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Cultural Processes in Psychotherapy for Perinatal Loss: Breaking the Cultural Taboo Against Perinatal Grief

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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 feelings of grief and loss, and helping patients to create personally meaningful mourning rituals. Lastly, the impact of within and between cultural differences and therapist attitudes on the therapy process is discussed.

Keywords: perinatal grief, disenfranchised grief, cultural processes, pregnancy loss

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It is perhaps a universal human response to turn toward others during times of grief and loss for support and comfort (Bowlby, 1969). Yet, every culture will uniquely define the explicit and implicit rules for how the community should come together to help the bereaved to mourn. In Fijan tradition, when a death occurs, related clans and family join in a religious and social gathering, called the *Reguregu*, to share their sorrow and to reaffirm the connections between them. Here, mats made from the Pandanus plant, Tabua (or whales tooth), and Yaqona (a cousin of a pepper plant) are presented. In India, families carry the *pyre* along the Ganges River, down public streets, as they earnestly chant for the release of their loved one's soul. Yet, the atmosphere at the giant funeral site is not one of sorrow, as mourners instead laugh, chat, and play cards. In traditional Judaism, family and friends are encouraged to place a shovel of earth on the casket, as a sign of the finality of death. There is then a 7-day mourning period of *sitting shiva* when the family gathers to receive visitors. Mourning rituals such as these may be viewed as culturally prescribed formalized structures that are inherently relational, as they bring together family, friends, and the larger sociocultural and/or religious group to help the bereaved to grieve. Overwhelming feelings of grief and loss that are too unbearable to hold in isolation are contained within the boundaries that these rituals and relationships provide. Essentially, although the specific response to death varies between cultures, every culture defines its own traditions and rituals for grieving in ways that foster connections among the living (Covington, 2006; Littlewood, 1996).

Perinatal Grief: Cultural Context and Psychological Implications for Parents

Before exploring how psychotherapy can provide the kind of relationship necessary for parents to mourn the loss of a pregnancy, it is first important to understand the cultural context in which these parents are forced to grieve in isolation and the psychological consequences of grieving a loss not recognized by society. Here, we note how the terms "society" and "culture" are used in this paper. Culture is typically defined as the set of learned behaviors and beliefs that characterize a society or group of people. Specifically, Western society, often used synonymously with Western culture, is a broad term used to refer to a set of social norms, ethical values, traditional customs, and belief systems that have some origin or association with Europe, including countries strongly marked by European immigration. There are of course many specific "sub" cultures within Western society/culture that, although they share certain common Western values, each possess its own belief system and way of life, uniquely shaped by religion, race and ethnicity, nationality, political and economic history, and so forth. We argue that Western culture as a whole invalidates perinatal grief, yet, the manner in which this is expressed likely varies depending on the specific cultural context.

Cultural Context of Perinatal Grief

In stark comparison with other types of losses, when a pregnancy is lost there are no communal rituals for grieving, no customary religious or social gatherings, no condolence cards or flowers, nor is there even a death certificate, burial, or gravestone for the lost baby

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(Frost & Condon, 1996; Keren, 2010). *Perinatal loss*, which is a broad term encompassing miscarriage, induced abortion following the ultrasound diagnosis of a lethal anomaly after 24 weeks gestation, stillbirth, and death shortly after birth, is the *only* type of loss in Western society for which there are no culturally sanctioned rituals or traditions to help the bereaved to say good-bye (Layne, 2003; Keren, 2010). Without clear and customary mourning rituals, parents are left not knowing how to mourn, deprived of their right to mourn, and feeling as if their grief is not recognized by society (Lang et al., 2011). Instead, there is an active culture of denial and intellectualization that discourages parents from grieving (Frost & Condon, 1996). For this reason, perinatal loss is often called the "silent" or "invisible" loss (Lang et al., 2011). Miscarriage in particular is seen as a "non-event" and the fetus is viewed as a "non-person" (Frost & Condon, 1996). Close family and friends as well as the medical establishment typically reassure grieving parents that the loss was for the best, that "it" happens all the time, and encourage them to move on and try again, minimizing and invalidating parents' grief (Lang et al., 2011). From this, *perinatal grief*, or a parent's emotional reaction following a perinatal loss, has been likened to Doka's (1989) concept of *disenfranchised grief*, which is used to describe the experience of loss, or a state of bereavement, not openly acknowledged, publicaly mourned, or socially supported. Western society's lack of recognition of perinatal loss sends an implicit message to parents that their grief is not real, should not be publicaly expressed, and should be coped with in isolation (Lang et al., 2011). In effect, there is a *cultural taboo* against the public expression and recognition of perinatal grief that leaves parents feeling isolated, alienated, and without the usual customs for mourning (Layne, 2003). As a result, grieving parents are forced to cope in isolation, thwarting their capacity to mourn and subsequent psychological adjustment.

