some participants are able to communicate verbally the rich texture of their experience can be possibly affected by how used they are in expressing their thoughts, feelings, and perceptions in words and that in turn may affect the richness and depth of their interviews (Moustakas, 1994; Willig, 2008). Indeed, in the present research the participants who were coming from professions that demand linguistic articulation (counselor, lawyer) appeared to be able to respond to the research questions more elaborately and reflectively.

Regarding the recruitment of these participants, the fact that they were mostly recruited through the website of a charity specialized on perinatal death (SANDS) might have limited the possible pool of participants and targeted only those strongly connected with the identity of the bereaved mother. It was explicitly said on the flyer that the researcher was searching for individuals who had experienced positive changes since the death of their firstborn child, and this "positive" label may have discouraged some women to participate. Generally, if at the time of designing the present research the researcher had the knowledge and understanding of the phenomenon of growth that she has today, she would have adopted different phrasing regarding growth in e.g., the flyer and interview schedule questions 7 and 8 that imply that growth can come as an outcome of the loss and not the coping with the loss.

In the present sample all the participants shared a similar cultural or ethnic identity (that of mainstream White UK, only one being American, but she had lived most of her life in the UK), and none of the participants was separated from her partner after her loss. In case the sample had been more diverse, then it is possible that richer results might have emerged, since we would have been able to obtain more information on whether the processes and

experiences reported were culture specific or more universal, or whether facing grief without the baby's father present would have made a difference. A final limitation of the present research is that only one of the participants had experienced a neonatal death, thus there is an issue of poor representation of this type of perinatal loss (she was the last interview taken), although both types of perinatal loss (stillbirth and neonatal death) were described in the research advertisement. The rationale for not attempting to recruit more participants with this type of loss was that after the first stage of analysis the themes that had emerged were not very different (apart from the description of the circumstances surrounding the death of her baby) from the those that had emerged from the majority of the participants who had experienced a stillbirth and thus saturation was reached.

4.9 Suggestions for further research

The confidence in the findings of the present research would be enhanced by additional qualitative work in this area. As the sample of the present study was limited it cannot be claimed that we now know the essence of the experience of growth after a perinatal loss. More women sharing their personal experiences could definitely enhance the understanding of the phenomenon for clinicians and researchers. However, future research should not only focus on the experience of growth in mothers but also on fathers. In quantitative research on growth and parental bereavement, fathers have been included in the sample usually in order to provide evidence of gender difference on the levels of growth, with mothers found to experience more growth (Büchi, et al, 2007; Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010; Znoj, & Keller, 2002). In order for the scientific community to understand the fathers' experience of growth and the possible reasons for gender differences, qualitative research should be carried out.

Furthermore, future research could explore the experience of growth for women that have gone through similar but not identical types of loss such as the loss of one twin perinatally, the loss of a baby that was not the firstborn, the death of a baby conceived through in-vitro fertilization, the death of a baby in

gay families, the experience of single women, and of women that because of medical complications related to the loss can no longer reproduce. Exploring these other occasions of perinatal death could enhance our understanding of the experience and the conditions facilitating or impeding growth. Regarding personality characteristics as determinants of growth more research is needed and possibly of a quantitative nature in order to assess personality characteristics with validated instruments. It is possible that we would then manage to identify personality characteristics related to the enhanced potential of some individuals to cope with adversity and grow out of it. In the present research no claims are made regarding the personality traits of the participants and how these affected their experience of growth, because solely the clinical judgment of the researcher outside a clinical setting cannot be considered a valid source of information.

Additionally, future research should further explore social support, the theme that surfaces in numerous studies on bereavement and growth. While it has been repeatedly reported that social support is an essential prerequisite for growth, an equally frequent finding is the reported lack of social support for bereaved parents. Qualitative research with families or close friends exploring the reasons for unsupportive reactions to parental bereavement would enhance our knowledge in very practical terms. We need more information on what clinicians, educators, media, social workers, and medical professionals should do in order to encourage the social support of this vulnerable group of individuals, bereaved parents. An interesting aspect of the issue of social support in parental bereavement is the possible cultural influences and differences.

