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TRANSLATING RESEARCH TO PRACTICE

Psychotherapy for Pregnancy Loss: A Relational Perspective

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Disclosures/Conflicts of Interest

- I have no conflicts of interest to disclose
- Generative AI was not used for the development or content of this presentation

Learning Objectives

1. Discuss common psychological consequences of pregnancy loss.

2. Describe how and why the therapy relationship can be a mechanism of change in therapy for pregnancy loss.

3. Identify specific implications for BIPOC and LGBTQ+ clients affected by pregnancy loss.

Psychotherapy for Pregnancy Loss: A Relational Perspective

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Today, we will cover. . .

- Types and rates of pregnancy loss (PL)
- Psychosocial consequences of PL
- Special considerations for BIPOC clients affected by PL
- Special consideration for LGBTQ+ clients affected by PL
- Goals of psychotherapy for PL: Symptomatic focus versus deeper level psychological effects
- The therapy relationship as a mechanism for change
- Video demonstration
- Q & A

Pregnancy Loss: Types and Rates

Miscarriage

- The loss of a pregnancy up to 20-24 weeks gestation
- Studies show that about 20-50 percent of pregnancies will end in miscarriage

Recurrent Pregnancy Loss (RPL)

- Loss of two or more consecutive clinical pregnancies
- 2-6% of couples will experience RPL

Stillbirth

- losses that occur after 21—24 weeks gestation
- About 2% of pregnancies will end in stillbirths

Pregnancy termination due to fetal anomaly (PTFA)

- Terminating the pregnancy of a much wanted but unhealthy fetus/baby, or one that has been diagnosed with a genetic anomaly, which in many cases may be lethal
  - *Legal and definitional differences make accurate prevalence rates difficult to gather*

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Pregnancy Loss: Psychosocial Consequences

- **Depression**
  - subclinical levels of depression and even clinical-level depressive disorders follow pregnancy loss in a substantial percentage of cases, but length and course varies
  - often confused with grief
- **Anxiety**
  - Small to moderate effect after loss
  - *Pregnancies after loss*: meta-analysis of 19 studies representing *n*=5114 women found a significant and large effect of previous perinatal loss on anxiety during subsequent pregnancies
- **Post-Traumatic Stress**
  - 25% of women meet criteria for PTSD 1-month post-loss, while much higher percentages meet partial criteria for PTSD, but studies vary
  - *Pregnancies after loss:* about 21% of women pregnant after a miscarriage or stillbirth have been found to meet PTSD criteria
    - PL psychologically and physically traumatic experience
    - Compounded with adverse medical procedures and experiences
    - Loss associated with feeling out of control/shocked/overwhelmed.
    - The loss is often unexpected, as if one's world has changed in an instant
- **Assault on Self-esteem and Identity**
  - Feelings of shame, guilt, and inadequacy
- **Complicated Grief**
  - Grief is often long-lasting, intense, and non-linear lasting from months to years
  - 25%–30% of women may have significant, prolonged, highly intense, complicated grief reactions, which may negatively affect their psychological well-being
  - correlated with anxiety and post traumatic stress
  - Role of lack of societal validation and support

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Cultural processes in psychotherapy for perinatal loss: Breaking the cultural taboo against perinatal grief

Rayna D Markin [1], Sigal Zilcha-Mano [2]

