The Death of a Child at Birth

The birth of a child is perhaps the most anticipated event in life. When a child dies during the birth process, profound grief sets in for the parents and those who care about them. Helping the family grieve this loss during the first year is an important process for their future mental health.

by
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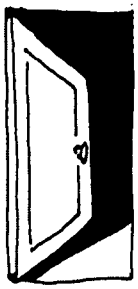


Some have called it miscarriage; some have called it silent birth or stillbirth, while others have labeled it sudden infant death (SIDS) in utero. Whatever language you use, it is in the psyche a cruel oxymoron.

I received a call from a trauma physician saying, " I'm Dr. G., please help." His voice was somewhat shaky, somewhat unclear. I wondered for a brief few seconds... was there another local tragedy? "Oh God" I said silently, "please no." While I have worked with trauma patients in the past, no one looks forward to them. They are sad, exhausting, and challenging. My small caseload had a mother dealing with her HIV-positive son, a couple who had suddenly lost their college-age daughter to a brain embolism, a single mother whose teenage child was killed in an auto accident, and a woman who had just attempted suicide. The tragedy Dr.G. was calling about was his own.

I listened... he said, "My wife is depressed and I'm worried about her... We had a baby born on February 3rd, dead." Asking for help, particularly mental health assistance, is usually not easy for physicians. They tend to be more physiologically focused. I have treated physicians in my practice but they were never the ones who made the initial call for help.

There are two types of stillbirth: fetal death in utero (FDIU) in which the baby's death is diagnosed days or weeks before delivery, and one where there is no warning or knowledge prior to the labor and delivery. This couple experienced the second type of stillbirth. I remembered how sad and depressing my earlier work with couples who had experienced stillbirth had been for me. The difference now is that I am a parent and it is hard to even allow myself to consider fully the depths of the loss. In anticipating my work with this couple, I knew my empathy would be helpful, but I felt it would be difficult to keep it in check in order for me to be therapeutically helpful. I was afraid at times that I would become sympathetic and that I would feel immobilized by their depth of sadness. I recalled a very skilled therapist retiring early because his son unexpectedly died. He had shared how he could no longer do this work because he could not listen in the same way as he had before. I assumed his grief was too painfully loud in his mind.

This article will offer the reflections and theoretical interventions I used in working with this couple through the first year after their tragedy. I had the couple take up journal writing

as a technique for venting their feelings between sessions, and to reminisce. Having used journals before, I was aware of the many benefits for the therapeutic process—safety, relaxation, spontaneity, integrity, experimentation, imagination, testing reality, integration, emotional release, self-understanding, and self-confidence (Capacchione, 1989). The quoted passages used in this article are actual excerpts written by Mrs. G. from her journal.

I saw the couple that evening. He was a somewhat overweight man of medium height. She was a thin woman. It was difficult to determine her height as she was hovered over, almost in a fetal position. They had a three-year-old son that was being cared for by their parents. She shared how she knew that the baby they were expecting was alive earlier in the day of the birth. What happened? They were very distraught. The couple entered the hospital with absolute joy-filled anticipation. What happened later would change their lives forever.

I was concerned about both of their levels of depression. The trauma physician had a strong, almost posturing presence. He felt he had to hold it together until his wife could fully function again. She was verbal and was able to discharge her sadness by crying and withdrawing. He had experienced a lingering depression that preceded this tragedy. He accepted my recommendation early in the therapy to see my psychiatric colleague who started him on antidepressants, which he responded to positively. She could have benefited from psychopharmacology, but refused to consider it.

They both had some control issues. They worried as others had about letting their feelings go, about grieving, fearing what might happen to them (Stauncher, 1994). She worried that their depression would never lift and that he would have to be on medication forever. His family had a history of depression and she worried that he would be "like them." I worried about whether she might become psychotic. She seemed fixated about something else bad happening to her or her family. I wondered if her nihilistic attitude was related to a typical Post Traumatic Stress Disorder reaction, or if it was more than that. Dr. G. worried about whether he could return to work. During the first three months of their treatment, I saw them several times a week. Sometimes the sessions would be individual sessions, while other times I would see them together.

