FAMILY THERAPY FOLLOWING PERINATAL BEREAVEMENT

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ABSTRACT

A perinatal death is an unfortunate event that does not just affect the mother, but has an impact upon the whole family. Yet, the literature on perinatal bereavement has tended to focus mostly upon maternal grief. Perinatal bereavement has received relatively little attention within the family therapy literature. This paper discusses the effects of a perinatal loss on the family including women, men, surviving children, and grandparents. A narrative approach to therapy is discussed as a helpful way of working with grieving families that have experienced such a loss.

Perinatal death was once considered by society as an event of relatively little consequence and not acclaimed as a noteworthy loss. However, in recent years perinatal death has received increasing attention as a significant issue for women (Cordell & Thomas, 1997; Côté-Arsenault, Bidlack, & Humm, 2001; Gensch & Midland, 2000; Hunfeld, Wladimiroff, & Passchier, 1997). While women are greatly impacted by the loss of an expected child, so too are men, surviving children, and grandparents. Yet, the needs of the family following a perinatal loss have not received extensive attention within the family therapy literature, which has tended to focus predominantly upon maternal grief and is disproportionately represented within the medical field. This has occurred despite the fact that a perinatal loss extends beyond the scope of medical management and has a profound effect upon the emotional health of the entire family (Day & Hooks, 1987). This paper examines perinatal grief in the context of the family and considers a family-oriented model of intervention.

A perinatal death refers to any death occurring within the perinatal period, including spontaneous and therapeutic abortions, stillbirths, and neonatal deaths (Moscarello, 1989). Although other perinatal losses such as elective abortions have an important effect upon the

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family, especially for example in the context of genetic abnormalities, these issues are beyond the scope of the present paper. The incidence of perinatal loss among the general population is relatively common (Cordell & Thomas, 1997). As many as 10% of known pregnancies end in miscarriage during the first trimester (Franche & Mikail, 1999) while approximately 2% are lost during the second trimester and perinatal period (Mahan & Calica, 1997). It has also been reported that in most instances the losses are unexpected and are not preventable (Rich, 2000). Clearly, such losses touch the lives of many parents and families. Family therapy, therefore, has an important role to play in assisting families whose members are having difficulty coming to terms with such a loss. Here we will first review the literature related to the experiences of women, men, surviving children, and grandparents following a perinatal death; then we will discuss a narrative approach to therapy as a helpful means of intervening with families that are struggling with perinatal grief.

Women

For women, the experience of grief following a perinatal death is perhaps unique. Since the child was not physically known to anyone other than the mother who was carrying the life inside of her, the death of the fetus or neonate carries an impact that is psychologically different from the impact for other members of the family. Women who are carrying a child undergo physical changes of their own body making them acutely aware of the existence of another human being within them. As the mother experiences these physical changes such as quickening, her emotional connection to the developing child begins to develop (Newman & Willms, 1989). Women attribute characteristics to the child in pregnancy based on their growing love and emotional response to the unborn, and their development of a maternal identity. The death of a child in the perinatal period is a tremendous loss to women based on their prior prenatal attachment formation.

Several empirically based research studies have shown that a substantial degree of attachment precedes the birth of a child (Cranley, 1981; Fowles, 1996; Grace, 1989; LaRoche et al., 1984; Lindgren, 2001; McCoyd, 2001; Muller, 1996). Cranley (1981) defines maternal-fetal attachment as "the extent to which the woman engages in behaviors that represent affiliation and interaction with her unborn fetus" (p. 282). Many women enhance the pre-natal bond by engaging in behaviors that acknowledge the reality of the life within them. Positive attachment behaviors have been identified as talking to the fetus, calling the fetus by a pet name, and positioning the fetus in order for the

spouse to feel the movement (Leifer, as cited in Kemp & Page, 1986). Technology also assists in the formation of the bond between mother and fetus. The ability to hear the heartbeat of the unborn child as early as twelve weeks, see the child through ultrasound, and use fetal monitoring as a means of tracing the child's heart rate and movements, contributes to the formation of a mental image and emotional attachment that begins before birth (Furlong & Hobbins, 1983; Hunfeld, Wladimiroff, & Passchier, 1997; Kennel, Slyter, & Klaus, 1970; McCoyd, 2001; Moscarello, 1989; Theut et al., 1989). Quickening and advanced gestational age have been determined to be the most significant correlates to positive maternal-fetal attachment (Fowles, 1996; Grace, 1989; Lindgren, 2001).