Finally, qualitative future research with bereaved parents could enlighten the scientific community on which processes and representations are experienced as helpful by parents and which as unhelpful in their journey to grief resolution and growth. The models suggested in the psychotherapy section, although promising, have only anecdotal support, with no controlled trials conducted to date. Researchers employing quantitative methodologies should be informed of the insights offered by qualitative research and develop more sensitive and rich questionnaires that will not only provide growth

achievement scores, but will be also able to address the fountains of this growth. Regarding theory development, in order for the scientific community to have more vertical (in depth) understanding of the phenomenon of growth rather than horizontal (superficial), researchers should focus more on the elaboration of existing theories and the clarification of their key constructs, rather than developing new theories, with similar key constructs phrased in neologisms. The endless development of scientific nomenclatures that name and describe similar phenomena and processes has been destructive for the emergence of an elaborate model of growth.

4.10 Implications for Counselling Psychology

The four pillars upon which *Counselling Psychology* in the UK was built were: (a) The importance of the helping/ therapeutic relationship; (b) Its reaction to the medical model; (c) Its focus on well-being and personal development; and (d) The scientist-practitioner role (Woolfe, 1996). The findings of the present research could potentially serve all four of them. The researcher, as a counselling psychologist herself, throughout the research process acted as both a researcher in psychology but also she approached each stage of the research as a practitioner. The methodological approach taken (qualitative, IPA) and also the way the research question was posed takes distance from the medical model that usually explores the psychopathology that can occur after traumatic losses. The absolute focus of the present research was on human well-being and personal development after facing extreme adversity. Hopefully, the counselling psychologist who will read the stories of the generous participants of this project and will get informed of all the available research on perinatal loss and posttraumatic growth will be able to form stronger therapeutic relationships with his/her future clients who will have suffered such a loss; thus the present research hopes to serve this principle of *Counselling Psychology* as well. The present project was an attempt to bridge *Counselling Psychology* with the rapidly emerging movement of *Positive Psychology*, a movement that appears to be so closely related to the

philosophical roots, the unique identity, and the mission of *Counselling Psychology*.

Appendix A: Research advertisement on SANDS main page and linked information.

How mothers experience personal growth after a perinatal loss

Olga Thomadaki, a bereaved parent herself, is conducting research for her Doctorate in Counselling Psychology at City University, London with the title “How mothers experience personal growth after a perinatal loss”. The research has been approved by City University, London and is supervised by Fiona Bailey, CPsychol.

Olga is looking for mothers whose first baby was either stillborn or died within the first month of life between 1 and 5 years ago and who did not get pregnant again for at least year after their loss.

If you feel able to participate in Olga's research please contact Olga direct on [thomadakio\(at\)hotmail.com](mailto:thomadakio(at)hotmail.com) or via the Message Boards (Username Olga).

Further details and an explanation of the research, why it is being carried out to enable you to make a decision whether or not you wish to participate in the study are below or you can download a copy by [clicking here](#).

Flyer

Rebirth

*I am emerging from an ocean of grief
from the sorrow of many depths,
from the inevitability of tragedy
from the losing of love,
from the terrible triumph of destruction
I am seeing the living that is to lived,
the laughter that is to be laughed,
the joy that is to be enjoyed,
the loving that is to be accomplished.
I am learning at last
the tremendous triumph of life.*

(Marjorie Pizer)

Do you feel reborn, grown, changed while coping with your baby's loss?

Do you feel that the loss and mourning for your baby changed you as a person, your relationships with others or your perspective in life?

Did you lose your baby between 1 and 5 years ago?

Was it your first baby?

I am very interested in hearing your experiences of personal growth after a perinatal loss.

