“Please Don’t Ask!”: A First-Person Narrative of Coping with Loss

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Abstract: This narrative discusses my experience of pregnancy loss from the perspective of an “insider.” Issues of grief, frustration, and confusion are explored as they influence my decisions, coping mechanisms, and actions. Despite the challenges and disappointments associated with the loss of motherhood, there is a sense of resilience and strength through my self-reflection.

Keywords: grief, motherhood, pregnancy loss, self-reflection

Introduction

Research suggests that between 10 to 20 percent of medically confirmed pregnancies will end in miscarriage for women in the United States; of these, 80 percent will occur during the first trimester (Mayo Clinic, 2021). Pregnancy loss at any point in the pregnancy is often a devastating experience for mothers and can result in feelings of inadequacy, grief, powerlessness, depression, and guilt (Slot et al., 2022). Mothers experience complex and conflicting emotions after a pregnancy loss. For a hopeful mother experiencing her first pregnancy, her shift in maternal status is among the losses.

Disenfranchised grief (or hidden grief) is more challenging for people to understand. Disenfranchised grief is not usually openly acknowledged; consequently, individuals do not receive the social support and degree of sympathy from others that they need to move forward in healthy ways (Walter & McCoyd, 2015). It is not in the DSM-5; therefore, it is not even a diagnosis that mental health practitioners can ascribe to their clients. When pregnancy loss occurs, women are simultaneously coping with the loss of identity as a parent while also mourning the loss of their baby (Harden, 2018).

For sufferers, disenfranchised grief can be extremely painful and isolating. The loss of “identity” can be perceived as less tangible and, as a result, less understood and/or validated. This narrative provides insight into the loss of motherhood so that in the therapeutic process, disenfranchised grief does not go unnoticed, undiagnosed, and untreated as mental health professionals work with the more “noticeable” losses.

An Insider’s Perspective

When you’re married and of a certain age without kids, the first question that everyone seems comfortable asking is “when are you all planning to start your family?” It is an expectation, assumption, and conversation that even strangers seem comfortable initiating. I always wanted kids and was told to “have fun trying,” but I must admit, when you try over and over and don’t get pregnant, the fun starts to fade away, and frustration begins to set in. With science and medical professionals, a couple can now have a more deliberate approach to pregnancy. But

even this process is daunting and invasive. Privacy becomes impossible when seeking medical assistance for fertility issues for persons who prefer to be discreet about their bedroom activities.

My first experience was humiliating. When I shared with my physician that I had been trying to conceive for several months, she flippantly told me to try harder and keep a log. I burst into tears when I left her office and vowed to change doctors. I was angry and sad that she would be so simplistic with her response and have such a poor "bedside manner." She never allowed me to tell her that I had done extensive research and tracked my ovulation cycle taking detailed notes, to no avail.

When I met with my new doctor, recommended by a friend, her approach was much different. She understood that I wanted to try something different because of my age and failed efforts. But first, my husband and I had to undergo a series of tests to ensure that we didn't have any medical issues interfering with my ability to get pregnant. I had a hysterosalpingogram; the pain I experienced was severe. But what the excruciating pain from that procedure did for me was reconfirm my commitment to being a mother. Armed with positive test results, we proceeded to the next step, and I started fertility medication.

As I saw it, this miracle pill worked, and I became pregnant. I read everything I could find about the first trimester, including when to share your pregnancy. Although many blogs and posts recommended waiting until after the first trimester, I was eager to have others share my joy. Conflicted, I battled with feelings of happiness and feelings of caution. But, on Mother's Day, when sitting with family and being around women who were experiencing and sharing their joy of motherhood, I blurted out, "I'm pregnant and will be a mother too!" Cheers, embraces, and congratulatory exchanges followed. I was a part of the club and was initiated into this special group. I was six weeks pregnant and overjoyed. I miscarried five days later, and things were never quite the same.