They had been on a six-year roller coaster ride of trying to have a second child, after having one son, which made this loss even more complicated. They had prior marital conflicts and dissatisfaction related to money, stress, work, and infertility and struggled with limited interpersonal conflict resolution and communication skills. This was another blow to their relationship. My clinical experience is that some couples get stronger working through a crisis, while others fall apart.

What was it like for this physician to be in his wife's delivery room watching their baby enter the world without the long-anticipated cry? "There is a tendency to believe that somehow a mistake has been made and the infant is still revisable" (Kirkley-Best and Kellner, 1982, p. 421). Dr. G. began CPR on the baby, trying hard to breathe air, give life to this beautiful little baby girl that was his. He had performed CPR on thousands and had saved strangers along roadsides after long hours at the hospital. I tried to think about my being on the operating table as they performed a caesarian section and what my reaction would have been if this tragedy had happened to my husband and me. Despite several attempts, I could not do this mental exercise. It was too draining, too scary, too overwhelming. The depth of depression and the emotional threat left me feeling "there by the grace of God, go I." I had been one of the lucky ones.

Mrs. G. was able to share her pain with me in her first major journal entry five weeks into their treatment. "On Monday, Feb 3, 1997, our baby girl was born—still. She was beautiful. She had all of her fingers and toes and everything else that would make her appear like a normal healthy newborn. She resembled my maternal grandmother, her namesake, and had our son's chin. There are no words to describe the horror, pain, emptiness and isolation we felt on that day. My husband, an emergency physician,

tried unsuccessfully to assist in resuscitating his own child. There was nothing he could have done. She was already dead. He had saved so many lives in the past, but could not save that of his daughter. This is the burden that he has to shoulder. He had to look into my eyes and tell me that the baby we wanted and loved so much, the one we went through one full year of fertility treatments to conceive, was gone. The tests reported that our daughter died of overwhelming sepsis from Group B Streptococcus (Strep B). The bacteria came from my body. My body killed my baby girl. There was nothing I could have done. This is the burden that I have to shoulder." I offered how they both felt terribly out of control and that the first step towards healing would be to accept that neither of them did anything "wrong."

Bowlby (1980) and Parkes (1972) offer the stages of grief as shock and numbness, yearning and searching, disorganization, and reorientation. This theoretical frame seems to more fully describe the stillbirth grief process than Kubler-Ross's (1969) stages of denial, anger, bargaining, depression, and acceptance. The burial was complete but the shock and numbness remained.

Shock and Numbness

They held a funeral before I began working with them. This first step of saying goodbye to Baby J. was an important one for this couple. The funeral home was sensitive and respectful. They made the right choice for themselves. Mrs. G. reflected: "The funeral home treated us with decency, humanity, and generosity. Without them, an impossible task would have been made more so. They were available at all times, allowed us to make the choices that made us most comfortable, and were genuinely caring and comforting. They accepted no fees for their services. They graciously stated, 'We are not in the business of burying babies.' Their only goal was to assist us in giving our daughter a beautiful and loving burial." Some couples choose not to hold a funeral. Their decision was the right one for them as the ceremony allowed for many people to join and embrace them in their long grieving journey.

Yearning and Searching

With all parents, there is some discrepancy between their ideal infant and their real infant; however, in a normal outcome it is not difficult to reconcile the differences. "In still birth, however, parents suffer the worst discrepancy—not only is their real infant obviously different from their ideal infant, but death, one of life's greatest sorrows, has occurred at precisely the moment in which the opposite joy at birth was expected" (Kirkley-Best & Kellner, 1982, p. 421).

Mrs. G. experienced the classic signs of grief: thoughts of the baby, flashbacks of giving birth, not hearing her cry, holding her, anger, guilt, difficulty sleeping, somatic distress, and depression. Mrs. G. felt her body had betrayed her, that she had killed the baby. This is not uncommon. Wolff (in Kirkley-Best & Kellner, 1982) found in his study that of 50 mothers, 17 blamed themselves, 10 blamed God, and 9 blamed husbands and doctors.