If you are a mother of a "baby angel" and you would like to tell your story or to receive further information please contact Olga Thomadaki, Counselling Psychologist in training, City University, London, on : 07891733634, at thomadakio@hotmail.com, or sent me a message via the forum, surname:

Olga

Thank you

*This research is part of my Doctorate in Counselling Psychology,
Abides by the Code of Conduct, Ethical Principles and Guidelines published
by the British Psychological Society*

*Research supervised by Fiona Bailey, CPsychol, Department of Psychology,
City University, tel.: 020 7040 4557, email: fiona.bailey.1@city.ac.uk.*

Information Sheet

My name is Olga Thomadaki and I am conducting research for my Doctorate in Counselling Psychology at City University. The research has been approved by City University and is supervised by Fiona Bailey, CPsychol.

Below I offer a brief explanation of the research, why it is being carried out, in the hope that it will assist you in deciding whether or not you wish to participate.

What is the purpose of the study?

The aim of this research is to gain a deeper understanding of the experience of growth after the perinatal loss of a baby. Growth can be broadly defined as any perceived positive change in an individual's sense of self, relationships with others, or in one's general philosophy of life. This study is developed to help counselling psychologists, health care and mental health professionals to better understand the essence of this experience. This understanding will promote their ability to offer support and valuable therapeutic interventions for those affected by such a traumatic loss.

Who can participate in the study and why?

In such research projects in order for the researcher to be better able to obtain meaningful and useful findings homogeneity in the characteristics of participants is very important. Without undermining your experiences, the importance of your loss, or the value of your feelings some inclusion criteria have been set. Mothers, whose first babies were stillborn or died within the first month of their lives, one to five years ago, and who did not get pregnant again for at least a year after their loss are invited to participate in the study. Your age, educational level, ethnic background, relationship status, sexual orientation or the method of conception are not among the participation criteria. The most important aspect is that you need to feel that you have something to say regarding my research question, something that you would

like to share with me. So, if you feel reborn, grown, changed after coping with your baby's loss you are invited to participate in this research.

If I participate, what will I have to do?

If you decide that you would like to be involved in this research project you will be asked to participate in a one-to-one interview with the researcher which will last for approximately an hour. The interview will be audio recorded and the researcher might also keep notes during this interview. You will be asked to complete a very brief demographic information sheet, and a consent form. You will keep a copy of the consent form and a resource pack which gives details of available support resources for bereaved mothers and their families.

What about confidentiality and anonymity?

This research follows the Code of Conduct, Ethical Principles and Guidelines published by the British Psychological Society (www.bps.org.uk).

Confidentiality and anonymity are ensured throughout. No personal characteristics will be attached to the transcripts or the interview notes. All interview recordings, transcripts and notes will be kept in secure location with access permitted only to the researcher. All gathered information will be kept for the duration of the research only and then will be destroyed. The demographic information sheets and the consent forms will be treated in the same way. No names or identifying characteristics will be used in any reports or future publications.

What will happen with the findings of the study?

The findings of this research will be included in my Doctoral Thesis. In order to communicate my findings to health care and mental health professionals the study may be published in a scientific journal at a later date. In any of these cases, no names or identifying characteristics of participants would be included. Please let me know if you would like to receive a copy of the research findings.

If you have any further questions or wish to take part on the study please contact:

Olga Thomadaki, Counselling Psychologist in training, City University, on: 07891733634, or at thomadakio@hotmail.com

If you have any concerns or complaints on the study please contact:

Fiona Bailey, CPsychol., Department of Psychology, City University, on: tel.: 020 7040 4557, email: fiona.bailey.1@city.ac.uk.

Appendix B: Consent Form and Demographic Information Questionnaire

Consent Form

Dear Participant,

Thank you for agreeing to contribute in this research which aims to explore a mother's experience of psychological growth after the loss of a baby.

Please read the following before signing this form and agreeing to fully participate in the study. Please note that two copies of this form need to be signed both by you and the researcher, so that each keeps a signed copy.