Affiliations + expand

PMID: 29565619 DOI: 10.1037/pst0000122

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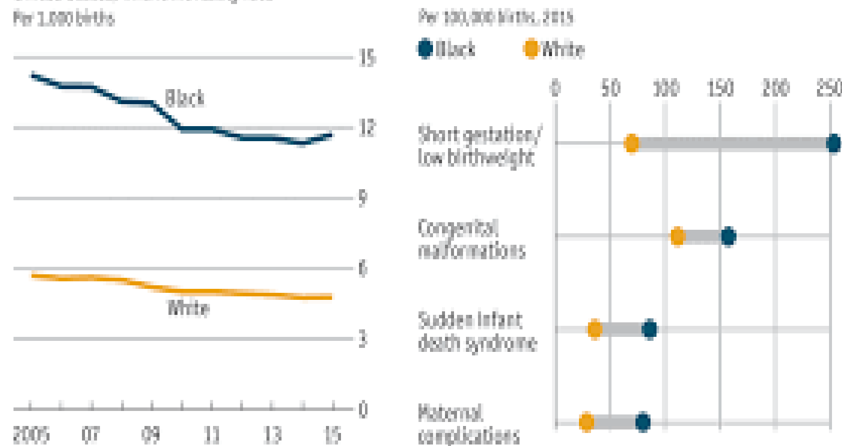
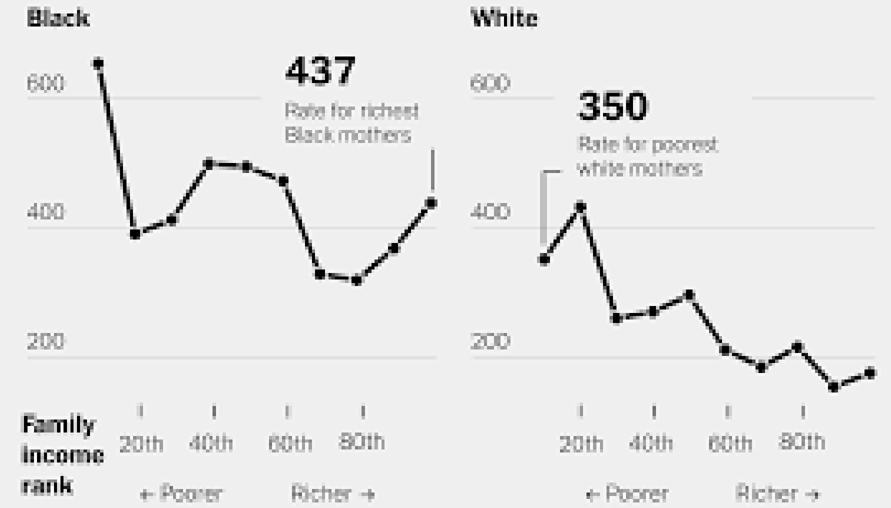
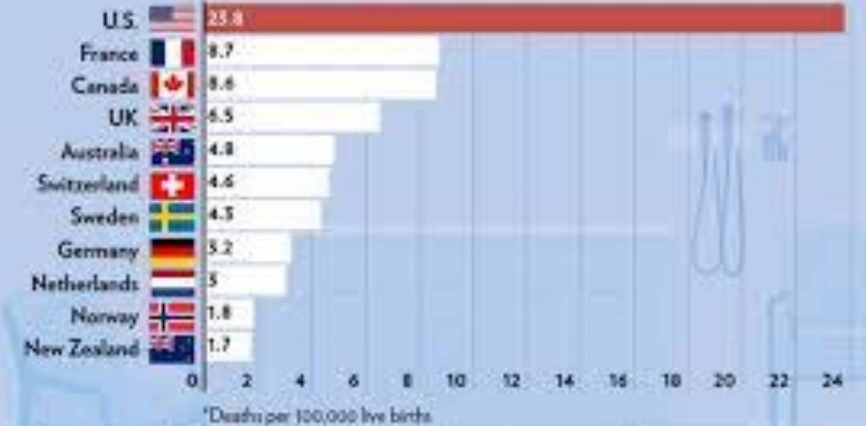
Abstract

This paper argues that there is a cultural taboo against the public recognition and expression of perinatal grief that hinders parents' ability to mourn and their psychological adjustment following a loss. It is proposed that this cultural taboo is recreated within the therapy relationship, as feelings of grief over a perinatal loss are minimized or avoided by the therapist and parent or patient. Importantly, it is suggested that if these cultural dynamics are recognized within the therapy relationship, then psychotherapy has the immense opportunity to break the taboo by validating the parent's loss as real and helping the parent to mourn within an empathic and affect-regulating relationship. Specifically, it is suggested that therapists break the cultural taboo against perinatal grief and help parents to mourn through: acknowledging and not pathologizing perinatal grief reactions, considering intrapsychic and cultural factors that impact a parent's response to loss, exploring cultural reenactments within the therapy relationship, empathizing with the parent's experience of loss and of having to grieve within a society that does not recognize perinatal loss, coregulating the parent's

Special considerations for BIPOC Clients







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Intersections of Gendered Racial Trauma and Childbirth Trauma: Clinical Interventions for Black Women

