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Grief counselling for women experiencing procreative loss

The paper draws attention to essential aspects of social life, such as procreative loss and the psychological state of women experiencing a miscarriage. It can be shown that miscarriage can be understood as premature termination of pregnancy and the loss of an unborn child, hence mourning is the natural process after the loss. The article discusses Izabela Barton-Smoczyńska's model of adaptation to procreative loss. Based on the assumptions of grief counselling by J. William Worden, the role of counsellors who support women after the procreative loss was highlighted. The article shows that the main tasks carried out in this type of counselling are to help in expressing emotions connected with the loss and accompany the woman and her family in the process of accepting the miscarriage.

Keywords: grief counselling, miscarriage, procreative loss, support, bereavement

Procreative loss (miscarriage) is something highly complex and ambiguous. From a medical point of view, it is understood as the pregnancy termination before the 22nd week, with the foetus weight of less than 500 g. Research results indicate that more than 30% of pregnancies are affected, and this figure signals that many women have experienced this situation in their lives (Malewski, 2008). In turn, psychologists' research shows that the experience of miscarriage is highly individual. How a woman and her loved ones will experience their loss is influenced by many factors and, above all: the woman's personality, her life situation, her attitude towards pregnancy, and personal and social resources for dealing with difficult situations (Barton-Smoczyńska, 2015; Guzewicz, 2014; Prażmowska et al., 2009; Sikora, 2014). Therefore, the author has raised the topic as vital due to the complexity and scope of the phenomenon. That is because a relatively large percentage of women have trouble delivering a pregnancy, therefore the miscarriage can be a negative, traumatic and stressful experience. The studies show that unwanted pregnancy and the act of (legal or illegal)[1] abortion not necessarily have to be traumatic experiences (Dolińska, 1980).

[1] In Poland, a pregnancy can be terminated by a doctor if the mother's life or health is in danger or in case the pregnancy was an act of a rape (The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion. Act of 7 January 1993).

The increase in the number of miscarriages is attributed to the civilisational changes associated with science, industry, and technology development. The duality of the effects of these changes is emphasised. On the one hand, civilisational progress causes chaos and unfavourable ecological changes in the living environment, and these are cited as the cause of many diseases and pathological disorders in people's health. On the other hand, the development of inventions applied in medicine makes it possible to diagnose relatively early the pregnancy and sex of the child to be born, and the state of its health and even enables carrying out appropriate life-saving medical procedures even before birth. A positive aspect – if everything goes well – is the possibility of obtaining an early diagnosis and "getting" enough time to prepare to welcome a new family member. The development of ultrasound and other diagnostic techniques that confirm pregnancy at a very early stage means that women can identify with their children very quickly.

On the other hand, cultural changes shaping lifestyles have led to a deeper analysis of the nature and role of miscarriage in the personal and social dimensions. In this context, it has been noted, among other things, that the age at which women give birth to their first child has increased in recent decades[2], with consequences. The later age at which the first child is born is linked to the fact that women plan their professional development as crucial; they also take longer to find the right life partner and want to have a stable financial situation. Most often, when they succeed in achieving those goals, the time comes to expand the family. However, the biological consequence of the decision for late motherhood is an increased probability of pregnancy failure (including miscarriage) and reduced time for procreative diagnosis[3]. Therefore, contemporary couples trying to have a child experience previously unknown concerns and high time pressure.

In this article, it is pointed out that a miscarriage can be understood not only as a premature termination of pregnancy but as the loss of an unborn child, so that the natural process after its loss is bereavement. Izabela Barton-Smoczyńska's model of adaptation to procreative loss is discussed and it is emphasised that the experience of a miscarriage may lead to a process of mourning, as understood by J. William Worden. Referring to his assumptions of grief counselling, the role of counsellors who support women after procreative loss is shown.

Grief counselling is a relatively new issue in the Polish context. For many years, coping with grief was of interest only to those psychologists and psychotherapists who supported patients with a "pathological course of the grief reaction."[4] In recent years, popular scientific publications have appeared to familiarise readers with this

[2] There has been a shift in the age of highest female fertility over the 30 years. In 1990, the highest fertility was recorded in the group of women aged 20-24, while in 2018 it was recorded in the group of women aged 30-34 (Cierniak-Piotrowska et al., 2019, p. 21; Podogrodzka, 2013, p. 170).