- This study is conducted in partial fulfilment of a Doctorate in Counselling Psychology at City University and is supervised by Fiona Bailey, CPsychol. In the event of any concerns, comments or complaints arising from this study you may contact Fiona Bailey, Department of Psychology, City University, tel.: 020 7040 4557, email.: fiona.bailey.1@city.ac.uk.
- Any information you may give will be handled as confidential and anonymous. Your name will not be attached to the transcripts of the digitally audio recorded interviews, the sheet of personal characteristics or the notes kept by the researcher during the interview. The researcher, supervisor, and anyone involved in the immediate research process, written reports, or future publications will treat this information in accordance with the Code of Conduct, Ethical Principles and Guidelines published from the British Psychological Society (www.bps.org.uk). The hardcopies of the interview transcripts will be kept in a locked cabinet at City University during the research process and will be destroyed by the researcher herself after its completion.
- Your participation is voluntary and you are free to withdraw from the study and free to withdraw your data from any future analysis and/or publication at any time without having to give any explanations. The interview will be recorded on a voice recorder for transcription purposes. However, you can request the cessation of the recording at any time without needing to give

any reason. The researcher will keep notes during your interview for research purposes, you can again request that the researcher stop at any time.

➤ If you wish you can be informed of the results of the research by providing your e-mail or postal address.

- | | Yes | No |
|--|--------------------------|--------------------------|
| ➤ I have had the opportunity to ask questions about the interview process and the research. | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ I have read and fully understand the requirements of the research. | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ I hereby fully and freely consent to participate in the research entitled: How mothers experience personal growth after a perinatal loss. | <input type="checkbox"/> | <input type="checkbox"/> |

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature

Request for summary of the findings (optional)

Please tick box

I would like to receive a copy of a summary of the research findings at either:

my e-mail address: _____

or my postal address: _____

Thank you very much for agreeing to take part to this research. Please do not hesitate to contact me or my research supervisor if you have any further enquiries.

Olga Thomadaki

Counselling Psychologist in training, City University,

thomadakio@hotmail.com

Demographic information Questionnaire

Please answer the following questions or tick the appropriate box. The information that you give is confidential, no personal identifying information will be included in the study.

Your age: _____

The highest educational qualification you have completed:

None

GCSE(s)/O-LEVEL(s)-CSE(s)

A-Level(s)

Diploma (HND, SRN, etc)

Degree

Postgraduate degree/ diploma

Number of children in the family: _____

Age and Gender of children: _____

Ethnic Background: _____

Religious views (if any): _____

Thank you

Appendix C: Resource Pack

If taking part in this research has raised any issues that you or any member of your family feel you would like to discuss further, in a professional and confidential setting, you can find a qualified therapist by contacting the following accrediting bodies:

The British Psychological Society:

Tel.: 0116 254 9568

Email: info@bps.org.uk

Or visit www.bps.org.uk to search online

The British Association for Counselling and Psychotherapy

Tel.: 0870 443 5252

Email: information@bacp.org.uk

Or visit www.psychotherapy.org.uk to search online

- The following organizations offer free specialized support to bereaved parents and their families:

- ✓ Stillbirth and Neonatal Death Society (SANDS)- www.uk-sands.org,
tel.: 0207 436 5881 (Helpline-open every day)
- ✓ The Foundation for the study of Infant Deaths (FSIDS)- www.fsids.org.uk,
tel.: 0207 233 2090 (Helpline-open every day)
- ✓ Child Death Helpline- www.childdeathhelpline.org.uk
tel.: 0800 282 986 (Helpline-open every day)
- ✓ The Compassionate Friends- www.tcf.org.uk
tel.: 0845 123 2304 (Helpline-open every day)
- ✓ Cruse Bereavement Care- www.crusebereavementcare.org.uk
tel.: 0844 477 9400 (day by day helpline), 0808 808 1677 (young person's helpline)
- ✓ Winston's Wish (Support for bereaved children and young people)-
www.winstonswish.org.uk , tel.: 0845 203 0405 (Family Line)
- ✓ www.babyloss.com- Useful website with details of National baby loss awareness week.

