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A Strong Woman: A Psychodynamic Perspective on Religion and Culture in a Grieving Mother

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Abstract

This is a case report that depicts spiritual integration in grief psychotherapy with a culture-sensitive perspective. Topics addressed by this article include: 1) The impact of death of a neonate on an individual's faith; 2) The role of psychosocial development and factors on the process of grieving; 3) Therapist self-disclosure as a tool in working with resistance.

Keywords

Spirituality, grief, neonatal death, african, birth trauma, psychotherapy, christian

Author

I am a reproductive psychiatrist with an interest in perinatal loss and infertility. I practice mainly as a psycho-pharmacologist. However, I have a subset of patients I do individual therapy with, with a focus on supportive psychodynamic techniques but also incorporate cognitive and dialectical behavioral techniques as needed. I tend to lean towards an object-relation focus in theory, but incorporate all theories as clinically indicated.

I am also a Christian. I grew up as a Baptist and identify with the doctrine. However, I consider myself non-denominational. My desire to become a psychiatrist stemmed from an interest in integration between spirituality and mental health. I felt in my own community as a Nigerian-American there was a lack of understanding of how the two could be integrated and used to bring healing to many. In my culture, many times those struggling with mental illness are seen as morally weak. An emphasis on healing, physical and mental, through exhaustive fasting and praying was encouraged in my church with less of an acknowledgement of the role of medical or psychiatric care. I believe that understanding and living the culture of religion and faith has brought more depth and passion into my work as a psychiatrist.

The case described is of a woman I am currently doing supportive grief therapy with who shares a similar culture and faith of my own. I will discuss the history, relevant cultural and religious factors, course of treatment, and formulation and integration of spirituality into the therapy.

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Case Presentation

Presenting Problem

Mrs. G is a 41-year-old, married mother of Afro-Caribbean descent. She was referred by her gynecologist to a reproductive psychiatric clinic, co-located in a high-risk obstetrical practice, six weeks after the loss of her newborn daughter for grief assessment.

Obstetrical/medical History

Mrs. G reported difficulty in her first pregnancy with her now 9-year-old son. She had an incompetent cervix requiring a cervical cerclage in her second trimester. Given her history, it was recommended that she have a cerclage placed in the first trimester of her most recent pregnancy. At 30 weeks gestation, she had pre-term premature rupture of membranes (PPROM) and was hospitalized for the remainder of her pregnancy. She reports hearing from the medical staff assurance that her daughter would be fine.

However, at 32 weeks gestation, she went into spontaneous labor with concerns of a uterine rupture requiring an emergency caesarean section. She developed sepsis and was admitted to the intensive care unit (ICU) postpartum. She was unable to see her daughter initially. Her daughter was also ill and was in the neonatal intensive care unit (NICU). She recalls when she did see her daughter she appeared weak and tired.

Approximately 12 hours after the birth, she received a call from the NICU physician stating that her daughter passed away after a failed resuscitation. She was devastated with a mix of emotions, such as shock, anger, and disappointment. She never suspected she would lose her child. She was in recovery in the hospital for two weeks and struggled to get well with a desire to at least view her daughter. However, upon being discharged from the hospital she tried to see her daughter but was told that she could not given hospital rules regarding the viewing of deceased individuals. She only had pictures that her husband had taken and footprints to remember her by. She was never even able to hold her daughter. She eventually was able to view her daughter and had a private burial with her husband one month after she passed.

Developmental History

Mrs. G was born and raised in the Caribbean. She is the eldest child of her living parents. She describes her childhood as overall "good" initially, but later describes a form of "tough love" used by her parents. She had the responsibility in her home of caring for her younger siblings and house duties. She was raised to be both a peacemaker in the home and a caregiver for even extended family members. She was told by her father that because he saw intelligence and strength within her, he would not help her achieve goals academically or personally. She would have to accomplish them on her own. She was also instilled with the idea of being proper, having high morals, and doing well as to not embarrass her mother. She developed a strong work ethic and excelled in most things she did. She is married and has a 9-year-old son. She works as a nurse and identifies as a Seventh Day Adventist Christian. She has no previous past psychiatric history and no known relevant family psychiatric history.