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Studies suggest that racism affects the type and quality of health care that patients who are Black receive, perhaps in part because poorer patient–provider communication and less provider encouragement of patient involvement have been consistently reported for patients of color. In particular, Black women are 3–4 times more likely to experience dangerous and even life-threatening complications, and more likely to report mistreatment and neglect from medical providers and staff, during childbirth. Experiences with gendered racism during childbirth, which in itself is a vulnerable, intense, and potentially traumatic experience when proper support is absent, may lead to posttraumatic stress reactions. Psychotherapy can help affected clients to process gendered racial and childbirth traumas through: (a) the establishment of a safe, trusting, and collaborative therapeutic relationship, in which careful attention is paid to repairing alliance ruptures caused by cultural misunderstandings or gendered racial microaggressions, and (b) framing experiences and "symptoms" as understandable reactions to gendered race-based traumatic stress during childbirth. In addition to direct therapeutic intervention, therapists should collaborate with doulas and/or medical providers on patient care, and, separately, advocate for systemic-level change, supporting clients' lived experiences outside of the therapy room.

Clinical Impact Statement

Question: What are specific traumatic experiences that Black women are more likely to experience during childbirth, what are the psychological consequences, and how can psychotherapy help? ***Findings:*** Clinicians can hopefully use this paper to help clients who are Black women and have experienced gendered racial and childbirth traumas to process the emotions and experiences associated with the traumatic event within a safe and trusting therapeutic relationship. ***Meaning:***

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Stillbirth rates at ≥24 weeks gestation overall and among White and Black women: United States 1980–2020.

	Total number of births (number of stillbirths)			**Stillbirth rate (95% CI) per 1000 total births**			**Rate ratio (95% CI)[a]**
	1980–2020	**1980**	**2020**	**1980–2020**	**1980**	**2020**	
Total population	157,902,864 (710,832)	2,666,646 (28,301)	3,635,736 (20,949)	4.5 (4.5, 4.5)	10.6 (10.5, 10.7)	5.8 (5.7, 5.8)	0.54 (0.53, 0.55)
Black women	24,962,153 (182,672)	394,196 (6869)	589,987 (5942)	7.3 (7.3, 7.4)	17.4 (17.0, 17.8)	10.1 (9.8, 10.3)	0.57 (0.55, 0.59)
White women	123,396,274 (492,158)	2,196,956 (20,189)	2,662,967 (13,208)	4.0 (4.0, 4.0)	9.2 (9.1, 9.3)	5.0 (4.9, 5.0)	0.54 (0.53, 0.55)
Rate ratio (95% CI)[b]				1.84 (1.83, 1.85)	1.90 (1.85, 1.95)	2.01 (1.97, 2.05)	

CI, confidence interval.

Table can be found in " Ananth, C. et al. (2020). *Evolving stillbirth rates among Black and White women in the United States, 1980–2020: A population-based study*, The Lancet Regional Health – Americas, Volume 16, 100380"

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Vignette: Special Considerations for BIPOC Clients

The doctor came in the room in a rush. Without even looking at me, he told me to lie down and spread my legs. I remember thinking, 'something about this doesn't feel right,' but I was confused. I never did this before, maybe that was normal. I was in pain. I was scared. The contractions were so strong, and they were getting closer and closer together. I was desperate for them to stop. Worse, I was alone. I was planning on having my husband with me, but because of COVID the hospital said I wasn't allowed a support person in the room. I'm ashamed to say I probably would have done anything that doctor told me to do in that moment. So, I did what he asked. Next thing I know there are what seem like 20 people in the room, all men, all White. Without asking me first or telling me what was about to happen, they took turns checking my dilation and discussing amongst themselves the numbers. They all talked to each other like I wasn't in the room, half naked, in kind of an embarrassing position. I think I was in shock and it took me a few minutes to realize what was going on. I finally said, "I'm not comfortable with all these people in the room." The doctor snapped back at me not to be difficult and that he had a right to have medical students in the room because it's a teaching hospital. I felt violated and angry, but I was dependent on this man to get me through this. I didn't know what I was doing. I was afraid of dying, or of something happening to the baby, so I stayed quiet and went along with what he told me to do. You have to understand I had four losses before Dwight and my entire pregnancy with him I lived in constant fear of another miscarriage and I was so scared of making it to this point and something happening to him at birth. I know the statistics and especially for me, since I don't exactly trust my body anymore after all the losses, I didn't want to be a number. I still have nightmares about those doctors hovering over me, and I wake up in sweats. It's true, I didn't know what to expect exactly, this being my first time, but I know it wasn't this (based on Markin & Coleman, 2024).