[3] The perspective refers to the biological reproductive capacity of the human being.

[4] The pathological course of the bereavement reaction arises from difficulties in experiencing the feelings that are inherent in coping with the loss. These feelings may be repressed, inhibited or

topic from a slightly different perspective. The books include *Experiencing Bereavement* by Helena Alexander (2013) and *Are you suffering? You're entitled to it: the experience of grief in a culture that doesn't understand it* by Megan Devine (2021). These books describe how a person may react to the loss of a loved one and how they may cope with the experience.

To confirm the recognition of the social validity of the phenomenon observed, an excerpt from an audit conducted between 2017 and 2020 is quoted. It aimed to analyse the medical care of patients in cases of miscarriage and stillbirth: "(...) the majority of hospitals did not exercise due diligence to ensure that all patients who so wished received psychological assistance and did not reliably document whether the standard of allowing the woman to receive psychological assistance as soon as possible was observed for each patient experiencing obstetric failure"[5] (Najwyższa Izba Kontroli [Supreme Audit Office], 2020, p. 38).

The experience of procreative loss

Parents often experience a miscarriage alone as, generally, even relatives do not understand their problems. The suffering they experience is often downplayed, causing embarrassment or a "conspiracy of silence." I can refer here to my own research, which consisted of an analysis of Internet entries posted on the portals dedicated to parents who have experienced loss. On the one hand, they contained very personal and emotionally involved content, reflecting the full scope of their suffering and describing the loss. On the other hand, they described how the women remembered what had happened to them from the people who should provide professional support and comfort. The analysis of the stories proved that the women did not receive professional assistance in this challenging situation. One of the contributors says that she heard the following words: "'nothing will come of it, the pulse is missing, you have to induce...'. And that was it, nothing more. No words of comfort, no support, nothing. He didn't try to explain to me why it happened. It was there and it's gone, just like that. It's a horrible memory that still evokes sadness and incomprehension in me. I wouldn't wish something like that to anyone." Another contributor to the post talks about the reaction of the midwife on the ward: "'Why are you shouting like that? It is the middle of the night. There is nothing going on.' – I only heard. To this day I lack the words to describe what I felt at that time." Another woman recalls her stay in hospital as follows: "and the nightmare in the hospital, where there was a lack of understanding. The doctor was vulgar, the staff very unkind, and that terrible emptiness after the curettage and the breakdown again,

over-expressed, which may consequently lead to various difficulties in the functioning of the bereaved (Kubacka-Jasiecka, 2010, p. 270).

[5] Obstetric failure is defined as a situation in which a patient does not take home a healthy baby at the end of pregnancy due to: miscarriage, stillbirth, unfitness of the infant or their lethal condition.

I couldn't pull myself together. Still in the room, I was lying with a girl high into pregnancy. Every two hours her heart rate was measured and I felt the emptiness because my baby was not there. Something terrible." These entries show how much suffering the women experienced and how the medical staff did not understand them (Chojnacka, 2020). It is noticeable that such portals' very existence indicates the great need to share experiences even with a stranger (potential reader). The Internet gives women a chance to have a conversation that they might not have in the real world, with their relatives and family. The phenomenon results from a lack of understanding of the suffering experienced by women after a loss and is related to the tabooisation of this experience (Chojnacka, 2020).

A well-known researcher on the meaning of illness and death, J. William Worden (2009), believes that the bereaved person must tackle specific "mourning tasks" and do "grief work." Such an approach assumes that the bereaved individual can actively participate in the grieving process and that the actions to take and the support of others can be a cure for the helplessness that occurs as the result of the death of a loved one. The first "mourning task" is to accept the reality after or in connection with the loss. What makes the loss experience real is participation in the ritual of saying goodbye (e.g. a funeral), but the essence of this task is the recognition that the relationship with the deceased was important and that their death affects the subsequent life of the bereaved. The second task is related to the experience of the pain, i.e. a variety of distressing emotional experiences such as sadness, grief, anger, loneliness, despair, guilt and anger. What can make it difficult to fully embrace this experience is denying and avoiding the feelings. The third task is adapting to life without the deceased; it is done by becoming aware of the roles they played in life. It is a time of adaptation to the new roles that are associated with the death of a loved one. The fourth task aims to find a place for the deceased in memories (instead of real life) and learn how to love the world again. By realising that the deceased was present and had been an important part of the bereaved person's life but in the past, they can begin to engage in things that are enjoyable and enter into new relationships (Worden, 2009).