Clinically Relevant Considerations

It is important to highlight that 50% of infant and child deaths occur in hospitals, and most occur in the NICU (Center for Disease Control and Prevention, 2015). Many parents have identified the death of their children in this manner as one of the most painful and traumatic experiences they have undergone (Youngblutt et al., 2017). Mrs. G described clear symptoms of bereavement and

trauma related to her own prolonged hospitalization and death of her daughter. She had symptoms of insomnia, panic attacks, poor appetite, intrusive images, and thoughts of the hospital/doctors. She also had feelings of excessive guilt and shame. She meets criteria for both bereavement and the *Diagnostic & Statistical Manual* (DSM-5) diagnostic criteria for post-traumatic stress disorder. She was recommended to have individual therapy for grief and trauma as well as prescribed a short-term supply of a low dose benzodiazepine to help with anxiety and insomnia.

The patient described developmental, cultural, and religious conflicts and expressed what she felt were negative emotions in the process of her grieving. She developed a strong tendency towards suppression, isolation of affect, and intellectualization when faced with uncomfortable feelings. Developmentally, she was always told to behave well and to not embarrass her family, particularly her mother. Introjection of this quality of her mother has stayed with her as she had complex feelings about showing sadness or crying after her loss. She was actually discouraged to do so by her mother who lived with her for weeks after she returned home from the hospital.

This idea of being strong in grieving has been described as an almost norm in African Americans, particularly private, suppressed grieving (Rosenblatt & Wallace, 2005). Parental influences tend to set a standard on appropriate ways to grieve, and also serve the function of dampening the pain and hurt of not just the affected person but the entire family and community after a loss (Rosenblatt & Wallace, 2005). Mrs. G carries the weight of needing to be strong for others and this has particular significance for her role as the eldest child and caregiver for so many as a developing youth.

Culturally, strength in grief has historical significance with African American mothers. Outward expression of grief in the face of being separated from one's child (through death or slavery) could lead to exploitation revealing vulnerabilities in the woman who needed to be strong, particularly during oppression (hooks, 1993). Mrs. G being of Afro-Caribbean descent lives in the current culture where others would still perceive her to be African American. She has an awareness of a desire to not live up to stigmas regarding black women and ideas of aggression and anger.

This awareness silenced her in areas where she desired to be more outspoken in both her own medical care and her daughter's. She felt that perhaps something was missed in the hospital with her daughter's care and that she was not given the opportunity to bond appropriately with her. She was understandably angry, but felt she could not display her rage particularly in the hospital due to fears of being labeled in a negative manner. Williams (2016) in her essay, "Toward a theorization of Black maternal grief as analytic," describes the factors of historical prejudices and marginalization that have led to black women grieving in a way that is "animated by silence, unintelligible responses, and vulnerability" (p. 17). In essence the desire to be strong in grief may paradoxically make one feel weaker and more subject to psychiatric symptoms (Goldsmith et al., 2008).

Religiously, she also struggled with both the emotion of anger and the idea of acceptance and sovereignty in her relationship with God. The literature does support the idea that parents who grieve tend to look towards religion/spirituality for coping, to create meaning and find comfort and healing (Cowchock et al., 2011; Lichtenthal et al., 2010). One study that looked at religious coping practices after the loss of a child found that at one month grief symptoms tended to be very intense with guilt, sadness, and anger predominating as well as anger and blame towards God (Hawthorne, 2013). Mrs. G presented for treatment at six weeks postpartum and like many grieving parents during this time, struggled with her faith. She felt the internal and external conflict of being grateful to God for her life but also anger towards God for the hole in her heart from the loss of her daughter.

Case Conceptualization

Mrs. G always arrived on time to her appointments. She easily identified with the emotion of anger in the initial sessions over her loss. However, she was unsure how to express this to others or deal with the intensity of her feelings when alone. Given the developmental, religious, and cultural

aspects of her presentation she developed methods of coping with intolerable feelings that helped me outline an understanding of her personality structure.

She appeared to have many personality traits consistent with an obsessive compulsive character. She utilized defenses of intellectualization, isolation of affect, and suppression. For instance, she would describe aspects of her family's lack of support to her during her loss without expressing much emotion. She also described when hospitalized she was angry with various aspects of her care. However, she chose to consciously not express herself for fear of being stigmatized. She would often compulsively research answers for her daughter's death in an attempt to not feel powerless in the way that she came to realize her parents and others made her feel. We discussed the implications of having to appear strong and at times silent for others. We discussed the idea of a more flexible definition of strength in the face of grieving. She was introduced to the idea that a strong woman can withstand the intensity of her feelings by accepting, embracing, and being compassionate towards them. In fact, experiencing and acknowledging feelings is crucial in healing.