As a result of this strong attachment and bond formation before the child's birth, it follows that a woman who loses her child in pregnancy or in the neonatal period experiences a profound emotional response. Although a woman who loses a child in utero or within the neonatal period has not had a significant interaction with her child, the grief response can be profound. Theut et al. (1989) describe a mother's grief as unique in that she is grieving for a part of her self. Several authors have studied the impact of perinatal bereavement on women. Results vary, however: deterioration in health and psychological functioning range from 20% to one-third of women studied (Forrest, Standish, & Baum, 1982; laRoche et al., 1984; McColgan, 1989; Nicol, Tompkins, Campbell, & Syme, 1986). For some women who experienced a stillbirth, psychological symptoms, such as severe depressive states, anxiety attacks, and phobias, can be present for up to two years after their baby's death (McColgan, 1989).

Certain risk factors have been identified as predisposing women who experience a perinatal death to a pathological grief reaction. A real or perceived lack of support from one's spouse or significant others is a crucial component in determining pathological grief and the need for follow-up counseling (Lake, Johnson, Murphy, & Knuppel, 1987; Laroche et al., 1984; Nicol et al., 1986). Those women who lack support experience a more profound sadness and sense of isolation. An analysis of the effects of intervention from a perinatal grief support team concluded that individuals who received ongoing support from the team experienced less difficulty with physical complaints such as diarrhea and aches and pains, as well as psychological manifestations such as irritability and anger (Lake et al., 1987). This study suggests that continued support greatly impacts the health and well-being of the family. Follow-up counseling is a particular benefit to women who do not have a positive support system.

Perhaps because the cause of death is often unknown, women frequently blame themselves and feel that their body has failed them in some way (Cole, 1987; Knowles, 1994). This sense of failure evokes extreme feelings of guilt and self-blame which could also instigate a pathological reaction and decreased self-esteem. Furlong and Hobbins (1983) state in their article on grief in the perinatal period, that since medicine so often does not have an explanation for the death, women are left feeling confused about what has happened to them and could require ongoing reassurance. To make matters worse, following the delivery, women are left to cope with physical symptoms such as breast engorgement, after-pains (painful abdomen), and a painful perineum or abdominal incision. Also, since she is post-partum, the woman also must cope with hormonal changes that again only she experiences. With all of these physical reminders, and no baby to celebrate as a joyful event, women can be overwhelmed by the trauma and painfulness of the experience (Newman & Willms, 1989).

Studies indicate that women grieve more intensely and for longer periods following a perinatal death than men (Moscarello, 1989; Theut et al., 1989). One factor that influences women's grief reaction involves the feelings of responsibility for the death. Women report feeling guilty because they were unable to protect their child while it was inside their body and this complicates their experience of grief (Cole, 1987). Beck-Black (1991) conducted a study in which women were asked to identify differences in the ways they had experienced the pregnancy and the perinatal death when compared to their spouse. Women described their grief as more intense than the grief of their male partners and stated that although the initial response to the loss was distressing for both of them, for the women the grief tended to become further intensified on the baby's expected due date. Women also generally noted that their partners were often perceived to be bystanders to the physical events and did not feel that men shared the same feelings, whereas women were the key players experiencing the loss first hand. These perceived differences reveal the potential for miscommunication or a sense of lack of support between the genders that could further complicate the grief process.