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Special considerations for LGBTQ+ Clients

- Conception is a **well planned** and **intentional** process
  - Involving having to navigate **complex** medical, financial, and legal systems
  - Bias and discrimination across multiple complex systems
- **Double Disenfranchisement of Parental Bereavement in Same Sex Couples**
  - Who suffer from a lack of social support common among all bereaved parents after pregnancy loss as well as from "chronic invalidation" of their same-sex relationship
- **Role of Empathy in the therapy relationship**

Vignette: Special Considerations for Same Sex Couples

Sandy and Claire, two cisgender women in their 30s, have been married for three years. They started the fertility journey, with the assistance of anonymous donor sperm and IVF, two years ago. While Sandy never had the desire to become pregnant, Claire has dreamed about being pregnant and giving birth since she was a little girl. Unfortunately, for unexplained reasons, Claire has experienced much difficulty staying pregnant and has suffered six miscarriages and multiple invasive and painful related medical procedures. Claire explains that she constantly feels a lack of support from others who often ask her why she continues to put herself (and everyone else) through 'this' when Sandy (who is 7 years younger) can 'just' carry their child for them. Claire explains such statements feel like an invalidation of her dream of parenthood and makes her feel like an older, defective, and less desirable car model as compared to Sandy. Sandy similarly explains she feels a lack of understanding and support from others who often assume she is not grieving their multiple losses as Claire is, which invalidates her role as a second mother. When Sandy reached out to her own mother for support and comfort after their first loss, her mother stated " *well in least it wasn't really your baby*," which was deeply hurtful to Sandy and as a result the two have not spoken since. Sandy and Claire both make comments in passing that they are sick of completing constant paperwork for insurance companies, fertility clinics, etc. that is geared toward heterosexual couples. The therapist reflects back that all these experiences must feel not only incredibly invalidating, but also like someone is taking a pencil and constantly erasing important aspects of their experience.

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Psychotherapy goals

Processing unresolved trauma and loss

- PL involves multiple losses of actual pregnancy/baby but also of hopes and dreams for the future
- What did the pregnancy and loss mean to this particular parent? Defining what and who was lost?
- The loss itself is a traumatic one
  - Need to process horror of the event(s)

Restoring healthy self esteem and identity

- PL often attack one's self esteem and identity, women feel like they cannot do the "one thing" they were born to do and don't feel like a "real" woman, leave one with feelings of shame and inadequacy and like a failure

Post traumatic growth

- Make meaning and grow from the trauma of loss

The Therapy Relationship as a Vehicle for Change

Trauma and Loss and The Therapy Relationship

- Mourning is an inherently interpersonal process, yet bereaved parents often grieve in silence and isolation
- Trauma of event, and attachment trauma of feeling alone in that event
- Resolving trauma requires someone to understand and hold our experience and reflect back to us a more coherent narrative of our experience

Repairing the Self and the Therapy Relationship

- PL often experienced as an attack on one's self-esteem and identity, leading to feelings of shame and inadequacy
- The 'self' feels broken, inadequate, and inferior or defective
- Therapist empathy, validation, and normalization help to make sense of one's experience and decrease feelings of shame and isolation