Psychological Impact

Because of the taboo status of perinatal loss in Western cultures, grieving parents are left with the daunting task of reconciling their intense feelings of loss with society's lack of validation and support (Lang et al., 2011). More specifically, research clearly reveals that pregnancy loss is often a traumatic event in a woman's life, leading to symptoms of psychological avoidance, intrusion, and hyperarousal, comparable with other types of trauma. Additionally, studies have found that following a pregnancy loss, women often report symptoms of depression, anxiety, and grief that may extend for years, even beyond a subsequent pregnancy. Despite the fact that Western cultures view miscarriage as a nonevent, research shows that women often attach to the fetus relatively early on in the pregnancy and experience intense grief and despair upon miscarrying. Several studies suggest that men also grieve the loss of a pregnancy, but that their grief responses often differ from those of their partners (see Diamond & Diamond, 2016 for a review on the psychological effects of perinatal loss). In sum, despite the fact that studies show the devastating impact of perinatal loss on parents, others generally view it as less traumatic than other types of loses. This lack of recognition from important others complicates parents' adjustment following a loss (Lang et al., 2011).

Cultural Opportunities in Psychotherapy for Perinatal Loss

Acknowledging and Not Pathologizing Perinatal Grief: Accounting for Cultural Factors

Clinicians should understand that the complexities involved in grieving a pregnancy loss exist on a psychological and sociocultural level (Keren, 2010). Parents are forced to grieve the loss of a pregnancy within a cultural context that forbids talking about pregnancy loss and prohibits the expression of perinatal grief in public circles (Covington, 2006). Given this, it is no wonder that studies have found that perinatal grief is often chronic, severe, and long-lasting, and that it does not show the typical linear decline over time as found with other types of grief (Lin & Lasker, 1996). Because of the long-lasting and severe nature of perinatal grief, it is often described as *pathological grief*, particularly among women. For example, studies suggest that 20–30% of women experience significant psychiatric morbidity following a perinatal loss (Zeanah, 1989). The authors argue that these so called "pathological grief" reactions are less a result of intrapsychic deficiencies or conflicts as often assumed, and more a consequence of parents feeling shun from society and deprived of the usual cultural structures and support systems for mourning. In our view, perinatal grief itself is not problematic, but a natural reaction to the loss of an attachment object. What remains problematic is society's response to perinatal grief, which is to actively avoid and discourage it. Grieving parents may seek therapy after a perinatal loss for the understanding, validation, and emotional containment typically received by family, friends, and religious or cultural groups after other types of loses. Deprived of culturally sanctioned mourning rituals, parents may enter therapy feeling stuck in their grief or depression but completely lost as to how to mourn and move-on. When the therapist solely focuses on intrapsychic causes and minimizes cultural factors contributing to the parent's unresolved grief, then the parent/patient becomes overpathologized and the therapist becomes yet another person who does not understand the patient's experience of loss.

Breaking the Taboo Against Perinatal Grief Within the Therapy Relationship

When a woman loses a pregnancy she not only loses a baby,[1] she also loses her emerging social status and role as a mother in the process of becoming. Having gone from what many cultures perceive to be the sacred social status of "expecting mother" to some undefined and unrecognized social status of a "mother without a baby," she is challenged to mourn the loss of her child and her hopes and dreams for the future, alongside the loss of belongingness and status within society. After the loss of a pregnancy,

[1] Research shows that women vary to the degree that they perceive the fetus as a real baby with an identity; the more a woman perceives her fetus as a person/baby, the more intense her grief reaction is likely to be upon a loss (Hutti, 1992). Women in Western industrialized countries, where pregnancy loss is less common due to changes in medicine and science, are more likely to think of the fetus as a baby and to attach early on in the pregnancy than in developing countries were pregnancy loss is still relatively common (Covington, 2006).

