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ScienceDirect
Cognitive and Behavioral Practice 19 (2012) 161-173
Cognitive and Behavioral Practice
www.elsevier.com/locate/cabp

Development and Preliminary Evaluation of a Cognitive-Behavioral Intervention for Perinatal Grief

Shannon M. Bennett, *Weill Cornell Medical College/New York Presbyterian Hospital*
Jill Ehrenreich-May, *University of Miami*
Brett T. Litz, *Boston University and VA Boston Health Care System*
Christina L. Boisseau, *Brown Medical School and Butler Hospital*
David H. Barlow, *Boston University*

Perinatal loss, typically defined as fetal death beyond 20 weeks gestation through infant death 1-month postpartum, is a potentially traumatizing experience for parents occurring in approximately 1% of births in the United States. Although many women recover, 15% to 25% have enduring grief-related symptomatology and functional impairment. Perinatal grief is a unique bereavement experience, but clinical resources for detecting and treating severe perinatal grief are rare and interventions are largely without empirical support. We developed and pilot tested a cognitive-behavioral intervention targeting the psychological and behavioral sequelae of perinatal bereavement. To initially evaluate the feasibility and efficacy of the intervention, 5 women who suffered a perinatal loss were randomized to a 2-week, 4-week, or 6-week baseline period in a multiple-baseline single-case experimental design. In most cases, after the respective baseline periods, there was a steady decline in reported grief symptoms. These gains were largely maintained at a 6-week follow-up assessment. This study provides initial evidence in support of future research and clinical efforts tailoring cognitive behavioral interventions to meet the specific needs of women who experience perinatal loss.

Approximately 1% of pregnancies in the United States results in a perinatal loss, typically defined as fetal death beyond 20 weeks gestation through infant death 1-month postpartum (MacDorman, Munson, & Kirmeyer, 2007). Between 10% and 25% of pregnancies may result in a spontaneous abortion (miscarriage) before 20 weeks gestation (National Library of Medicine, 2006). The experience of pregnancy loss or perinatal death can be devastating and potentially traumatizing for some parents regardless of the type of perinatal loss or the gestational age of the child (Berman, 2001; Cote-Arsenault & Mahlangu, 1999; Klier, Geller, & Ritsher, 2002; Vance et al., 1995). Thus, the use of the term perinatal loss in this manuscript is not meant to exclude the experience of women who have a miscarriage before 20 weeks gestation or a neonatal death beyond 1-month postpartum.

Research and clinical reports suggest that the severity of mental health distress generally wanes over the first year following perinatal loss; however, approximately one-fifth of women continue to experience clinically significant symptoms 12 months after the loss (Boyle, Vance, Najman, & Thearle, 1996; Leon, 2001). Hughes, Turton, Hopper, and Evans (2002) reported that approximately 20% of women who suffer a perinatal loss experience depression or posttraumatic stress disorder (PTSD). The lifetime risk for PTSD from perinatal loss has been estimated to be 29% (Turton, Hughes, Evans, & Fainman, 2001). In another study, Vance et al. (1995) found that perinatally bereaved parents reported significantly greater symptoms of depression and anxiety than parents who experienced a successful pregnancy when assessed 2 months and 8 months after their loss, with a substantial drop in symptoms between these two time points. A number of studies have shown that women who suffer miscarriage are also at increased risk for anxiety and depressive disorders (e.g., Geller, Klier, & Neugebauer, 2001; Klier, Geller, & Neugebauer, 2000; Klier et al., 2002). During the subsequent pregnancy following a loss, approximately 15% to 20% of mothers report a host of mental health symptoms and syndromes, including depression, anxiety disorders, reexperiencing of the prior loss, and/or fear about suffering another loss (Cote-Arsenault & Bidlack, 2001; Geller, Kerns, & Klier,

Keywords: perinatal loss; prolonged grief; cognitive behavioral therapy

1077-7229/11/161-173$1.00/0

2004; Theut, Pedersen, Zaslow, & Rabinovich, 1988; Turton et al., 2001).