I attempted repeatedly to exculpate her. She seemed stuck. I felt like a failure. Why wasn't she making any movement? The truth is that there are no answers. Worried that she would not move, I found her sadness hard to stay with at times. I felt drained and uncertain of her progress. I tried to reassure her that she was not to blame for this loss—she had tended to this pregnancy with extreme care and consideration. Approximately 60 - 70% of stillbirths remain unexplained (Ilse, 1982; Kirkley-Best & Kellner, 1982).

Did this event create her negative outlook on life or did other events precede this? She seemed even more hurt and desperate than the other women who have lost children that I've worked with.

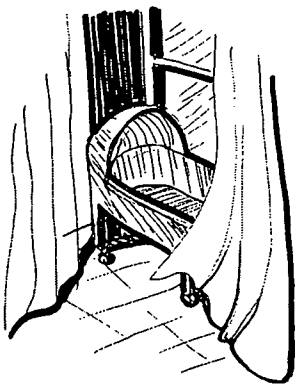
They both in some way blamed themselves, and perhaps each other, in their loss. The most difficult aspect for this couple, particularly Mrs. G., would be the issue of control. She would at some point need to make peace with the concept of powerlessness. Neither she nor her husband had any control over their baby's fate. That was in the hands of a higher power. They were Jewish, but were not connected with a tem-

ple. They had grown distant from their religion and felt betrayed by God. This would make my work more complicated. They seemed to abandon their spiritual belief system. For them nothing seemed predictable anymore.

No one is ever prepared for a sudden death; therefore, they are the most complicated to grieve (Bernstein, 1997; Rando, 1988; Tatelbaum 1984). "When you have experienced the elation of learning you are pregnant, only to feel the despair of discovering you have miscarried, the magnitude of the loss is understood. It is a shattered dream - the death of a wished-for child" (Covington, 1987,p.1.). "In sudden death you are called upon to face a massive gap between the way the world should be, with your loved one alive and the way the world is" (Rando, 1988, p.91). Life for this couple had become no longer predictable. Their stance of expecting things to go wrong may have been a way of protecting themselves.

Traditional grief literature (Kubler-Ross, 1969; Parkes, 1972; Rando, 1986; et. al.) describes the physical, emotional, spiritual, and mental aspects of grief reactions. However, in the case of stillbirth, some unique dimensions exist. For this couple, the grieving felt more complicated by the fact that they had some difficulty conceiving, which created a greater emotional investment and attachment to the pregnancy.

Why did their baby die? Could they or I accept that Strep B was the cause? I did not know what Strep B was all about. I wrote to the Strep B Foundation in North Carolina and asked several other physicians to educate me. It did not really matter except that I, also, began to wonder if this was really what happened. This wondering is common for the parents. A parallel process was occurring for me as I felt Mrs. G.'s uncertainty. I wanted to validate her curiosity but I was uncertain whether it would be helpful to join with her anger and suspicions, so I tried to remain neutral. Anger alone would keep the client defended against her feelings of powerlessness. She wondered why the fetal heart monitor tape was missing from her chart and wondered if the doctor had begun the delivery sooner, whether the baby would have been born alive. My own mother worked in many delivery rooms and had shared stories of things going terribly wrong due to human errors.



Dr. G. seemed settled with the explanation while Mrs. G. continued to wonder. He had experienced deaths in his own work. Maybe his medical training gave him the edge of understanding the unthinkable outcome of a child born with Step-B, or maybe he could not consider other physicians making errors that would result in the death of their baby. She ambivalently considered beginning a lawsuit but she didn't want to make it any harder on Dr. G., who had grown disappointed over the past couple of years with his chosen career and seriously considered leaving the field of medicine. His issues of abandonment and betrayal within the medical family had to be explored and resolved. Physicians are human and they make mistakes. Physicians sometimes can also do everything "right" and still the outcome is tragic. They are not trained to accept their humanness. At one point I shared the Strep- B information with Mrs. G. as she wanted to speak to an expert to determine her risk factors in trying to conceive again.