I am not a quitter. I licked my wounds, put aside my extreme disappointment, and started the process again—ending in another miscarriage. By this time, my ob-gyn had referred me to an endocrinologist. This man and his team quickly became close allies in my quest for motherhood. After consulting with my team and other medical professionals, my husband and I decided to try in vitro fertilization (IVF). IVF meant entering a whole new world of weekly tests and checkups, scheduled procedures, and daily injections/medications. This was a scientific process with detailed requirements and specific instructions. The calendar outlined every aspect of the process, and there was little room for errors or missed appointments. Everything was on a schedule. During this process, my weight fluctuated, leading persons to speculate on my pregnancy status. This was difficult because I continued to have miscarriages even with IVF: one after eight weeks, another after six weeks, and another after five weeks. The physical, psychological, and emotional toll this took on me and my husband is hard to describe, but we were fortunate to have different support systems. But there were still a lot of hard times. One of the most challenging times was when so-called "friends" would say things like, "you're glowing; are you pregnant?" And my answer was, "No! I miscarried." This response would leave an uncomfortable silence. Often the person would sheepishly move away. Feeling

embarrassed by the question and ashamed to have prompted the blunt answer led to infrequent interactions and superficial conversations.

I still wonder why you thought that it was appropriate for you to ask.
If I didn't share, it's because there was nothing that I wanted you to know.

My longest pregnancy was five months—a little girl. I thought that I had finally done it. But, yet again, I had another miscarriage. I had seven miscarriages before telling my doctor, husband, and friends that I couldn't do it anymore. I had mounting medical bills and nothing to show for it. I considered donor embryos and was on the waiting list for over a year with no viable prospects (African American embryos are somewhat scarce). I wondered if the world was ready for me to give birth to a Caucasian baby, but I decided not to pursue that avenue. I gave up. I was on the mat and finally tapped out. I was mad, sad, ashamed, frustrated, prayerful, and confused. But also stoic, resilient, and optimistic that I was experiencing and following the path that was paved for me. I appreciated the numerous options, such as surrogacy, fostering, adoption, etc. A child does not have to be biologically related to me for us to have a mother-daughter or mother-son relationship. Reflecting on my experience, I also realize that I was very fortunate. My ability to pursue motherhood was primarily due to my robust health insurance plan. It provided excellent coverage for fertility treatment. Not all states require insurance companies to provide coverage for infertility treatment. As such, many women with fertility issues have limited options.

I share my story because I don't want to feel ashamed about not having kids, and I don't want pity, either. I want the world to be more sensitive when discussing infertility because many of us wish to discuss this very personal issue in a safe space. The World Health Organization (2022) states this:

> Whatever the circumstances surrounding the loss of a baby, every single woman deserves respectful and dignified healthcare that acknowledges her loss, provides support for any psychological issues she may face, and empowers her to make future decisions about having a child. (para. 2)

Coping with the loss of motherhood is an ongoing journey. You occasionally question if you should have tried harder to conceive, different doctors, different medication, etc. For me, it's a complicated struggle where you learn to manage the feelings associated with the loss of motherhood, but you don't truly achieve that fifth stage of acceptance. I found a quote that I believe speaks to me in a therapeutic way: In your journey to healing, "you must let the pain visit. You must allow it [to] teach you. But you must not allow it [to] overstay" (Umebinyuo, 2015, p. 182). The kindest, most thoughtful, and compassionate message I received after losing my daughter was a card that read, "Sorry for your loss." This empathetic message was instrumental to my healing process.

Implications for Social Work

Social workers frequently work with clients facing adverse situations. With the extensive COVID-19–related loss and grief, there has been increased exposure to trauma-related experiences. Social workers need to watch for signs of compassion fatigue. Helping others heal can take a mental, physical, and emotional toll on the practitioner. Professional self-care is paramount for competent and ethical social work practice (Murray, 2021). Self-care suggests activities or strategies that social workers make time for that help to provide them with the emotional and psychological capacity to cope with the demands of the profession (Smullens, 2015). Recognizing its importance, the National Association of Social Workers' *Code of Ethics* advises social work organizations, agencies, and educational institutions to promote organizational policies, practices, and materials to support social workers' self-care (Murray, 2021).

Conclusion

As a gerontological social worker, I have had significant experience helping older adults cope with grief and loss. As such, I understand that there is no ideal way to deal with a loss. However, some strategies that can help with depressive symptoms include boosting self-esteem, staying active, building support systems, and seeking early therapeutic intervention (National Institute of Mental Health, 2021). Practitioners must be aware of the compounding factors and experiences accompanying a woman's grief journey in providing therapeutic care for a pregnancy loss.

The loss of motherhood is more than a loss of identity; it includes a loss of purpose, a loss of belonging, and a loss of possibilities. For practitioners working with women who have experienced pregnancy loss, they will need to unpack the meaning of motherhood with their clients. In doing so, they will be better able to provide targeted support, appropriate coping mechanisms, and effective treatment surrounding their loss.

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