- Alternatively, you may find the following books helpful.

- Kohner, Nancy & Henley, Alix (2001). When a baby dies: The experience of late miscarriage, stillbirth and neonatal death. London: Routledge.
- Kubler-Ross, Elisabeth (1983). On children and death: How children and their parents can and do cope with death. New York: Touchstone.
- Noel, Brook & Blair, Pamela (2007). I wasn't ready to say goodbye: Surviving, coping, and healing after the sudden death of a loved one. Naperville, Illinois: Sourcebooks.
- Sanders, Catherine M. (1999). Grief: The mourning after: Dealing with adult bereavement. New York: John Wiley & Sons.

Please do keep this document attached to your copy of the consent form for future reference.

Appendix D: Interview schedule

1. Is there anything you would you like to share with me about your loss?

This question is included to allow the mothers the space to talk about their baby and establish rapport with the participant.

2. How did you make sense or find some meaning of your baby's death?

Prompt: Can you tell me more about this process of finding a meaning?

3. How did you come to understand or interpret the meaning of your baby's loss?

4. How is your sense of spirituality after the loss of your baby?

Prompt: religious beliefs, existential dilemmas.

5. How is your sense of personal identity after the loss of your baby?

Prompts/ Sub questions: a) how would you describe yourself as a person? b)

The loss of your baby made a difference to how you see yourself? c) What

about compared to before you lost your baby? d) What about the way people see you?

6. How is your sense of priorities and your view of the world since the loss of your baby?

Prompts: Regarding interpersonal relationships, career, family, charity.

7. Sometimes people who lose a loved one find some positive aspect in the experience. For example, some people feel they learned something about themselves or others. How do you feel about this?

Prompts: learning, development, maturity, strength.

8. What would be the greatest gift you got from your baby?

Appendix E: Extract from participant transcript

were on offer but I didn't feel that I wanted to take that up. It was kind of – like I say, it was this joint thing, we kind of really turned to each other and that got us through yeah.

Um, so I started with the basic course and then really enjoyed it and the next thing it was a certificate and I did that and then I did the diploma and, er, so it kind of went hand in hand with – all these things I felt were a positive step in this – in this – this new reality where I was up to and I had to challenge myself a lot, you know, and obviously a lot of stuff came up for me, losing my son and, you know, the complete alterations and everything that I thought these certainties in my life to the extent that I'd worked out and these attitudes, um, and I just – I just really embraced it all, you know. It was a very different way for me to do things because I, you know, I just used to immediately think – anything like it was like no, don't do that so I had to challenge myself to open up to anything – any experience.

It was kind of – I'd been through such a traumatic thing nobody could hurt me again in that way, you know, um, and then to lose my job as well that was a traumatic thing to happen. So it was like, you know, it was like, um, you know, let's give it a go, let's just put ourselves out there and what's the worst that could happen, well it's already happened so [laughs], you know. Yeah and so many good things came my way because I – I altered the mindset...

Your mindset.

...completely opposite. I – it was probably when you think back now, you know, because people try to be very logical, don't they, no I can't do that because – I can't go on a course and I can't have a baby, I can't do that because they won't fit in. But it was like if we have a baby that's a bonus and I had two babies on the course [laughs] and everybody thought I was – how do you cope, how do you do it, how are you doing a dissertation, how are you doing - and you just do it because I wanted to do it because it was my witness to my son, this is what it was all about and that was the – that was the driving force because I would have given up on it.

Having the – my second child would have been the excuse for me to go I'm not doing that anymore but, no, that was the – that was the thing I wanted to do, you know, so I carried on and carried on and I eventually got there and, er, had my third child two months before I graduated. So – but it's amazing what you can do [laughs].