Men

While both men and women plan for and conceive a child, a commonly held societal myth contends that women grieve the loss of a child, and men do not. The reality of grief following a perinatal death is that both parents are greatly impacted by the death of their child, but the expression of their grief differs significantly (Laroche et al., 1984).

Men have been socialized from a very young age to conceal their emotions, be protectors and providers, and "keep a stiff upper lip" (LeeStrange & Kennedy-Reeves, 1996; Stinson, Lasker, Lohman, & Toedter, 1992). While men and women may experience similarities in the trauma of a perinatal death, the influence of cultural expectations lead men to express their grief differently. Freedom to express emotions is not supported for men; often men do not have an emotional support system comparable to women outside of the immediate family (Davis, 1996; LeeStrang & Kennedy-Reeves, 1996; Stinson et al., 1992). These factors contribute to an "invisible grief" where support systems are not acquired, emotions are not portrayed, and painful feelings are repressed.

The literature concerning the grief process for men following a perinatal loss is scarce. The vast majority of research in this area addresses the complex needs of women who have lost a child, and when men are mentioned, it is most often surrounding their role as supporter of their wife (Johnson & Pudifoot, 1996). However, while expression of grief differs, evidence suggests that men are in fact intensely affected by the loss of a child in the perinatal period. Johnson and Puddifoot (1996) studied male partners of women who miscarry and reported that the grief of men is statistically significant. Men scored high on the Perinatal Grief Scale and the Impact of Events Scale lending evidence that men experience considerable psychological impact following the loss of their unborn child. Furthermore, men outline their grief for their child as secondary to the sense of helplessness and grief they feel for their wife. Bach-Hughes and Page-Lieberman (1989) conducted a study of men's response to a perinatal death and found that 45% of fathers stated that they felt close to their unborn child, but qualified the statement by suggesting that they did not feel as close as their wives to the unborn child. It appears as though the grief of men is two-fold. Not only must they realign their expectations for fatherhood, but they must struggle with their wife's emotional pain (Bach-Hughes & Page-Lieberman, 1989; Johnson & Puddifoot, 1996).

The pain that men feel upon the untimely death of their child is significant. Stinson et al. (1992) found that men and women do not differ on feelings of despair following a perinatal death, but given that men's grief scores tend to increase over time, it appears as though at least initially, denial is a common coping mechanism employed by men following a perinatal loss. While it is acknowledged that despite the absence of physical knowing, men grieve for their unborn child. It appears as though the grief of men tends to be shorter and milder in intensity compared to their female partners (Bach-Hughes & Page-Lieberman, 1989).

The role acquisition of men following a perinatal loss influences their grief process. Men frequently assume the practical role in terms of memorial service arrangements, completing documents, and informing family members of the death. While women recover physically from the death of a child, fathers describe the death as an intensely active time based upon their need to complete the practical aspects of the event (Armstrong, 2001; Bach-Hughes & Page-Lieberman, 1989). This can force men to face the finality of the death immediately following the event, and can act as a displacement process that allows them to conceal or suppress their grief. Less emphasis is placed on the expression of feelings and traumatic stress, and often due to the practical tasks, men are not available when health care professionals are present to offer support and counseling (LeeStrang & Kennedy-Reeves, 1996; Moscarello, 1989). Health care providers heighten the role of men as protectors by encouraging their involvement in decision-making, task completion, and answering the common question of "how's your wife?" (Knowles, 1994). In this regard, men may feel that their grief is minimized and withdraw further into silent bereavement.

Surviving Children

When a woman is admitted to a hospital to give birth to a child, other children are frequently left in the care of loved ones to allow both parents to be involved with the birth. Thus, it is less likely that children will be present during the crisis event. However, children are usually acutely aware of the impending arrival of a sibling and are often prepared by their parents to expect the new baby. When no baby returns with the parents and when the surviving children are told about the death, they are also affected by the loss.