society does not recognize the woman as a mother, as she has no living baby, yet she no longer feels like a single woman, leaving her to feel marginalized and misunderstood (Côté-Arsenault & Brody, 2009; Layne, 2003). Psychotherapy can help these patients mourn the loss of a baby that society tells them never existed. Yet, this requires the therapist and patient to be aware of, acknowledge, and directly defy the taboo status of perinatal grief, validating the loss as real and openly expressing feelings of grief and loss. Here, it is proposed that through providing grieving parents with a relationship in which to mourn conjointly rather than in isolation, the therapy relationship acts as a vehicle for breaking the cultural taboo and for expressing adaptive feelings of grief. For, it is within a relationship with a trusted and empathic other that the grieving parent, perhaps for the first time, feels as if her grief is real because someone else has seen it and as if his loss has been given a voice because someone else has heard it. Within this type of relationship, perinatal grief is not marginalized or excluded, but rather recognized and understood, facilitating the process of mourning and healing the scars of social exclusion. This perspective is consistent with the theory that mourning is an interpersonal process (Littlewood, 1996) and with research suggesting that the therapy relationship predicts outcome across treatment orientations (Norcross, 2011). Thus, although the authors conceptualize perinatal loss from an attachment/object relations perspective, the fundamental hypothesis of this paper—that it is the therapy relationship that ultimately facilitates positive changes for perinatal grief patients—is applicable across theoretical orientations and approaches. The specific relational elements proposed to break the cultural taboo and help parents mourn are elaborated upon below.

Addressing cultural reenactments. Cultural forces have a tendency of silently creeping into the therapist–patient discourse, through which the same sociocultural dynamics that unfold outside of therapy are recreated within the therapy relationship. With perinatal loss specifically, the authors argue that, on an unconscious or implicit level, patients and/or their therapists may minimize or deny the psychological impact or reality of the loss as a recreation, or microcosm, of the larger cultural taboo. This might take the form of the therapist and/or patient avoiding the topic of loss altogether, denying important affects related to the loss, or focusing on trying again and subsequent pregnancies (Markin, 2016). Therapists should be aware of how the cultural taboo against perinatal grief is expressed in the patient's particular culture in order to accurately identify reenactments within the therapy relationship. In essence, the therapist and patient may internalize cultural attitudes that invalidate perinatal loss as real, just as family, friends, and health care providers often do, impacting if and how these loses are discussed in therapy. Yet, when these dynamics are recognized and explored within the therapy relationship, then the therapist has the opportunity to step outside of them and to offer the kind of support and validation to the patient that is so often denied in relationships outside of therapy, as seen below.[2]

Therapist: *I've been thinking about our last session. You were saying that your family and friends do not understand why you want to have a funeral for the baby and how this leaves you feeling very alone and misunderstood. I wonder if I unintentionally fell into this role by giving you advice, rather than really trying to grasp what a funeral would mean to you. What was your experience of that?*

Patient: *Now that you mention it, I did feel more closed off when I left last week but I'm so used to other people dismissing my feelings about this that I thought I was just being oversensitive.*

Therapist: *I do not think you were being oversensitive. Our culture doesn't condone rituals for mourning a pregnancy loss, even though they are so critical for expressing our feelings and moving-on. I was probably feeling some of the danger or caution in approaching this topic that your family and friends feel. But that doesn't mean your need for a funeral is not valid or important. How can we talk about this today in a different way that feels better?*

Empathy. Because these patients feel shun from society, they typically enter psychotherapy feeling alone and misunderstood. Accustomed to others invalidating their feelings of grief, they are often sensitive to criticism, self-critical of the fact that they have not yet "moved-on," and reluctant to express their feelings to their therapist for fear of being dismissed once again (Covington, 2006). Grieving parents generally lack empathic close relationships in which they could safely express their grief and loss and have these feelings accepted and understood. From an attachment perspective, when close others are not available to mirror and regulate overwhelming affective experiences, then feelings and experiences are denied or distorted. Thus, the process of mourning is thwarted without close relationships in which we can coregulate and make sense of our experience (Bowlby, 1969). From this, it is argued that an empathic therapeutic relationship is particularly important for pregnancy loss patients to mourn. Similarly, Leon (2015) argues that therapist empathy allows the patient to integrate the trauma and emotions of a reproductive loss and to rebuild self-esteem. More broadly, research has established a moderate correlation between empathy and therapy outcome (Elliott, Bohart, Watson, & Greenberg, 2011).