I asked the couple to bring their baby's mementos into a session. They could reminisce and share their thoughts of their baby. I did not want to do what others had—avoid their baby. It made their baby real in the session. She proudly brought in a box with the baby's wristband tag, hat, blanket, and pictures. She showed me a picture of her holding Baby J., a beautiful baby with dark hair. Many people are uncomfortable sitting with a dead baby. I know I would be, but I did not want to avoid their baby. She had been alive for them for nine months. Mrs. G. wrote: "We held our lifeless child in our arms, kissed her, told her how

much we loved her, and that we would carry her memory with us forever." The couple spoke often of how family and friends are uncomfortable talking about the baby and fear that bringing up the subject will injure the grieving. Mrs. G. wanted and needed friends and family to speak about Baby J.—doing so was not a reminder as she was always emotionally with her.

I had used pictures before in my grief work with clients so I encouraged them to bring in the pictures they had of Baby J. Pictures "can relieve your fears that time will dim your memory" (Schwiebert & Kirk, 1993, p. 17). The literature confirms almost unanimously that seeing and holding the infant is helpful in successful grief (Kirby-Best & Kellner, 1982). In my clinical experience, parents do benefit from being able to hold and see their child, even if it is a picture. It helps them hold on to the reality of their experiences.

Disorganization

The intense grieving gives way to feelings of depression, devaluing of self, and apathy (Kirkley-Best & Kellner, 1982). Questions re-emerged for Mrs. G.: Who am I? Will we ever have another child? They both felt as if they had failed themselves and that they had failed each other. They remained depressed and uncertain about their future. They continued to struggle with questions that at that time had no answers.

Mrs. G's Body

Mrs. G. was readmitted to the hospital with terrible abdominal pain due to complications from the caesarian section. "My mind and body responded in ways I didn't think possible. My gastrointestinal system shut down. I had excruciating neck spasms. I developed anxieties that disabled me from participating in everyday activities and chores."

Having had a cesarean section myself, I know it is a tough operation. But I had my baby girl to buffer my physical pain; she did not. Concerns were that some of her physical problems were psychosomatic, hormonal, and a re-visiting of her most profound loss in that hospital. Mrs. G. needed concrete love and physical attention. She felt that her own body had failed her. She felt connected, yet detached. She was angry, sad, frustrated, and hurt and experienced some emotions we may not have words for.

Mrs. G. had experienced a set back: "Screams came from my lips so frightening and primal that I still hear them in my dreams and flashbacks. As each day passed, my grief became worse. Each day was one more day farther away from the only time I had with this child. My pregnancy and five minutes of holding her were the only memories I had. I recall accidentally focusing on a mirror about five days after the burial—no one was looking back at me. There was no life in my eyes at all. A few minutes earlier, a friend who was visiting said I was looking better than I had a couple of days before. I cannot imagine what I must have looked like then. I have gained about 15 pounds since I lost my baby. It is not due to a nervous habit developed from my loss. My body change is my chosen form of self-destruction. It is the least harmful one I could think of, most important, it is my banner. It says, I am not OK. Please do not think that I am OK, even if I laugh. Please do not forget my beloved baby."

It is not uncommon for women, after miscarriages and stillbirth to gain weight—perhaps psychologically to make their bodies feel "full," unconsciously a wish to be pregnant. She was able to understand her weight gain although she was critical of herself.

Reorientation

Mrs. G. had resumed her major roles in her life. While she continued to think of the loss of Baby J. the time spent on it is decreasing. She was becoming more present in her interactions with her son and some of the couple's friends. Covington (1987) describes this as a reorganization period in which the loss of the baby is no longer consuming all of one's energy and emotions. This is the time when the loss is accepted as part of reality, not as being fair or right.