Children grieve differently than adults (Kirkley-Best & VanDevere, 1986), and their grief is dependent upon multiple variables such as age, developmental stage, individual characteristics, concurrent life stressors, and the support they receive from parents and others (Furman, 1974; Forrest et al., 1982). The meaning of a perinatal loss on surviving children is powerfully influenced by the ways in which the family deals with the crisis event (Leon, 1986).

Parents have an intuitive need to protect their children from pain. When a perinatal death occurs, parents often attempt to protect their children from intense grief by concealing their own sorrow (Moriarty, 1978). It is assumed by many people that young children will not be affected by a perinatal death, because they will not understand that a death has occurred. However, Kirkley-Best and VanDevere (1986) indicate that while children may not seem affected at the time of the

death of their sibling, comments made months or years later indicate that children are not only aware of the death, but they are also giving a lot of thought to the loss.

Parents are in a difficult position of experiencing their own grief while supporting their surviving children in the grief they experience at the loss of a sibling. When parents shelter their children by suppressing their own grief, children in turn learn to suppress their own feelings, or fear of death by reaching their own fantasized conclusions of what has happened (Moriarty, 1978). Whether children as young as toddlers understand that a death has occurred, they are acutely aware of the response of their parents. The disruption of daily routines and the visible emotional distress of parents confirm for children that something is wrong. They may not necessarily grieve directly for the deceased child, but for the loss of normalcy within the home (Davis, 1996; Mahan & Calica, 1997). Without a forum to express feelings, thoughts, or questions, children's fantasized perceptions of the death will become their reality (Leon, 1986; Moriarty, 1978).

Children often carry a burden of responsibility for a child's death. Young children are naturally egocentric (Davis, 1996; Forrest et al., 1982), and are subject to magical thinking, which blurs the distinction between fantasy and reality. The anticipation of a new addition to the family may cause children to be insecure about their place in the family, and feel the need to compete for parental love. Surviving children can misconstrue the anger or jealousy towards an anticipated sibling as the cause of the child's death and the parent's intense emotional pain (Kirkley-Best & Vandevere, 1986; Leon, 1986; Moriarty, 1978). The belief that their thoughts may have caused their sibling's death can be detrimental to the mental health of surviving children, and can be carried throughout the lifespan. In addition to guilt prompted by jealousy, children may also feel guilt due to being unable to prevent the death from happening, or being less saddened than their parents (Moriarty, 1978).

The reality of a perinatal death is often difficult for children to grasp (Leon, 1986). Since the vast majority of surviving children will not have seen the deceased infant, and given that a common response to a perinatal death is denial, many children may experience a severely unsettling perception of what is or is not real (Leon, 1986). Consequently, children may develop a fear of death, or fear of separation from parents and loved ones (Leon, 1986, Moriarty, 1978).

Despite the tendency of children to feel jealous or angry pending the birth of a new sibling, they also eagerly anticipate the birth of their new playmate (Leon, 1986). Parents often prepare young children for

the birth of their sibling by encouraging "mommy's little helper," or by reinforcing the "BIG brother or sister." Anticipation of their new role and relationship influences the grief experience of surviving children. Grief manifests itself in children in a variety of ways based upon several factors. Common manifestations of children's grief include somatic complaints, regressive behavior, and emotional disturbances such as withdrawal, anger, depression, guilt, delinquency, chemical use, nightmares, aggressiveness, anxiety (Forrest et al., 1982; Furman, 1974), and fear of going to sleep (Leon, 1986).

Children are often the forgotten mourners in families that have lost a child in the perinatal period. Parents, teachers, counselors, and family therapists must be acutely attuned to the response of children to a sibling's death in order to facilitate open communication within the family.

Grandparents

While a significant amount of research addresses the grief response of parents to a perinatal death, the literature concerning the grief response of grandparents is lacking. Nevertheless, there is a small body of literature that recognizes the intensity and complexity of grandparents' grief to the loss of a grandchild.