To empathize with the experience of perinatal loss, the therapist must understand the specific sociocultural dynamics that impact the patient's grief reaction. This means empathizing with the difficulty inherent in mourning a loss that is not recognized by Western society, and with the specific ways in which different cultures may disenfranchise perinatal grief. Relatedly, for these patients, empathy also entails understanding the anxiety, depression, isolation, and confusion that come from the lack of a clear social status or role. Specifically, Côté-Arsenault and Brody (2009) theorize that pregnancy represents a transformative liminal experience which changes a single woman into a mother. They explain that society has rituals or rites of passage that assist with this transformation (e.g., baby showers). When a pregnancy is lost, there are considered to be two incomplete rites of passage. As they state, the single woman has not transformed into a mother with a living baby and the fetus has not transformed into a living infant. Côté-Arsenault and Brody (2009) argue that society generally does

[2] All clinical material is an amalgamation of clinical experiences and thus no one patient can be identified.

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not acknowledge either loss because both are between two fixed points of classification, causing confusion and anxiety. From this, after a pregnancy loss, the mother has a normal desire to be out of the liminal stage, to move through the rites of passage, and to be incorporated back into society. However, she can no longer go back to the social category she left behind, single woman, but she cannot move forward either into the new social category of mother, as expected. She is stuck in social limbo without a culturally defined social status or role (Côté-Arsenault & Brody, 2009). The therapist's empathy into the impact of cultural factors on the patient's experience of loss is illustrated below.

Patient: *I do not know if I can do this anymore* (crying).

Therapist: *OK, What is "this"?*

Patient: *Living.*

Therapist: *I hear so much despair and exhaustion* (patient: nods). *What is this like for you?*

Patient: *It would be so much easier if I were dead and with Sam* (baby who died one hour postdelivery). *He is all I think about, all I want. But no, I do not deserve that comfort.*

Therapist: *Your grief and longing for Sam are so overwhelming that it feels as if it would be easier to kill yourself than to feel these unbearable feelings.* (Patient: yes). *All this self-loathing you are carrying around on top of all this grief. No wonder you imagine it would be easier to be dead, if not literally than dead inside emotionally.*

Patient: (crying). *Yes, exactly. I already feel dead, like I lost myself when Sam died.*

Therapist: *Tell me more about those parts of yourself you lost?*

Patient: *My old self is dead. That single happy woman with hopes for the future is gone. I cannot go back to her, but my image of the future "me" is dead too. I do not get to be a mother like I expected. I have no self. I have no role. I do not know who I am.*

Therapist: *You feel stuck because you lost your old self but there is no clearly defined new self to step into. You do not know who you are or where you belong in the world. You're not a single woman anymore but society doesn't view you as a mother either. It's like "do I even exist?"*

Patient: *Yes, it's as if I'm already dead to the world.*

Therapist: *An anchor lost at sea comes to my mind. Does that mean anything to you?*

Patient: *Yes, but I imagine purgatory. I'm alone, stuck in between two places waiting to move-on.*

Therapist: *What if you imagine me there beside you in purgatory. Tell me what it's like and maybe we can find a way out together?*

Emotional expression. The patient's emotional expression of grief and loss, within an empathic affect-regulating therapy relationship, is proposed to be key to treatment for perinatal grief (Covington, 2006). Although there are no studies on the role of affect in the treatment of perinatal loss specifically, research suggests that emotional experiencing and expression and emotional processing are important to the outcome of psychotherapy (Diener, Hilsenroth, & Weinberger, 2007). At the heart of the taboo against perinatal grief lies a prohibition on recognizing and expressing feelings of grief and loss, as others invalidate the loss as real and minimize or deny parents' feelings. Approaching these feelings in the therapy context chips away at this taboo that thwarts parents' ability to mourn, as seen below.

Patient: *I had lunch with my mother yesterday. It was the one year anniversary of Abby's* (baby terminated at 21 weeks gestation due to lethal abnormality) *death. I had to call her to schedule lunch. I do not think she even remembered the anniversary.*

Therapist: *How do you feel toward your mother when you say that?*

Patient: *I'm angry. Come on, how hard is it to remember your daughter lost a child a year ago?*

Therapist: *That anger, it feels like it has so much to say . . .*

Patient: *I'm not just angry at my mother. I'm angry at the world. I'm angry at every single doctor and nurse who never even asked how I was doing. I'm angry at every single supposed friend who didn't even call to say a simple, "I'm sorry." I'm angry at my church for not having some sort of memorial service. I'm angry at the world for expecting me to just move-on.*