I found myself impatient at my inability to move Mrs. G. into the later stage of the grief work. "A final unique aspect of the grief that parents experience following a prenatal death is that many parents are reluctant

to complete their grief because, they say, to do so feels as though they are 'abandoning' the baby. Since other people did not honor the life of their child, many parents feel they must 'hold on,' even when they are otherwise ready to 'let go and move on'" (Doka, 1989, pp. 121-122). When she was not holding on to the loss of the baby, she was holding on to her loss of feeling protected by G-d. She felt punished and betrayed by Him. This was hard for me, as I believe things happen for reasons and that we may not like what happens, but later find meaning and purpose. She did not share this idea. She could see that her relationship with her husband was stronger, but she remained fixated on her anger at G-d. She refused to celebrate any of the Jewish holidays.

Grieving Differences

Dr. G. seemed farther along towards the final stages of the grief work. I offered him support to reassure Mrs. G. that grieving differences between men and women were common. Rando (1986) found in her research that mothers and fathers grieve differently. For fathers, grief seems to decline much more rapidly than for mothers. This implies that the father's grief decreases while the mother's grief is either remaining the same or increasing. It should be recognized and understood as a normal phenomenon (pp. 82-84).

Mrs. G. seemed to benefit from knowing that there are differences in grieving and seemed to accept that Dr. G.'s difference in grieving did not mean that he did not love the baby or that he did not care anymore. Abraham Lincoln had three sons who died: Edward, 4; William, 11; and Thomas,18. He wrote the following poem (in Ilse, 1982): "In this sad world of ours, sorrow comes to all/It comes with bitterest agony/Perfect relief is not possible, except with time. You cannot now realize that you will ever feel better/And yet this is a mistake. You are sure to be happy again/ to know this, which is certainly true, will make you become less miserable now. I have experienced enough to know what I say" (p.56).

Sibling Loss

Mrs. G. vacillated between wanting her son to be "okay" with the death of Baby J. and wanting him to be distraught and to share in her sadness. He needed to act out and express his own ambivalence about not having a sibling. Children grieve and deal with loss in their own way. They need role models and a stable environment. "Children often have three basic questions: Did I cause this illness or death to happen? Will this eventually happen to me? Who will take care of me now?" (Papenbrock & Voss, 1990).

A four year-old child does not quite understand death but certainly experiences a sense of loss. Their living son had escorted mom to most of her prenatal doctor visits. They had spoken about and prepared him for his new sibling. The baby's room had been painted, wallpapered, and furnished. Children sense distress of parents and the change in atmosphere within theirhome. I advised them that their son might regress, become irritable and/or withdraw but the changes would be temporary. When he acted out, this was hard for Mrs. G. as she, at times, blamed herself that she may have failed him.

I encouraged her to allow her son to see a child psychologist so he could express his own ambivalence about not having a sibling. She did not accept the referral and continued to struggle with her feelings that she was in some way to blame for her son's struggles. Later in the therapy she would work that through with me, and she allowed her son for a short time to see a psychologist colleague whom I had recommended.

I offered literature and pointed out suggestions: "provide security and a stable environment... follow a schedule... hold the child often... play with the child" (Papenbrock & Voss, 1990). I encouraged Dr. and Mrs. G. to buy their son a doll, as he had anticipated the arrival of a new baby sibling. They agreed to do this and found their son often playing with it, trying to resolve his positive and negative anticipations of having another child in their home.

I educated Dr. and Mrs. G. about the fact that children at this age cannot fully understand the concept of death. They need to ask questions, which come in cycles, and to know that death is not sleep

and that not all illnesses result in death. Children are unable to stay with painful emotions for any length of time and need to resume their normal activities and play as a way of protecting themselves from their loss (Papenbrock & Voss, 1990).

"Our 4-year old son wanted to know where his sister was. He wanted to meet her. When we told him that she went to live with God up in heaven, he responded, 'OK, when she's done living with God, she'll come to live with us.' He still speaks of her every day, 12 months later. The death of a child is so shocking and ambiguous to us as adults—how was he to grasp that he lost something so intangible to him to begin with?" I had explained to them that surviving children need stability. Their son would be able to grieve and move on when he sensed they were able to.