Therapy Relationship as Mechanism of Change in Therapy for PL

Empathy

Alliance

Feedback

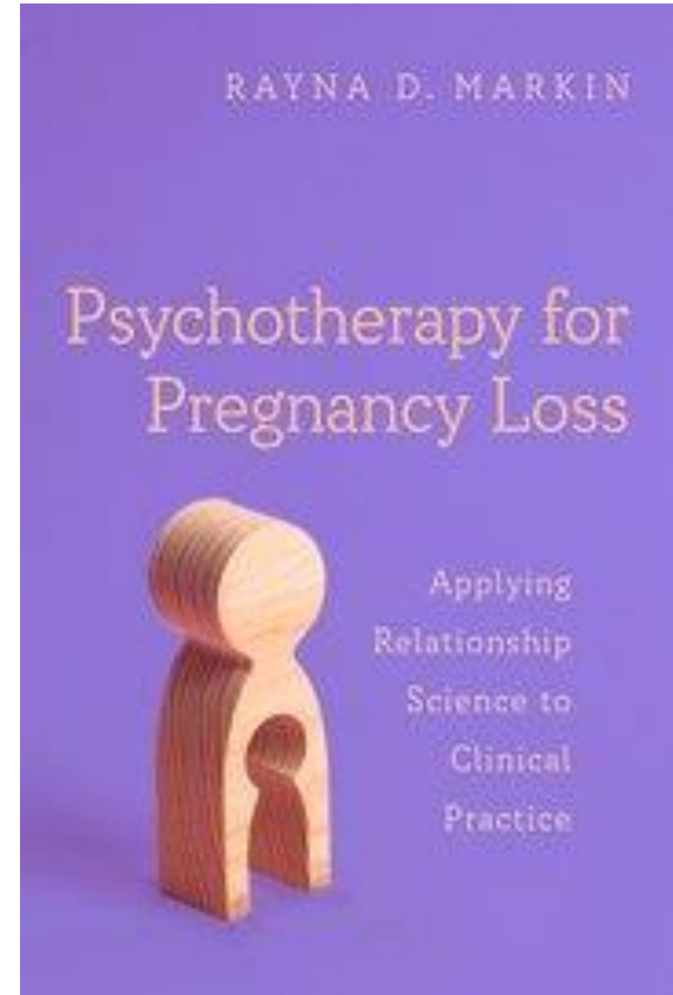
Alliance Rupture repair

Countertransference Management

Self-Disclosure

Attachment Style

Emotional Expression



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How Does the Relationship Heal in Therapy for PL?

It provides clients the support and understanding sometimes missing in society yet necessary to grieve

- mourning as an interpersonal process

The therapist’s empathic support and sharing of sadness helps clients to feel less alone and facilitates the processing of trauma and loss

- grief is painful but grieving alone is unbearable

Normalization, empathy, and validation help heal the client’s injured self esteem and reduce feelings of shame

- for what is understood by another can then feel understandable to the self and not all that different or “bad;
- isolation grows shame; empathic sharing and validation extinguish it

Empathy and Post Traumatic Growth

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How Does the Relationship Heal in Therapy for Pregnancy Loss? Cont.

Empathy and the co-regulation of emotion

- the client not feeling alone helps her to feel safe to approach traumatic affects not processed at the time of the event
- therapist provides emotional regulation and containment

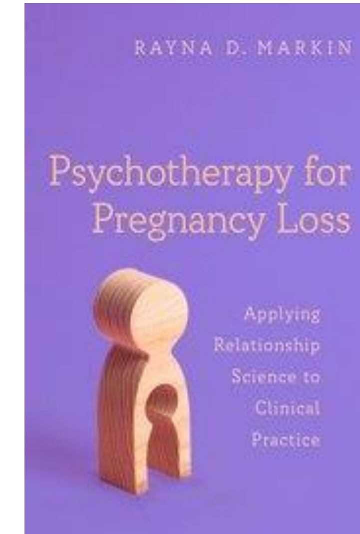
A trusting and empathic relationship with the therapist helps to heal wounds of being mistreated, invalidated, or neglected in the healthcare system due to invalidation of PL (medicalization, minimization), and /or experiences with racism and discrimination

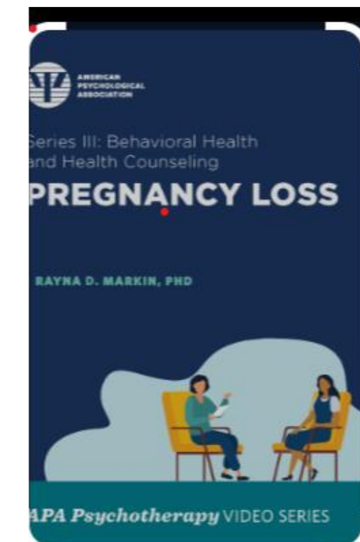
Infertility and PL are times of intense distress when the attachment system is activated and grieving parents are left with heightened need for support, emotional holding, and understanding