Similar 'tasks' are included in Barton-Smoczyńska's model of adaptation to procreative loss.

Stages of adaptation to procreative loss	Counselling
Recovering from the first emotions related to the loss	Verbalisation and social dialogue
Working through trauma-related emotions	
Giving meaning to and accepting the experience of loss	
Integration of the event into current life	

Fig. 1. Model of adaptation to procreative loss
Source: Barton-Smoczyńska, 2015, pp. 92-100.

The author stipulates that the scheme she presents is a kind of simplification and generalisation of the process of adaptation to procreative loss and is only a "model description of reality" (Barton-Smoczyńska, 2015, pp. 92-100). As can be seen, she distinguishes in it, like Worden, four stages and emphasises that throughout the coping process, there is a strong need to verbalise the experienced state and maintain a social dialogue. At the same time, she believes that at each of the stages the woman has different needs that must be met for her to return to a good bio-psycho-social condition.

Thus, in the phase of recovering from the initial emotions of loss, women can be emotionally labile. They may show this through very different behaviours, from extreme breakdown to apathy to a sudden need for contact with their environment. According to Elżbieta Zdankiewicz-Śmigała and Maja Przybylska (2002), numbness, denial, a sense of alienation and isolation from the environment are symptoms indicative of a psychological trauma leading to a loss of control over one's life. Women experiencing it may, for example, not believe the medical personnel and deny the information about the miscarriage. And when the finality and irreversibility of the diagnosis reaches them, they may feel intense bitterness, sadness and grief (Barton-Smoczyńska, 2015, p. 37).

At the stage of working through trauma-related emotions, grief is the predominant emotion, and it may be reinforced by the physical experience of losing something essential and the emergence of a sense of devastation of self and/or the world. "Grief work" is an ongoing and long-lasting activity designed to lead to recovery and acceptance of the situation. During this activity, women may experience a whole range of different feelings: sadness, anger, rage, helplessness, bitterness, guilt or shame (Barton-Smoczyńska, 2015, p. 94; Dodziuk, 2001; Guzewicz, 2014; Zisook & Shear, 2009). At this stage, women often seek answers to the question

why this happened to them. The search is accompanied by confronting changing feelings and emotions. This confrontation is the essential and most challenging experience for coping with the experience of loss (Barton-Smoczyńska, 2015, p. 94; Frost et al., 2007). Their general acceptance of the pain and grief they experience indicates that the women can slowly free themselves from thinking about the loss experienced (Majewska, 2016; as cited by Lindemann, 1944).

The third stage of coping with the experience of procreative loss is an attempt to understand and accept the loss of the child. It is a period of recovery in which women regain control of their lives and can relinquish former roles (including that of the mother of the unborn child). Therefore, the construction of a reborn identity is based on the acceptance of the child's death and the acceptance of death as a natural cycle of life. At this stage, once they have dealt with the emotionality of the loss they have experienced, some women begin to search for the meaning of the experience (Frost et al., 2007, pp. 1015-1016). This search gives them a chance for personal development, looking at death as a natural stage of human existence, altering the recognised life values and changing the goals and priorities important in life (Barton-Smoczyńska, 2015; Frost et al., 2007; Herman, 2020). Understanding and accepting the death, leading to the creation of a new identity, the re-creation of one's self, can take place when the woman in the biographical work experiences a kind of forgiveness for herself and feels it from others and defines the meaning of the loss experienced (Sanders, 2001).

The event integration stage occurs when women treat a miscarriage as an integral part of their personal life story (Barton-Smoczyńska, 2015, 2016; Jarosiewicz, 2010, p. 51; Kleszcz-Szczyrba, 2016a, 2016b; Majewska, 2016). Personal development, greater awareness of self-important values and turning towards health are the effects of life restructuring work triggered after difficult experiences. At this stage, women can consciously decide to work with a psychologist or therapist to get help in discovering their possibilities and meeting the need to "put their lives together" after the loss they have experienced. Many women cope with the grieving process naturally and effectively[6], but a percentage need professional support.