Therapist: *You feel so alone and maybe abandoned right at the time you needed others the most.*

Patient: *Yes* (crying). *It's like when I lost Abby, I also lost the people closest to me.*

Therapist: *So many feelings unheard by those who were supposed to hear and understand them.*

Patient: (crying) *Yes, I feel so betrayed. What am I supposed to do with all these feelings eating away inside me if I have no one to talk to and understand?*

Therapist: *In here with me can we look at these feeling at a pace that feels comfortable to you?*

Creating Mourning Rituals

Mourning rituals symbolize public recognition that the bereaved has suffered a loss and provide clear and customary procedures for saying good-bye. The fact that there are no culturally sanctioned mourning rituals for grieving a perinatal loss invalidates parents' grief and makes it difficult for parents to mourn (Côté-Arsenault & Brody, 2009; Covington, 2006; Frost & Condon, 1996; Keren, 2010; Lang et al., 2011). Therapists have the opportunity to col-

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laborate with these patients to create personally meaningful mourning rituals and traditions that are relevant to the patient's specific cultural context. Yet, this kind of public recognition of perinatal loss cuts at the very chord of the cultural taboo, making it feel somehow improper or "silly." In general, therapists and patients often struggle with how to mourn a loss not validated by society and for which there are no culturally sanctioned ways of mourning (Diamond & Diamond, 2016). The authors suggest that it is generally helpful to create rituals and traditions that bring the patient's grief out of isolation and into a somewhat public space, wherein others are available for support, validation, and comfort. Additionally, from an attachment perspective, it is important for the mourner to find a way of internalizing and transforming his or her relationship to the deceased, rather than severing all ties to the lost object. Rituals like creating a grave site and writing letters to the lost baby help the parent to internalize the lost baby and transform the relationship (Diamond & Diamond, 2016). It may be helpful to adapt culturally specific mourning rituals for other types of loses to grieving a pregnancy loss, as exemplified below.

Shelly is a 31-year-old married Jewish American female who entered therapy after three pregnancy losses that were conceived using in vitro fertilization. Shelly's mother tragically died of cancer when she was just 11 years old. Shelly felt stuck in her depression, cycling round and round between feelings of guilt and despair, but never truly grieving. The therapist suggested that creating a mourning ritual might help Shelly to grieve her multiple losses. At first, Shelly felt it was "stupid" to have a funeral for babies that never existed. Yet, Shelly possessed a very rich fantasy of the unique personhood of each of her lost babies. The therapist inquired whether there were any rituals or traditions that helped Shelly to mourn the loss of her mother at the time of her death and whether there are currently ways in which she still feels connected to her. Shelly stated that while nothing much comforted her when her mother first passed away, she does remember feeling some relief when, during a Shiva call, family and friends sat around the dining room table telling stories of her mother and laughing as they reminisced. She now feels connected to her mother when talking to others who once knew her, recalling special moments from the past that exemplified her mother's character. The therapist reflected that this storytelling tradition is hard to recreate now since others never knew the lost babies, as they existed in Shelly's mind. The therapist explored with Shelly ways in which the spirit of the storytelling ritual could be replicated when mourning her miscarriages. Shelly decided that she would hold a funeral service with her husband and sister, where she would give a speech about how she imagined each of the lost babies. Shelly stated it would help her to mourn and move-on if she felt confident that the memory of her lost babies lived on in the minds of those people closest to her.

Attending to Within and Between Cultural Differences

Although it has been argued that Western society as a whole invalidates perinatal grief, there are likely important within and between cultural differences pertaining to how the taboo is expressed in specific cultures and how it impacts grieving parents. Most research about the psychological impact of perinatal loss has been conducted in the United States, Western Europe, and Australia, with an underrepresentation of minorities (Keren, 2010). Keren (2010) points to several studies as exceptions, including a qualitative study on low-income African American couples that found that socioeconomic hardship was a risk factor and spirituality a protective factor in how couples grieve a perinatal loss (Kavanaugh & Hershberger, 2005). In a small study of middle-class Indian women after perinatal loss, substantial grieving and common family blame for not producing a healthy child were reported (Mammen, 1995). Lastly, among Taiwanese women, one study found that a strong social expectation that women would ensure the continuity of the family had an adverse impact on their adjustment after stillbirth (Hsu, Tseng, & Kuo, 2002). In traditional Israeli-Jewish culture, women are encouraged to have large families, expecting the mother to serve as *the national womb*, and the society generally shows less tolerance for pregnancy loss and infertility issues. Sociological research suggests that this is for demographic reasons, as a long history of persecution and traumatic loss has led to the understandable cultural pressure to produce Jewish children to keep the religion and culture alive (Guilat, 2011). Israeli society is becoming more aware of the potential negative consequences of certain traditional attitudes around perinatal loss, and, starting in 2014, parents of stillborn babies or fetuses that died toward the end of pregnancy are permitted to participate in funerals. These within and between cultural differences point to the important role that cultural attitudes play in a parent's response to perinatal loss. Cultural beliefs about motherhood, a woman's role in the family, religion, medicine, and death, are all likely to influence society's response to pregnancy loss and thus a parent's grief response and psychological adjustment.