- activations of insecure attachment internal working models and difficulty using others as a source for support, comfort, and understanding
- changing insecure attachment internal working models

Relational-Attachment Psychotherapy For Pregnancy Loss

- Self Psychology
  - Pregnancy loss is often experienced as an attack on one's self esteem and identity and therapist empathic attunement and the repair of ruptures arising from therapist miss-attunement is believed to help restore healthy self-esteem and identity
- Trauma Theory
  - The experience of pregnancy loss is often so overwhelming and shocking that a person's normal defenses no longer work and as a result many symptoms can be understood as the individual's best attempt to cope with trauma
- Emotion Focused/Experiential
  - intense feelings of grief and loss, anger, shame and guilt often arise from the experience of pregnancy loss and in this approach experiential interventions are used to help process these emotions to completion and release the adaptive action tendencies of each
- Attachment-Based
  - Therapist acts as a secure attachment object from which patients can explore intense and overwhelming internal experience
  - Past adverse attachment experiences of feeling unsupported, misunderstood, or alone in one’s intense distress, particularly related to separation and loss, are likely to be evoked after a pregnancy loss and replayed or “revisited” within the therapy relationship. While this presents unique challenges to treatment, it also provides an opportunity to revise negative or insecure attachment internal working models, as the client comes to experience a safe, trusting, attuned, and responsive therapy relationship in which feelings of trauma and loss can be safely approached and processed, unlike in early attachment relationships.





Video

“Techniques” to look for:

- Processing trauma within a secure affect-regulating attachment relationship with the therapist
- Empathy and emotional soothing
- Therapist tracking of client moment to moment experience
- Therapist presence and joining

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Let’s See It!

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Thank you!!!!

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Clinical Resources

- Markin, R. (2024). *Psychotherapy for Pregnancy Loss: Applying Relationship Science to Clinical Practice.* Oxford University Press.
- Psychotherapy for Pregnancy Loss (2024). *APA Therapy Demonstration Video Series.* Washington, DC: APA.
- Markin, R. D. (2023). "A little bit pregnant": Counseling for recurrent pregnancy loss. In S. Covington. (Ed). *Fertility Counseling. 2nd Edition.* Cambridge Press. Cambridge, UK.
- Markin, R. D. (2018). "Ghosts" in the womb: A mentalizing approach to understanding and treating prenatal attachment disturbances during pregnancies after loss. *Psychotherapy, 55*(3), 275–288. https://doi.org/10.1037/pst0000186

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Q&A With Dr. Makin

- We will now discuss select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

References

- Diamond, D. J., & Diamond, M. O. (2017). Parenthood after reproductive loss: How psychotherapy can help with postpartum adjustment and parent–infant attachment. *Psychotherapy, 54*(4), 373–379. https://doi.org/10.1037/pst0000127
- Jaffe, J. (2017). Reproductive trauma: Psychotherapy for pregnancy loss and infertility clients from a reproductive story perspective. *Psychotherapy, 54*(4), 380–385. https://doi.org/10.1037/pst0000125
- Leon, I. G. (2017). Empathic psychotherapy for pregnancy termination for fetal anomaly. *Psychotherapy, 54*(4), 394–399. https://doi.org/10.1037/pst0000124
- Markin, R. & Coleman, N. (2023). Intersections of gendered racial trauma and childbirth trauma: Clinical interventions for Black women. *Psychotherapy, Mar;60(1):27-38.* doi: 10.1037/pst0000403.
- Markin, R. D. (2017). An introduction to the special section on psychotherapy for pregnancy loss: Review of issues, clinical applications, and future research
- Markin, R. D., & Zilcha-Mano, S. (2018). Cultural processes in psychotherapy for perinatal loss: Breaking the cultural taboo against perinatal grief. *Psychotherapy, 55*(1), 20-26. http://dx.doi.org/10.1037/pst0000122
- Markin R. D. (2016). What clinicians miss about miscarriages: Clinical errors in the treatment of early term perinatal loss. *Psychotherapy*, *53*(3), 347–353.
- Wenzel, A. (2017). Cognitive behavioral therapy for pregnancy loss. *Psychotherapy, 54*(4), 400–405. https://doi.org/10.1037/pst0000132