As can be seen, both models of bereavement assume that after the death of an important person, there is a need for a deep process in which the bereaved person does biographical work. Worden calls it "grief work," Barton-Smoczyńska calls it "adaptation," but – regardless of the name – the essence of this process is that it supposedly leads to reconciliation with the situation of losing someone important in life. Such reconciliation takes time, requires effort and is a painful struggle with emotions to complete the bereavement fully (Barton-Smoczyńska, 2015; Worden, 2009).

[6] A typical grieving process does not require therapy (Parosło, 2020, pp. 55-56; Zisook & Shear, 2009).

Grief counselling

> Counselling is solving people's life problems. When we speak of problems, we have in mind certain complex tasks of an adaptive or decision-making nature and/or emotional states, sometimes frustrating, which an individual must deal with in life, and whose independent optimal solution through undertaken actions, contemplation, self-reflection or drawing on biographical experiences exceeds his/her capacity in a given situation.

This definition by Alicja Kargulowa introduces the world of counselling (2016, p. 145). Due to the type of problems experienced, one speaks of family, professional, educational, existential, organisational counselling (cf. Czerkawska, 2012; Drabik-Podgórna, 2010; Minta, 2014; Kargulowa, 2007; Siarkiewicz, 2010; Wojtasik, 2011). One of those little represented in the Polish literature is grief counselling.

According to the classic of this issue, William Worden, the general aim of grief counselling is to help people experiencing loss adjust to reality without the presence of the bereaved person. The essence of these counselling activities is to support people in experiencing grief to undertake the tasks of bereavement. Other activities that can be undertaken in this area – beyond counselling – include trauma healing, learning to express emotions, helping to cope with guilt, building a support network, and training to reconcile with a new reality (Worden, 2009). Worden does not address these and, in demonstrating the role of grief counselling, focuses on the tasks of counsellors for people experiencing uncomplicated bereavement. He points out the meaningful role of talking to the Other, who helps understand the grieving process and takes care of the need to talk about loss after the death of a loved one. He believes that counsellors in these circumstances may become different professionals with whom the person experiencing the loss has contact (cf. Siarkiewicz, 2010). Colin Parkes (1980) distinguishes three groups here. The first includes professionals (doctors, nurses, psychologists, social workers) who offer professional support to bereaved people. This help can be provided individually or in groups. The second group are volunteers who are selected and trained and receive support from professionals. The third type of counsellors are self-help groups in which bereaved people offer support to others. Such groups may operate with or without professional support.

Bearing in mind the basic assumptions of Worden's mourning counselling, who – to put it briefly – believes that counsellors are supposed to lead the bereaved to accept the death of a loved one and help them survive the mourning, one can refer to the tasks of the counsellor proposed by Dorota Kubacka-Jasiecka (2010). According to her, the counsellor should assess the level of the crisis, choose appropriate strategies of confronting the loss, describe emerging emotions verbally, accompany the bereaved and accept their ways of experiencing various stages of grief work. Accompanying and accepting the forms of behaviour of mourning people,

taking into account the stage of the loss experience, is therefore the essence of bereavement counselling. Counselling aid should therefore consist in supporting the abandoned person so that they can free themselves from the relationship with the deceased person that threatens their stabilization and learn to find new, rewarding interactions. The intervention of the bereavement counsellor may include accepting pain, loneliness, and feelings of abandonment; working over the relationship with the deceased; helping overcome the fear of loss of health and death. Through psychoeducational counselling in the field of expressing experienced emotions, a bereaved person has the opportunity to release various emotions that arise as a result of the loss of a loved one. It is possible thanks to acquiring freedom from pain, guilt, fear, hostility, aversion to both the deceased person and the environment, in shaping the process of coping with the loss.

Grief counselling following procreative loss

The comments cited above regarding counselling for the bereaved are primarily applicable to counselling for women experiencing procreative loss. Such counselling can be understood as helping the individual to experience mourning for the child that was expected but was lost (Barton-Smoczyńska, 2015; Kleszcz-Szczyrba, 2016b; Majewska, 2016, p. 156) by facilitating her to express emotions connected with the loss of the child, the hopes and plans attached to the child, and sometimes even dreams of parenthood (Frost et al., 2007; Guzewicz, 2014; Kornas-Biela, 2003; Parosło, 2020, p. 92); it also involves helping her to accept the loss, adjust to life after the loss, and cope with the changes after losing hope of having a healthy baby from the pregnancy that was not delivered (Harris & Winokuer, 2021, pp. 139-154). Grief counselling following a procreative loss can also be understood in a broader context as actions taken towards the environment and community of a woman who has experienced a miscarriage. The role of professionals in grief counselling is, in the first place, emotional support and taking such psycho-educational actions that are to broaden the person's awareness of suffering that accompanies loss and enable them to share emotions in the process of coping with the situation (Kubacka-Jasiecka, 2010, p. 282). These activities take the form of support for individual and social activities related to the expression of experienced emotions.