A key emotion that is not uncommon in women after perinatal loss as well as individuals with obsessive compulsive traits is shame (McWilliams, 2011; Barr, 2004). In addition, some element of narcissism is inherent with motherhood and can make the shame of child loss particularly shattering to one's identity (Furman, 1978; Leon, 1990; Wurmser, 1987). The individual who feels shame feels "dejected, small, exposed, helpless and powerless" (Tangney & Fischer, 1995). Mrs. G was deeply aware of her feelings of shame which helps to understand why she declared herself to be powerless in her youth and her current circumstances. A study that assessed shame and guilt proneness personality types to enduring grief symptoms did find a relationship between shame proneness to enduring grief into 13 months after the loss of a child (Barr, 2004).

Mrs. G described feeling like a failure after her daughter passed away and felt that others, particularly her family, would view her in this manner. She felt undue pressure of having to appear "put together" and felt if she expressed her sadness to others outside of her husband she would be subject to more shame. A goal in the therapy was to have her utilize self-compassion in viewing her situation. She was encouraged to reframe her thoughts of being a failure or that she missed something in her daughter's care. Rather than blame herself, she could see what happened as a tragedy that happened to her, and she had not done anything to cause it. She was taught mindfulness and visualization exercises to help her deal with panic symptoms and personal regrets regarding her daughter's death, respectively. She visualized hopes she had for her daughter's last moments and seeing her currently at peace and in a safe place.

One difficulty I experienced throughout treatment was balancing the role of therapist and psychiatrist. Mrs. G appeared to value me as her therapist, but devalued my role as psychiatrist in medication management along with the use of various psychiatric words related to her symptoms. This may be related to her birth trauma with resultant decreased trust in physicians as well as cultural and personal stigma about seeking mental health treatment. She did not feel comfortable initially with taking prescribed lorazepam for anxiety and insomnia for fear of feeling "crazy" or not having control. Control was important to her and the lack of control over her daughter's death still devastates her. She did allow herself to take medication the night prior to having the autopsy report and this was important in lessening the need for control and allowing herself to be vulnerable.

Integration

Discussing the feelings of not having control in her life led to a deeper understanding of the role of trust, particularly with trusting God. Mrs. G described early in the treatment that she was given a journal by a friend. However, she struggled with beginning to write in the journal as the cover had a Scripture verse that she had difficulty accepting. The Scripture discussed leaning not on one's own understanding, but acknowledging God in everything and allowing him to direct one's path (Proverbs 3:5–6). She stated that she found it difficult to not lean on her own understanding, as she strongly

desired to understand why she lost her daughter. We discussed this Scripture in detail and its relevance in her situation for themes of control and unbearable feelings. She was encouraged to journal as a tool to discuss even the anger and disappointment with God and begin to trust her emotions with Him.

She was able to subsequently write about her experience of her loss and relationship with God. Self-disclosure of my faith and my understanding of God came through our discussion about Scripture, biblical characters (e.g. Job), and Mrs. G's experience of church. She reflected on worries about returning to church after the loss due to fearing others would give stereotypical comments about trusting God that were meant to be helpful but were non-empathic. I expressed an understanding of how church culture can be this way at times. However, she did feel welcomed in the church environment when she returned and felt it was helpful in her grieving process. I decided to disclose my faith as it appeared important in helping her feel understood with her complex feelings about religion. She appreciated this disclosure and talked more freely about her frustration with how she felt she was supposed to feel towards God.

However, a challenge I faced was acknowledging my own countertransference regarding not only a strong investment in her psychological well-being but also her spiritual well-being. At times, I had to assure exploration of her faith and Scripture was done in a manner that served the therapeutic work and alliance and not to impose my own values on Mrs. G. In Denney, Aten, & Gingrich's (2008) article a recommendation is given regarding disclosing aspects of one's own spiritual life, particularly feelings about God. I incorporated this recommendation by letting her know that at times I also struggle in my relationship with God in the face of the death of a loved one. This disclosure brought a sense of community and mirrored a way to accept feelings of vulnerability and uncertainty.

The therapy is still ongoing as Mrs. G prepares to return to work and her normal routine. We hope to continue exploring and supporting the goal of regaining power in her life. The developmental, cultural, and spiritual elements of her character can be seen as key tools in her healing and power.

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