Appendix F: Master Table of Themes

How mothers experience personal growth after a perinatal loss

1. The Experience of Perinatal Loss as a Trauma
 - A. Maternal Determination and Investment
 - B. The absence of Predictability: Experiencing perfect pregnancies and babies
 - C. “No heartbeat”: The moment when the world collapses
 - D. Having a silent birth: The entrance to a lonesome motherhood
 - E. Death in the face of one’s baby: The first and last meeting with the baby
 - F. Iatrogenic Psychological Trauma

2. The Ripples of Loss
 - A. The amputated object relationship
 - B. A socially unrecognized maternal identity
 - C. The threatened reproductive ability

3. Working through the Trauma
 - A. Rumination and Disillusionment
 - B. Oscillating between Action and Avoidance
 - a. Avoiding the Pain
 - b. Active Emotional Coping Mechanisms
 - C. Religious or Spiritual Coping
 - a. Spirituality preserving an orderly world
 - b. Spirituality preserving an ongoing bond
 - D. Quality of Social Support as a Catalyst

4. Trauma Resolution and Growth
 - A. The fountains of Growth
 - a. Growth as an affirmation of the baby’s importance
 - b. Growth as an outcome of the awareness of personal vulnerability
 - B. The Ripples of Growth

- a. Transformations in Self Perception: Self-worth and Self- efficacy
- b. Transformations in Perception and Attitude: Appreciation of Life and Changed Priorities
- c. Transformations in Relationships: Empathy and Companionship

A. Maternal Determination and Investment

Charlotte	1/2-4, 2-3/44-50
Laura	2-3/40-1
Wilma	3/50-55
Patricia	1/2-14 , 1/19-21,19/520-523
Claudia	1/9-19, 4/68-70, 15/392-3, 1/14-9
Regina	8/189-92
Lorna	9-10/164-75
Julia	1/6-12, 2/14, 2/18-25, 3/30-4

B. The absence of Predictability: Experiencing perfect pregnancies and babies

Charlotte	1/12-3, 1/14-20, 2-3/46-50, 3/66-68
Laura	10/226-7, 2/32-5
Wilma	1/6-10
Patricia	1/14-6, 1/19-21, 2/25-8, 2/43-5, 3/47-51
Claudia	1-2/19-21, 2/30-4, 3/59, 3-4/66-7
Regina	
Lorna	1/3-12
Julia	3/41-50

C. “No heartbeat”: The moment when the world collapses

Charlotte	1-2/21-5
Laura	9-10/216-222
Wilma	1-2/19-26
Patricia	3/54-63, 3-4/68-92, 6/137-42, 7/169-170
Claudia	5/124-147, 9/222-3, 9-10/237-40, 22/597-601
Regina	1/11-7, 1/4-9, 1-2/20-7, 2/28-35, 3/78-80
Lorna	1/13-4, 1/21-34, 3/46-51
Julia	4/51-9, 4-5/60-71

D. Having a silent birth: The entrance to a lonesome motherhood

Charlotte	4/79-89
Laura	
Wilma	
Patricia	18/492-8
Claudia	7/173-8, 10/245-50
Regina	2/52-4, 4/101-10, 5/111-14, 5/114-8, 10/241-44
Lorna	3/45-6, 4/58-62
Julia	

E. Death in the face of own's baby: The first and last meeting with their baby

Charlotte	2/30-3
Laura	
Wilma	16/377-80
Patricia	7/166-8, 7/183-4
Claudia	12-3/316-29, 13/33-4, 18/496-503, 19/521-5
Regina	5/126-30, 5-6/131-6, 6/144-7, 6/151-63, 7/165-76
Lorna	3/40-2, 4/63-4
Julia	