In counselling, the procreative loss is treated as the termination of pregnancy and a child loss. It is taken into account that other losses also accompany this loss – e.g. dreams of motherhood and parenthood, health, sense of security, sense of control over one's life. However, it is worth emphasising that after experiencing a procreative loss, a woman has the right to mourn. As I have already written, recognition of this right is linked to enabling her to confront the loss, accept the loss, express the emotions associated with it and build a new life without the deceased person.

I argue that procreative loss first and foremost triggers the need to talk about it and requires acceptance of the loss by both the bereaved person and their loved ones. Barton-Smoczyńska (2015) calls this the need to talk about one's suffering, namely, "verbalisation and social dialogue." Ensuring that this need is met can be done through the practice of grief counselling. The counsellor's primary task is to be present in working with the bereaved, which requires listening and dialogue skills. Specific tasks include the diagnosis of the level of crisis and sensitising the loved ones to the signals of an "atypical" grieving process, communication about the loss, therapeutic and educational activities related to the acceptance of the loss, and the support of individual and social activities related to the expression of experienced emotions.

The first help given to women experiencing procreative loss should have the character of a crisis intervention, which is short-lived, transitory and consists mainly of accompanying the woman and her relatives in this exceptional time (Kubacka-Jasiecka, 2005, pp. 256-259; James& Gilliland, 2005). The intervention also involves giving the woman information about the abnormal course of the pregnancy and its premature termination. Both parents should be present when this is discussed, if possible. The conversation can evoke extremely negative emotions, but it is essential to confronting the loss. The ideal solution for communicating about the loss would be to have a grief counselling professional present who can provide reassurance and guide the communication process. The parents of the unborn child should be provided with a comfortable space, separate from pregnant women or mothers with children, so that they have the opportunity to express their feelings without restraint: sadness, anger, grief, rage (Napiórkowska-Orkisz & Olszewska, 2017). The communicator should remember that communicating about the loss must be a process, not a moment, and the amount of details should be tailored to the parents' needs and their intellectual capacity. The couple should not be left with unanswered questions, and information should be given (if possible) about the reasons for miscarriages in general. However, the most crucial thing for the medical staff is to show understanding and acceptance of the feelings that arise after the loss.

The counsellor performs subsequent diagnosis of the level of the crisis caused by the child loss by observing and assessing the regularity of the course of grief and ensuring that the process does not come to a halt at any stage. As stated, the essential feature of grief work is the fulfilment of specific "mourning tasks" rather than the time allotted for their completion (Keirse, 2004, Kleszcz-Szczyrba, 2016a; Parosło, 2020, pp. 55-56). People supporting women, both those providing formal (professionals) and informal (relatives) support, should carefully observe whether she experiences prolonged states of sadness, grief, guilt, or lack of willingness to confront these feelings. Such states are characteristic of an "atypical" course of grief, which leads to a vicious circle at the centre of which is the longing for the deceased child (the image of the child) and a strong desire to get it back. Stopping the grieving process does not allow for the rebirth of a new self, the reconstruction of the woman's

identity after the loss, and making plans for the future (Barton-Smoczyńska, 2015; Dreżewska & Sitarska, 2016, pp. 124-125, Zisook & Shear, 2009, p. 69).

The main activities that the bereavement counselling professional undertakes that lead to acceptance of loss are therefore therapeutic and educational. These activities are carried out by searching for the meaning of the loss together with the person who has experienced it (Barton-Smoczyńska, 2015, p. 196, 200, as cited by Schein 2012). The therapeutic relationship should be based on trust. The counsellor should try to understand the woman they assist while keeping a distance from her problems. It is also important that they do not take over the experience of resolving internal conflicts from the woman, but instead give her an opportunity to rebuild a sense of control on her own (Barton-Smoczyńska, 2015, p. 196; Herman, 2020; Wojtasik, 2009). An empathetic grief counselling professional should discreetly enable the full experience of the previously mentioned accompanying experiences by accepting the experience of pain, loneliness, and a sense of abandonment. Thus, they can help to work through the bereavement and to manage the fear of loss and own death (Kubacka-Jasiecka, 2010, p. 282).