Therapist Attitudes

The first author was recently giving a talk to a group of experienced clinicians, where she stressed the devastating impact that even an early term loss can have on parents. One therapist in attendance remarked, quite honestly, that he never thought about the grief that someone may experience after a pregnancy loss and wondered out loud why this never had occurred to him. We do not believe that this brave clinician was alone in his unconscious denial of perinatal grief, nor do we believe that his lack of understanding in this area was a reflection of his overall lack of empathy or insightfulness. Rather, as therapists, we too are products of our culture and absorb the cultural denial around perinatal grief. This denial has profound implications for therapy because feelings of grief and loss may go altogether undetected and not processed during the course of treatment. Although we lack research on therapist attitudes toward perinatal loss, research on nurses' attitudes and the impact of these attitudes on patients may inform future psychotherapy research. It has been reported that, more often than not, bereaved parents receive inappropriate or insensitive care following a perinatal death from health care providers (Joanna Briggs Institute, 2006). For example, in one qualitative study, Lang et al. (2011) found that parents grieving a perinatal loss felt that health care professionals minimized their grief and treated their loss as a medical event, treated the loss as if it was not significant, and made insensitive comments. These findings

suggest that therapists should examine their attitudes toward perinatal loss to sensitively respond to patients.

Suggestions, Limitations, and Future Directions

A culturally sensitive manner of working with parents who have suffered perinatal loss includes conscious and ongoing reflection about the cultural contexts and biases of both the therapist and patient. Therapists should seek to better understand their own as well as their patients' cultural attitudes toward death in general and pregnancy loss specifically, as well as toward womanhood and motherhood, all of which play a role in how society responds to perinatal loss. It should be noted that no communication about this topic is free of cultural effects, including the paper at hand, which is written by two women who are mothers to young children and from specific cultural backgrounds. Lack of space precludes a discussion of elective abortions due to special considerations. Varying treatment modalities, such as couples or family therapy, were not addressed and should be explored in the future. We chose to focus on individual therapy, particularly with the mother, because it is often the grieving mother in heterosexual couples who presents first to treatment. Future work should address psychotherapy for perinatal grief among same-sex couples. Additionally, future work should explore culturally sensitive treatments for perinatal grief from different theoretical perspectives. For example, the ways in which the relational guidelines proposed in this paper are expressed in the therapy room may vary greatly between treatment orientations and even between therapists within the same orientation. Still, the proposed relational approach to the treatment of perinatal grief is of great clinical importance to therapists of all theoretical orientations, for it is within a corrective experience with the therapist that the patient's relational needs for mourning are met.

Conclusion

Taboos are in the business of secret keeping. These cultural prohibitions serve to protect some social value that, if broken, would undermine the social fabric. This is why individuals who break a taboo are shunned from the group, because they hold some "truth" that threatens the social order. With perinatal loss specifically, its taboo status represents its very significance and importance (Layne, 2003). For Western society to validate this kind of loss as real would mean confronting us all with the depth of human fragility and immortality, as the boundary between life and death is instantly broken when a pregnancy is lost. Removing the taboo would challenge our culture's reliance on medical technology and our need to believe that medicine and science make us invincible from this kind of harrowing loss, when, in fact, despite all of our scientific advancements, life and death remain largely outside of our control (Côté-Arsenault & Brody, 2009). Lastly, it would challenge the cultural mythology that pregnancy and new motherhood are always idyllic periods in a woman's life and face us with the sometimes painful realities of motherhood. Although these taboos protect society from uncomfortable truths, this shelter comes at a great cost to grieving parents who are forced to mourn in silence and isolation. Psychotherapy has the opportunity to offer these patients what society has taken from them, a caring and empathic relationship in which to mourn.

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