It has previously been asserted (Bennett, Litz, Lee, & Maguen, 2005; Bennett, Litz, Maguen, & Ehrenreich, 2008) that prolonged grief disorder (PGD) may best capture the enduring mental health impact of perinatal loss. A rapidly increasing body of strong clinical, biological, and empirical evidence suggests that PGD is distinct from normal grief, PTSD, and depression (e.g., Boelen, van de Schoot, van den Hout, de Keijser, & van den Bout, 2010; Bonanno et al., 2007; Prigerson et al., 1996). PGD is not yet a formal diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994); however, provisional diagnostic criteria have long been used in bereavement research (e.g., Horowitz et al., 1997; Prigerson et al., 1999; Stroebe et al., 2000), and revised diagnostic criteria have been proposed for *DSM-5* (Prigerson et al., 2009).

There is evidence from a handful of randomized controlled trials (RCTs) that cognitive-behavioral treatment (CBT) significantly reduces chronic post-loss psychopathology. Shear, Frank, Houck, and Reynolds (2005) conducted a, RCT of an intervention designed specifically to target symptoms of complicated grief (as the construct was known at that time). Complicated grief treatment (CGT; Shear et al., 2005) includes education about grief processes and focuses on restoration of a satisfying life through attention to personal life goals. CGT also includes exposure therapy targeting the memories of the deceased and the time of their death. Shear et al. (2005) compared interpersonal psychotherapy (n=46) and CGT (n=49) over an average of 19 weeks and found that although both groups improved, the response rate was greater for the CGT (51%) than for interpersonal psychotherapy (28%). Other research shows that CBT for complicated bereavement is efficacious when administered in alternate modalities, such as the internet (Wagner, Knaevelsrud, & Maercker, 2006; Wagner, Knaevelsrud, & Maercker, 2007). Boelen and colleagues reported on several factors associated with the efficacy of CBT for complicated grief, and found that individuals who experienced the loss of a partner or child tended to have worse treatment outcomes than those who experienced other types of familial loss (Boelen, de Keijser, van den Hout, & van den Bout, 2010).

There are a number of factors that make grief specific to perinatal loss (referred to as perinatal grief) unique from grief related to the loss of other important attachment figures (see Bennett et al., 2005, for a review), thus potentially warranting a more specific treatment model. For example, parents have not had the opportunity to "know" their child for very long and have few positive shared experiences with the lost person-to-be. Thus, they mourn "what could have been" in the future, rather than "what was" in the past. Parents may feel as though the love, energy, time, and physical, psychological and sometimes financial commitments expended to bring the child into the world were largely unrewarded. Parents may have to face the task of explaining what happened to family and friends, when they themselves may not fully understand what happened, as often there is no identified cause for the loss (Nikcevic, Kuczmierczyk, Tunkel, & Nicolaides, 2000). Further, a perinatal loss can leave a woman feeling as though something she did caused the death of her child, as though her own body has betrayed her, that she is "unfit" to be a mother, or that there is something wrong with her womanhood, all contributing to self-blame and guilt (Barr, 2004; Cote-Arsenault & Mahlangu, 1999). In addition to the acute psychological consequences of perinatal loss, women sometimes experience physical trauma as well when the consequences of pregnancy loss and/or pre-term delivery require an invasive medical procedure or threaten the life of the mother.

Unlike other losses, where bereavement rituals are well established, extended family and friends often do not know how to react or provide support following perinatal loss. Some may even view this loss as insignificant, believing the parents can just "try again," which leaves parents feeling extremely alone and invalidated in their grief (Janssen, Cuisinier, & De Graauw, 1997; Lasker & Toedter, 1991). Turton et al. (2001) found that perceived insufficient or uncertain support from family members following a perinatal loss was associated with greater PTSD symptom severity. Inversely, Toedter, Lasker, and Janssen (2001) reported the convergent evidence from eight studies that indicated the perception of strong support from friends and family was consistently related to lower grief scores. However, perinatal loss has been called a "silent loss," particularly because others do not know what to say or believe it will upset the parents to bring up the loss, increasing parents' perceptions that others would feel uncomfortable talking about the loss (Leon, 2001).

Bennett et al. (2008) conducted prior research on the psychological needs of women who suffered a perinatal loss and the deficits that may contribute to the development of pathological symptomatology in the post-loss interval. Ninety-one women who experienced a perinatal loss within the past 5 years at one of four Boston area hospitals participated in this exploratory study. Using hierarchical regression analyses, Bennett et al. (2008) found that maladaptive coping strategies, such as avoidance, suppressing emotions, or accepting responsibility for the loss were generally associated with adverse outcomes, including increased reports of complicated grief (Std. β = .322, p = .024), PTSD (Std. β = .348, p < .002), anxiety (Std. β = .720, p < .001), and depression