In the closest environment of the woman's life, support activities concern the support of the whole family that experienced the loss. The professionals' activities include educating the loved ones, by promoting knowledge about miscarriage (Keirse, 2004, 2005) and showing them ways of providing support. Indeed, the close family can provide informal assistance, accompanying women daily in experiencing difficult emotions, motivating them to take action related to undertaking work on themselves (Di Fabio, 2014). Thus, counselling professionals counteract the emergence of a "conspiracy of silence" (Barton-Smoczyńska, 2015, pp. 110-111; Frost et al., 2007; Layne, 1997) and social denial of trauma (Barton-Smoczyńska, 2015, pp. 110-111; Keirse, 2005; Kleszcz-Szczyrba, 2016b, pp. 152-153; Parosło, 2020, pp. 48, 58, 70). "Conspiracy of silence" is a behaviour that involves social denial of the occurrence of a miscarriage and the trauma caused by it. It indicates an inability to behave in the face of someone's loss, indicating that people do not know what to say and how to react to such a situation. Trauma denial is a social mechanism through which the significance of miscarriage is belittled and thus the right to experience grief is denied (Barton-Smoczyńska, 2015, pp. 110-111; Keirse, 2005; Kleszcz-Szczyrba, 2016b, pp. 152-153; Parosło, 2020, pp. 48, 58, 70). Its use stems from the fact that contemporary society tends to taboo death (Guzowski et al., 2016; Kleszcz-Szczyrba, 2016b). Miscarriage, when treated as the premature death of a child, is seen as a 'small' death (Frost et al., 2007, pp. 9-10; Kleszcz-Szczyrba, 2016b, pp. 152-153). The lack of social recognition of the importance of miscarriage (Barton-Smoczyńska, 2015; Kleszcz-Szczyrba, 2016b, pp. 152-153; Parosło, 2020) and the specific nature of this experience (loss of the image of the child, inability to meet the child) may reinforce the "atypical and pathological" way of going through the grieving process. This may be prevented, to some extent, by the ritual of saying goodbye, which makes the experience of loss more real (Kwaśniewska et

al., 2015, pp. 92-95; Zisook & Shear, 2009) and allows one to confront one's emotions (Barton-Smoczyńska, 2015; Guzewicz, 2014, p. 20; Keirse, 2004; Kleszcz-Szczyrba, 2016b, p. 151; Kornas-Biela, 2020, p. 343).

The primary method of the grief counsellor is conversation. According to many researchers (Barton-Smoczyńska, 2015; Frost et al., 2007; Kornas-Biela, 2020; Worden, 2009), women experiencing reproductive loss have a strong need to tell their stories. Barton-Smoczyńska (2015) believes that they have this need throughout their work with this experience. Being able to talk about their feelings gives space to continue working through the loss. By talking about their experiences, women become accustomed to the loss and give vent to their emotions. They also signal to their surroundings that what has happened is difficult, painful and requires support in returning to complete professional, family and social functioning (Chojnacka, 2020).

In the different stages of grief and coping with miscarriage, the verbalisation of the experience takes place in different ways. In the first stage, it may be accompanied by outbursts of anger and rage, in the second by unexpected and sudden crying and the need to talk about everything that one has experienced, in the third stage, it is talking about the meaning of the experience, about its causes and effects, and in the last stage, it is simply telling one's story. These verbalisations and accompanying experiences are essential in women's biographical work, during which interaction with significant others is also vital, and the biographical processes themselves involve recreating the past, repeating stories, interpreting and redefining what has happened (Schutze & Riemann, 2012, p. 395).