F. Iatrogenic Psychological Trauma

Charlotte	4-5/90-121
Laura	2/16-7, 10/218-9, 10/235-8, 10/228-30
Wilma	18/428-30
Patricia	6/137-9
Claudia	2-3/38-49, 4/86-91, 10/241-4, 10/258-61, 11/284-6, 12/305-9, 12-3/316-29, 14/361-66, 14/367-70, 14/375-84, 17/462-69, 19/513-6, 19-20/531-5, 22-3/616-7, 24/654-57, 24/662-69, 24-5/673-7, 42/1130-41
Regina	2/40-3
Lorna	
Julia	

2. The Ripples of Loss

A. A socially threatened maternal identity

Charlotte	
Laura	
Wilma	18-9/450-3
Patricia	18/489-91
Claudia	44/1171-1184
Regina	15/353-62
Lorna	
Julia	13/221-24

B. The amputated object relationship

Charlotte	11/262-266, 11/267-69, 12-3/292-300
Laura	10/225-7
Wilma	3/50-55, 7/155-58, 10/225-7, 18/443-46, 18-9/450-53, 17/417-9
Patricia	1/11-14, 19/520-523
Claudia	33/914-19, 29/801-2, 37-8/1027-32, 44/1190-3, 47/1251-1255
Regina	15/357-62
Lorna	
Julia	22/378-85

C. The threatened loss of reproductive ability

Charlotte	3/66-8
Laura	
Wilma	10/236-39
Patricia	9/235-6
Claudia	
Regina	
Lorna	6/108-111
Julia	22/381-85

3. Working through the trauma

A. Rumination and Disillusionment

Charlotte	6/136-145
Laura	2/36-8, 12/243-53
Wilma	16/382-83
Patricia	11/287-90-12/305-7, 8/202-212, 19/502-515
Claudia	23/641-43
Regina	9/217-221, 19/458-460, 7-8/186-90
Lorna	6/104-7
Julia	8/140-1, 15/271-4

B. Oscillating between Action and Avoidance

a. Avoiding the pain

Charlotte	10/246-50, 7-8/173-85, 11/256-261, 11/ 267-271, 9/218-23, 3/51-54, 3/57-62
Laura	6/118-125, 10/223-25
Wilma	2-3/43-56, 9/210-226, 4/89-92
Patricia	
Claudia	
Regina	14/346-351, 15-6/365-74, 4/103-6
Lorna	4/70-75, 9/157-162, 13-4/238-45, 15/265-270,
Julia	9/145-8, 21/368-74, 25/435-42

b. Active Emotional Coping Mechanisms

	Benefit finding	Self-blame	Downward comparisons
Charlotte			7/175-8, 8/189-96.
Laura	10/223-25	1/9-11, 2/36-8, 9/206-212	10/223-4
Wilma	4/89-92	4/85-88, 5/101-7, 7/159-64	4/89-92
Patricia			
Claudia		4/72-83, 5/100-8	
Regina	15-6/365-74, 4/103-6		4/103-6, 23/552-560
Lorna	7/115-7, 8/141-44		7/115-7.
Julia		7/117-120	

C. Religious or Spiritual Coping

a. Spirituality preserving an orderly world

Charlotte	6/147-151, 7/157-162
Laura	4/65-71
Wilma	
Patricia	
Claudia	26/716-719
Regina	20/469-476
Lorna	5/89-91
Julia	

b. Spirituality preserving an Ongoing bond

Charlotte	10/237-42
Laura	
Wilma	6/138-9, 7/141-2, 16/392-98, 15/354-60
Patricia	
Claudia	26/699-700, 32-3/891-4, 34/925-6, 31/849-50
Regina	7/177-181, 18/429-31, 19/442-5
Lorna	
Julia	14/240-2