The expectation of grandparents includes the belief that they will predecease their grandchildren. This belief system is even stronger than the belief that they will predecease their own children (Ponzetti & Johnson, 1991). Consequently, when a child dies in utero or within the neonatal period, the entrenched beliefs concerning the natural order of life events is violated. In a study of grandparents' grief reactions to the death of a grandchild, Fry (1997) states that almost all of the grandmothers within the study felt a sense of shattering of "groundedness." Grandparents stated that the untimeliness of their grandchild's death disrupted a fundamental belief regarding children's safety, security, and the order of life events. The disruption of grandparents' belief system may leave them with insecurities about their own mortality, or the mortality of their own children.

Since it is highly likely that the entire family is greatly affected by the death of a child, it follows that grandparents experience a grief response following the loss of their grandchild. In a descriptive study of the reactions of grandparents to the death of a grandchild, Ponzetti and Johnson (1991) found that 56% of the grandparents in their study reported feelings of shock, numbness, and disbelief, upon learning of their grandchild's death, and 64% became physically symptomatic following their grandchild's death. DeFrain, Jakub, and Mendoza

(1991–92) found that 51% of grandparents involved in a study of grandparents' grief experienced flashbacks of the death of their grandchild.

The grief of grandparents on the death of a grandchild is complex and multidimensional. Often, grandparents are burdened with a three-dimensional grief; they grieve for themselves as grandparents, for the missed opportunities of their grandchild, and for their own children who have lost their loved child (Davis, 1996; DeFrain et al., 1991-92; Fry, 1997). Many grandparents report an extreme sense of helplessness, sadness, and pain for their children when a grandchild dies (Davis, 1996; Fry, 1997; Ponzetti, 1991). At a six-month follow-up interview to an original study of grandparents' grief response to the death of a grandchild, the overwhelming priority of these grandparents was to provide support to their children and surviving grandchildren. The grandparents also reported suppressing their own feelings of sorrow in order to shelter their families from further anguish (Fry, 1997). The parental instinct to protect one's children from pain continues throughout the lifespan; consequently, when adult children are burdened with the death of a child, grandparents feel unable to fulfill their natural parental role.

In addition to feelings of grief, grandparents report feelings of guilt upon the death of a grandchild. The guilt they report appears to be related to the possibility that the death could relate to a genetic predispostion or chromosomal abnormality and that they may be the original genetic carriers of a certain anomaly. Conversely, grandparents frequently report "survivor" guilt for outliving their grandchild. Grandparents carry a burden of a long lifespan in comparison to the premature death of a grandchild who will miss the opportunities that life has to offer (DeFrain et al., 1991–92; Fry, 1997; Ponzetti & Johnson, 1991).

Narrative Family Therapy

Clearly, the experience of grief in a family following a perinatal death is profound and multidimensional. The loss of an anticipated new addition to the family greatly impacts each family member and is influenced by the meaning they place on the loss, their relationship to the child, and their role in the family. The vast majority of literature in the area of perinatal bereavement addresses the individual needs of the mother, whereas the context in which one grieves, has largely gone unrecognized (Ponzetti, 1992). While women are greatly impacted by the grief for their lost child, grief within the family unit is ever-present and consists of the individual grief responses of each member, and their interplay of grieving in the relational context of the family.

Therefore, while all family members manifest their grief differently, the grief of each family member is affecting and being affected by others in the family unit (Gilbert, 1996). Despite the enormity of emotions within the family following a perinatal death, silent bereavement is common, since memories of the deceased are not available, and social acceptance of this type of loss is less than adequate. Family therapists have an important role to play in assisting families in discussing grief as a family issue and intervening with families based upon sound practice models that reflect the needs of families following the death of a baby.

A perinatal death challenges belief systems about safety, security, and the natural order of life (Davis, 1996). While traditional approaches to grief counseling suggest "working through" separation from a loved one and working toward final acceptance of the loss (c. f. Ewton, 1993), perinatal grief involves a separation from the family's expectations for their future. Because of the different impact of grief in the family, traditional approaches to grief counseling must be replaced with different models that reflect the needs of these families. McBride and Simms (2001), describe a disorganization phase of grief, which is characterized as "going crazy." Multiple issues including the parenting of surviving children, communication with family and friends, and the marital relationship, are all areas that can form stress points and may require further therapeutic assistance.