There are many barriers in Polish society that make it difficult for women to talk freely. Some of them have been already mentioned. The first is the tabooisation of death in general (Barton-Smoczyńska, 2015; Guzowski et al, 2016; Parosło, 2020, pp. 46-47). Thus, if we treat miscarriage as the death of a child, then automatically, this type of death is also tabooed. The second barrier is the lack of skills and knowledge of how to behave in the face of miscarriage, what words of comfort to use, how to support the woman (Barton-Smoczyńska, 2015, pp. 110-111; Frost et al., 2007; Layne, 1997). The third is a kind of 'internal' shame or guilt (Frost et al., 2007) for the miscarriage experienced. Women are afraid to disclose the fact that they are pregnant. There is a belief that the pregnancy should only be reported (e.g. to the family) after the first trimester is over when the risk of miscarriage decreases significantly.

The role of the grief counselling professional is to help overcome these barriers, not only in individual work with women but also through participation in support groups, both in-person and virtual. The counsellors' activity aims to make women experiencing procreative loss aware of the importance of grieving with dignity. Internet forums for post-loss people, where professionals are absent, can be a danger for distraught women as they can keep them in a state of hopelessness for the future and lead them not to take action to seek help for themselves (Parosło, 2020, p. 55).

Grief counselling professionals participating in online discussions can be the ones who not only demonstrate the importance of the grieving process in the lives of those experiencing loss but also foster hope for reorganising their lives.

An essential role of grief counselling professionals should be to educate hospital administration and medical staff about the nature of the phenomenon and how to help women after a miscarriage[7]. Hospitals or wards should be prepared so that women with similar experiences are in the same room (Regulation of the Minister of Health of 16 August 2018 on the organisational standard of perinatal care, 2018; Parosło, 2020, p. 102). On the one hand, the organisational heterogeneity of the hospital allows for the separation of the miscarried from parturients and pregnant women, and on the other hand, for women who in some way can support each other because they have experienced a similar loss to be in one space. This kind of support related to the presence of others who have experienced the same thing can be treated as counselling created by circumstances (Siarkiewicz, 2010).

The widely understood grief counselling may include social campaigns aimed at sensitising society to the needs of women experiencing procreative loss by spreading knowledge about the scale of this phenomenon and its psychological consequences (Keirse, 2004, 2005). Such activities include actions related to the World Day of the Lost Child, which is celebrated on 15 October.

Conclusion

The paper highlights a crucial aspect of social life, namely procreative loss and the needs of women experiencing a miscarriage. These needs can be met through support such as grief counselling. The main tasks of grief counselling are to help the woman express her emotions related to the loss and accompany her and her family in accepting the miscarriage.

I have attempted to show that at each stage of coping with procreative loss, it is fundamental to have the presence of a person who understands that the experience of miscarriage is part of the grieving process. Therefore, from the moment the woman is informed of the abnormal course of the pregnancy to the moments she accepts the miscarriage and integrates this experience into her life story, it is indispensable for her to have people who respect her psycho-physical state and emotions after the child loss. It can be noted that grief counselling seems to be the most appropriate form of assistance because the activities undertaken in it allow the person experiencing the loss (together with the counsellor) to work through sensations

[7] The need to educate medical personnel in the field of cooperation with the sick and their families is emphasised, among others, by Rita da Cruz Amorim and Lívia Alessandra Fialho da Cost, (2020) authors of the article "Illness and hospitalization. Some thoughts on family counselling as care." And earlier Grażyna Dolińska-Zygmunt (1980) (From the editor).

such as powerlessness, sadness, grief, anxiety, anger, loneliness, guilt, isolation, disorientation and numbness.

Silence or belittling the loss experienced by parents losing a child through miscarriage often prevents them from experiencing emotions and expressing their needs. The lack of social rituals of saying goodbye to the child, non-recognition of the loss, and the inability to talk about one's emotions and needs results in parents being trapped, making it difficult for them to come to terms with the loss and properly experience the process of mourning. Broadly understood educational and counselling activities should therefore include raising the subject of miscarriage in the public sphere. It is about the possibility of discussing the organisation of both medical and psychological care for women and whole families experiencing loss.

This study does not exhaust the subject, nor does it propose rigid schemes the implementation of which would ensure a successful grieving process. It is a review of views on experiencing grief after a miscarriage and a set of proposals of support activities that can be used in professional and non-professional assistance provided to women experiencing pregnancy loss.

From the counselling point of view, the analysis shows that it is vital to conduct research on biographical, qualitative and narrative patterns to gain a deeper understanding of the grieving process and to better organise counselling processes, with the participation of women experiencing reproductive loss.

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