It was terrifying for their son to see his parents so distraught and his mother so sad for so long. He felt powerless and out of control in his attempts to affect her. I encouraged them to allow the continuation of his involved grandparents to be with him and to offer containment and stability.

Mrs. G. would need help in responding to her living child. She became aware of how her complicated grief affected her son. She shared: "Our child lost his mother for awhile. On the day my second child died, part of me died too. How could I possibly be the same? Yet each time I would cycle back into a deep depression, my son would pay the price." He would ask questions and his parents would need to be open to his thoughts to help him grieve. Later they would need to tolerate his having moved on without concerns for Baby J. His life needed to return to normal.

Letting Family and Friends Help

This couple is blessed with two very supportive, involved families who remain available to them. This kind of support is unique in my experience. "Our parents moved in and took over our household for several weeks. Our siblings felt the pain as if it were their own. Aunts, uncles, and cousins completed the circle of family support. Our closest friends came to our side. They counseled us with words that only best friends are capable of saying. They kept silent and let us grieve in our own way. They took our son for playdates, shuttled him to school and parties, shopped at the supermarket, cooked and delivered food made with love, and were there in ways that are too numerous to describe."

Saying Thanks

On the anniversary of their loss, I encouraged this couple to plan for the day. They decided to let others know how they chose to spend time as a couple—to visit the grave site, to include their son in putting bird seed on a tree in their yard, and to involve family and friends in mourning rituals. Mrs. G. was able to write a thank you letter that included her story.

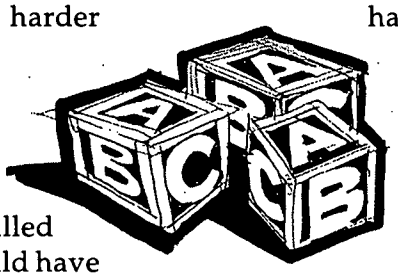
"I bought thank-you cards just a few weeks after our baby died. I began to compose letters of thanks on numerous occasions. But every time I picked up the pen to write, I became overwhelmed. Forgive me—it was too difficult a task to endure. There are no words to thank you enough. You sent cards with loving and caring sentiments; your words enabled us to continue through another day. You sent flowers; they added color to a gray time. You sent plants; they live on even now as a remembrance of a life that could not be. You sent platters and baskets of food; they nourished us and those who took care of us. You sent donations too. These were such thoughtful ways of remembering our beloved little one. We are touched by your heartfelt gifts and are consoled that others will benefit from all you have done. You thought about us, you waved from across a room. You took our hands. You hugged us. You consoled us. You kept us busy. You still ask how we are today. You left us alone and gave us our needed space. You understood when there were times when we could not speak. You forgave us for not returning your calls. These gifts of understanding are the best ones you can give us."

Other Births

Cain and Cain (1964) described how some couples try a "replacement child syndrome" strategy, to become pregnant and give birth in order to get over the loss of the dead child.

This was not the case for this couple as they had dealt with their loss and were continuing to struggle. The couple decided to try again to become pregnant. After a few months, they did. The three of us felt elated... and terrified. Would this pregnancy hold? Would the baby be OK? Unfortunately, after becoming pregnant, they suffered a miscarriage. Another loss, which escalated their sense that time might be running out and that the dream for a second living child may never be.

This has again set our grief work back. I am worried that I have failed to get Mrs. G. to a place where she is able to let go of an attachment to Baby J. that will only make it harder for her to accept a new baby. What complicates this process is that Mrs. G. doesn't have fond memories of her baby to fall back on. She is filled with dreams of what could have been. She longs to have a daughter to have a relationship with like she shares with her own mother.



Again, Mrs. G. began to question her role: identify. Who am I? What do I do with myself? What is my world view? Whom can I trust? Will I ever be a mother to a second living child? Will I ever have a daughter?