D. Quality of Social Support as a Catalyst

	Supporters				Detractors				
	Partner	Family	Friends & Community	Health Professionals	Partner	Family	Friends & Community	Health Professionals	Professional Context
Charlotte			10/227-30				3/73-5		
Laura	3/43-5		6/129-30			3/46-8, 5/89-91, 4-5/84-6	6/114-5, 7/135, 8/161-3	7/138-44	
Wilma		15/370-2	12/285-86, 12/289-91, 13/292-96, 13/316-22, 14/323-334		11/253-58-11- 2/263- 74		12/281-3, 12/290-1, 13/296-306	2/32-39- 4/76-80	
Patricia	11/287- 290						15/390- 97,17- 8/459-76, 10/250- 257, 17/453-58		9-10/243- 246
Claudia	33/905-12	36/1000- 1, 41/1110- 1118	35/959-72, 39/1068-76				29-30/806-18, 30/831-33, 15/409-15, 37/1020-23, 36-7/1001- 1011, 45/1210- 15, 48/1283-91	49/1303-6	

Regina	21/510-19	20-1/491-94					13/227-33		11/265-69
Lorna	11/203-5		7/126-132						
Julia	19/329-336, 20/350-53, 20/355-6		13/ 233-36, 8/126, 20-1/358-66	19/337-41, 20/350-53					16-7/287-96

4. Trauma Resolution and Growth

A. The fountains of growth

a. Growth as an affirmation of the baby's importance

Charlotte	8/199-201, 12/292-4-12-3/295-300-13/303-6
Laura	
Wilma	18-9/450-5
Patricia	18/483-95, 19/517-9, 13/344-55
Claudia	34/941-5, 44/1171-1174
Regina	
Lorna	
Julia	12/217-9, 16/278-82

b. Growth stemming from the awareness of personal vulnerability

Charlotte	2/38-41, 9/207-12
Laura	
Wilma	7/143-51, 16/382-89, 20/494-97, 8/181-86, 20/499-505, 20-1/505-9, 21/512-18
Patricia	10/247-52
Claudia	46/1219-29
Regina	11/260-2, 19/451-460, 23/551-2, 23/561-69
Lorna	5-6/92-101, 10/ 178-87, 11/189-95, 12/214-24, 14/259-61, 15/271-3, 6-7/111-114
Julia	

B. The Ripples of Growth

a. Transformations in self: self-worth and self-efficacy

Charlotte	
Laura	5/97-101
Wilma	7/153-4, 19/456-8
Patricia	13/342-47, 13/356-59, 16/430-42
Claudia	43/1156-61
Regina	13/302-14, 14/325-30, 14/337-45, 10/241-44, 11-2/271-85, 18/428, 23/573-6
Lorna	11/196-202, 12/211-13, 12/214-24
Julia	

b. Transformations in Perception and Attitude: Appreciation of life and changed priorities

Charlotte	
Laura	7/150-1
Wilma	19/464-5, 19/466-70, 19/459-62, 20/502-5, 20/494-97, 20/499-505, 20-1/505-9, 21/512-18
Patricia	9/241-3, 10-1/272-80
Claudia	46/1219-29
Regina	22/540-4, 23/551-2, 23/561-69
Lorna	11/196-202, 11/206-9
Julia	17/302-9, 16/282-86, 18/320-26, 25/341-2, 26/353-55

c. Transformations in Relationships: Empathy and Companionship

Charlotte	5/122-8, 8-9/204-206, 9/209-17, 12/279-89, 13/303-6
Laura	5/101-108
Wilma	6/130/134-9, 8/170-1, 8/175-80, 8/181-86, 8-9/186-97, 9/198-204, 14/335-46, 14-5/346-50, 13/307-13, 21/510-11
Patricia	12/323-26, 14-5/387-404, 15/412-3, 15-6/418-20, 16/427-29, 20/539-48
Claudia	47/1256-60
Regina	10/246-8, 10-1/249-53, 11/254-9, 12/291-6, 14/330-5, 18/428, 22/521-4, 23/552-60
Lorna	7/126-32, 11/203-5, 13/226-8
Julia	8/129-30, 9/162-4, 10-1/165-197, 11-2/198-214, 12/217-20, 18/316-7

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