Grief has received considerable attention in the literature, particularly since Elisabeth Kubler-Ross's publication of *On Death and Dying* in 1969. While her book and its focus on stage models of grief opened up the discussion of death, it does not specifically address the needs and emotional impact of families who are bereaved by the loss of a child in utero or shortly following birth. In a study by Cordell and Thomas (1997) involving a parent support group for individuals who have experienced the loss of their baby in the perinatal period, parents reported that their goals for the group included managing feelings of pain, and finding meaning in their child's short existence. Given the obvious quest for meaning, it appears that a promising approach to families bereaved by the death of a baby can be reflected in the narrative model which emphasizes the formation of meaning through the construction of stories (Neimeyer, 2000).

Family members construct different versions of the "story" of a perinatal death based upon the realities of their own personal experiences and shaped by their perceptions of the world in general (Sedney, Baker, & Gross, 1994). Given that a commonly utilized coping mechanism for this type of grief is denial and silence, an important role for

family therapists is to facilitate communication within the family and allow all family members to be present and to participate in therapy. The use of "stories" in the therapeutic relationship can be construed as a communication tool. It enables families to reflect on the shared trauma and shared memory of a difficult time within the family, while recognizing that there are multiple stories associated with the event and that for each member of the family his or her story would reflect a different reality and experience of the event or subsequent events (Sedney et al., 1994).

McBride and Simms (2001) draw attention to the importance for the family therapist to pay careful attention to timing, relationships, and pace. All family members, particularly men and women, will grieve at a different rate, and, as noted in the above reviews, will manifest their grief in different and sometimes contrasting ways. We noted how women tend to be more expressive and are vulnerable to feelings of guilt, while men can be more silent in their grief and immerse themselves in action and practicalities. Children and grandparents also harbor feelings of guilt for different reasons as well as express or conceal their grief differently. When the individual family members are not able to appreciate that the other members of the family may have similar feelings but express them differently or that they may be experiencing feelings that other family members were unaware of, then there is a greater likelihood that they will drift apart, such as when one individual has a strong need to discuss the lost child, and the other finds such discussions too painful (Koocher, 1994). The result is a challenge for family therapists to recognize possible fragility among and within families as well as strengths, and to pace the intervention in a way that reflects sensitivity to each individual's comfort level.

The use of the narrative metaphor can facilitate such sensitivity, pacing, and style of grieving within families by virtue of its flexibility and openness to modification and change (Prochaska & Norcross, 1999). Men, women, and children must be permitted to direct the extent to which they wish to disclose and hear emotionally charged issues. Since children are often unrecognized as participants in familial grief following a perinatal death, including them in therapy and encouraging their input and questions for parents, allows them to share their version of the story (Sedney et al., 1994). Every death creates a story, and the therapist can begin communication in families by directly questioning family members to uncover the trauma of the death and the impact of it has had on them. Sedney et al. (1994), suggest that simply beginning a session with "what happened?" and allowing all family members to express their thoughts and emotions, while ac-

tively clarifying sequence and relationship will assist in understanding the context of grief. Further, by actively pursuing the development of the family's story, the therapist is modeling a complete acceptance, and allowing for the "unspeakable" to enter the therapy session.

Koocher (1994) suggests using objects to bring the deceased into the counseling session as a means of beginning interventions with families. Further, McBride and Simms (2001) suggest that an initial step in assisting families to gain mastery over the painful emotions of the loss is to include the deceased in therapy by using pictures. In the event of a perinatal death, the mementos given to families in hospital can serve as an intervention strategy to facilitate discussion and model acceptance. If the therapist is able to bear to view the mementos and photographs, so too can individual family members. Using mementos to bring the unspeakable into family discussions is a major intervention in itself and acts to decrease silence and isolation (Sedney et al., 1994).