Mrs. G. had two friends that were pregnant at the same time as she was. At times, she needed to distance herself for self-protection. Doing so, however, created another loss—that of her friends. These births were bittersweet for Mrs. G. who spoke of this conflict often. "There have been several births and deaths in other people's lives since we have lost our babies. For those of you who have been fortunate enough to give birth to healthy babies, we wish you well. We wish your children a lifetime of health and happiness. We hope that you will allow us to see a glimmer of our child's life in your children. Please give them an extra hug each day in memory of all the children who could not be."

I am concerned about the hyper-vigilance that Mrs. G. has developed in relation to her son. What unconscious messages is she giving him about separation, safety, and independence as he begins kindergarten? She has some psychotic features—her reality seems at times distorted and paranoid. Is this "normal" given what she has gone through? Dr. G. does not share in the distortions. It seems somewhat of a waiting game... how do I address her features without her interpreting them as insensitive? I was frustrated by her lack of movement. I took a chance with her by using vignettes from other clients I have worked with who were able to move on. I confronted her gently and pointed out how she continued to be focused on the loss of Baby J. and how her relationships with those who are living (her son and husband) were suffering due to her inability to transition into the present. She seemed angry with me. I encouraged her to again attend a support group for couples who have lost children. This time she agreed.

Support Groups

The hospital runs a self-help support group. I needed the power of the group to assist me in my treatment interventions. "We have recently joined a support group called HANDS (Hope after Neonatal Death through Sharing). This group meets once a month. We are all parents of babies who are alive in our hearts only. If you share our common bond, please contact HANDS or any other group available in your area. Being with others who truly understand your pain is quite a peaceful experience."

Transformation is beginning to occur for Dr. & Mrs. G. "It is the true miracle of life that you can brutalize it, tear it apart, and still it survives" (Tatelbaum, 1984, p. 138). The power of other people telling their story and bearing witness to the potentials of the grieving process has helped this couple. I have begun to feel hopeful again with renewed faith in the process.

Dr. G. & Mrs. G. have attended the support group together. They see others who are at different stages of the grief process. Mrs. G. obtained a few telephone numbers from the other women who were further away than she from their loss.

Shadow grief (Covington, 1987) remains for this family. While they have passed one cycle of significant days, many more are ahead. Mrs. G's

friends' baby girl (born soon after Baby J.) is a reminder of what her baby should/could be doing in the here and now. The couple is trying again to conceive.

Conclusion

The grief process is never over. I am humbled by how complex and individually driven each grief journey is. Some interventions seem almost universal, while others need careful thought based on the client's prior losses and resolutions. Early grief work is like driving a car on a bumpy road. Each rotation of the tire could yield a smooth glide or a deep bump.

On the one-year anniversary, she wrote the thank you letter, which she had printed in the newspaper. Mrs. G. shared another part of her writing, which touched me and helped to validate in some ways that I had been therapeutically helpful. It validated our work together. "We have found a counselor who is a remarkable person. Her insights and skill have led us down a path of self-exploration and healing. We knew that our situation was one we could not cope with on our own. We thank her for the gifts of understanding and self-love she has given us."

She had wondered about putting my name in it. I encouraged her not to do so. Part of me felt undeserving of her praise. I unconsciously might have resisted because of not wanting referrals for more of this work. I also knew our work was still in progress and wanted our work to remain confidential.

After another recent miscarriage, Mrs. G. is pregnant again. Things are going well, but they were going well with Baby J. also. The wait seems so long for them and me. I defend myself around negative thoughts of something going awry. I find it impossible to strike a balance between optimistic support and realistic caution. In these cases, there is no safe ground for the clinician.

One clinical dilemma lingers for me. At what point do I support the effort to close their chapter on having more children? Mrs. G. recently described trying to conceive as an addiction to being preoccupied, anticipating, trying, waiting, and experiencing all the highs and lows. Ultimately I know this decision is client driven, but clients often look to us for some direction. I am unsure of myself here; holding my own daughter makes me even more uncertain. □

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