Since self-blame and guilt for any perceived or actual "wrong" committed during the period of pregnancy is a significant issue in families (Cole, 1987; Furlong & Hobbins, 1983) and guilt is also an issue for children and grandparents, the family therapist needs to make sure that feelings related to guilt do not go unexpressed. By allowing family members to disclose their version of the death, the therapist is able to decipher hints of guilt, anger, or responsibility, as the individual expresses his or her role in the death, or why he or she feels it happened (Sedney et al., 1994). In addition, through "storying," an assessment of the coping strategies utilized by each family member, and the relationship family members have to one another becomes evident and may prove to be useful when planning interventions.

The lack of information usually available to children following a perinatal death encourages more cognitive distortions and fosters a sense of isolation. Including children when reviewing and discussing aspects of the death signifies that talking about the loss is acceptable, and can bring parenting difficulties as well as the grief of children to the forefront. Due to their own experiences of grief, parents may require assistance in recognizing the needs of their children and learning to respond to them appropriately. The use of the narrative metaphor in storying a family's experience of loss and including children in the process, can allow for a safe environment where parental honesty influences a child's understanding of the death, and parents' understanding of their children's needs. When allowing family members to describe their version of the story, therapists act to model appropriate communication with children. Often parents do not know how to ap-

proach the issue of death with young children. Modeling appropriate language through avoiding euphemisms that often describe death, and defining death in concrete and straightforward terms is an important intervention with families (Leon, 1986; Moriarty, 1978). When asking questions to broaden the context of the story, the use of terms "dead" or "died" should replace common euphemisms that only cause confusion in children.

While surviving children pose particular issues in families, interventions directed towards the marital relationship are also necessary. Since pace and expression of grief have variations between men and women, misconceptions can easily occur to cause stress within the marital relationship. Stories require both a teller and a listener (Sedney et al., 1994) and allowing for both parties in the relationship to disclose their version of the loss can facilitate an understanding of discordant grieving. Since men often assume the practical role following a perinatal death, the storying of this experience and fostering of respect for a different style of grieving in men, may lessen the impact of marital distress. Similarly, men may benefit from hearing of women's prenatal attachment to their unborn child and its impact on the intensity of women's grief. Koocher (1994) suggests that the therapist involved with families acts as a guide and model while supporting families through the difficult task of sharing their personal loss experience with others in the family. Koocher (1994) believes that a primary goal of therapy is to strengthen the bonds of family to give to and receive support from each other, especially since, as so often is the case, the support received from outside the family most often decreases early in the bereavement experience.

As communication becomes less constrained and more open, changes to the story may signify an increased ability to accept the full range of individual and family feelings about the loss (Sedney et al., 1994). Levac, McLean, Wright, and Bell (1998), suggest a unique approach in concluding therapy sessions. They suggest an intervention with families termed "a reader's theater," where each family member and therapist involved reads aloud, his or her reflection about the therapy while others listen without interruption. The authors suggest that witnessing and affirming the experiences and beliefs of others is a profound experience, which allows for reflection, unconditional presence, and solidifies change within the family system. This reflective approach may prove to be an insightful conclusion to therapy, signifying an increased awareness and acceptance of the different approaches to grieving within the family.

CONCLUSION

A perinatal loss affects each member of a family including grandparents. Reactions to the loss by each family member are influenced by the meaning they place on the loss, their relationship to their child, and their role in the family. In this paper, we have reviewed how a family therapist can assist a family with their grief by facilitating open discussion of the different feelings and reactions experienced by the family members. Since the members construct different versions of the story of a perinatal death based upon the realities of their own personal experiences, a narrative approach to intervention is proposed as a means of sensitively addressing differences in the timing of grief reactions, feelings of guilt, and misunderstandings about the loss as well as each other's reactions.

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