THE IMPACT OF A SUBSEQUENT PREGNANCY ON GRIEF AND EMOTIONAL ADJUSTMENT FOLLOWING A PERINATAL LOSS

RENEE-LOUISE FRANCHE
Ottawa Hospital - General site, University of Ottawa & Carleton University

CATHY BULOW
Department of Psychology, Mississauga Queensway Hospital

ABSTRACT: The present study examined the impact of a subsequent pregnancy on emotional adjustment associated with a previous perinatal loss and on the following components of parental grief—active grief, difficulty coping, despair. Participants included 25 women and 24 partners who were expecting a baby for the first time since their loss and 25 women and 18 partners who were not expecting and had not had a child or pregnancy after their loss. Depressive symptomatology, anxiety, marital adjustment, as well as active grief, despair, and difficulty coping were measured. Mothers who were not pregnant were experiencing significantly higher levels of despair and difficulty coping than pregnant mothers, independently from the effect of time elapsed since the loss. For the fathers, no significant group effect in emotional distress or intensity of grief was found. Women reported significantly higher levels of negative affectivity than men. A new pregnancy may be associated with a beneficial effect on the mourning process of women with a previous perinatal loss, primarily by decreasing their despair and difficulty coping. However, in our sample, grief intensity remained high, suggesting that the mourning process may not be hindered by a subsequent pregnancy.

RESUMEN: El presente estudio examina el impacto que un embarazo subsecuente tiene en cuanto al ajuste emocional asociado con una previa pérdida perinatal, así como en los consiguientes componentes de pena-pena activa, dificultad en el enfrentamiento con situaciones, y la desesperación.

Entre los participantes se encontraban 25 mujeres y 24 de sus parejas que esperaban un niño por primera vez desde que habían experimentado la pérdida, y 25 mujeres y 24 de sus parejas que no estaban esperando y no habían tenido ningún niño ni habían experimentado un embarazo después de la pérdida. Se midieron la sintomatología depresiva, la ansiedad, el ajuste marital, así como la pena activa, la desesperación y la dificultad de enfrentarse con situaciones.

Las madres que no estaban embarazadas estaban experimentando niveles significativamente más altos de desesperación y dificultad de enfrentarse con situaciones que las madres embarazadas, independientemente del efecto del tiempo transcurrido desde la pérdida. En cuanto a los padres, no se encontró ningún efecto significativo como grupo en cuanto a trastornos emocionales o a la intensidad de la pena. Las mujeres reportaron niveles significativamente más altos de afectividad negativa que los hombres.
Un nuevo embarazo podría estar asociado con un efecto beneficioso en el proceso de aflicción de las mujeres con una pérdida perinatal previa, sobretodo porque alivia su desesperación y la dificultad de enfrentarse con situaciones. Sin embargo, en la muestra de este estudio, la intensidad de la pena permaneció siendo alta, lo cual sugiere que el proceso de aflicción pudiera no ser afectado o empeorado por un embarazo subsecuente.

RESUMEN: Este estudio examina el impacto de una gestación subsecuente en el ajustamiento emocional asociado con una pérdida perinatal previa y en los componentes del duelo parental — duelo activo, dificultad a enfrentarse, duelo pasivo, y dificultad a hacer frente. Los participantes fueron 25 mujeres y 24 hombres que esperaban un bebé por primera vez después de la pérdida de un bebé y 18 hombres que no esperaban bebé y que no habían tenido una gestación después de la pérdida del bebé. Las mujeres que no estaban embarazadas tenían niveles de duelo activo y de dificultad a hacer frente más altos que las mujeres embarazadas, independientemente del tiempo transcurrido desde la pérdida. Para los hombres, ningún efecto de grupo significativo de estrés emocional o de intensidad de duelo no se ha encontrado. Las mujeres tuvieron niveles más altos de duelo activo y de dificultad a hacer frente que los hombres. Una nueva gestación puede estar asociada con un efecto beneficioso en el proceso de aflicción de las mujeres que han sufrido una pérdida perinatal, especialmente en reduciendo su desesperación y su dificultad a hacer frente. Cependiente, en nuestra muestra, la intensidad del duelo y la pena permaneció alta, sugiriendo que el proceso de duelo podría no estar afectado o empeorado por una gestación subsecuente.

It is now well established that a perinatal loss constitutes a significant loss in one’s life, frequently involving a period of mourning (Benfield, Leib, & Reuter, 1978; Kennell, Slyter, & Klaus, 1970; Lasker & Toedter, 1991; Peppers & Knapp, 1980). The mourning process associated with a perinatal loss can be conceptualized as consisting of three factors: active grief, difficulty coping, and despair (Lasker & Toedter, 1991). Despair and difficulty coping are less common reactions compared with active grief, and are associated with more disturbed and chronic reactions to perinatal loss (Potvin, Lasker, & Toedter, 1989). Higher levels of despair and difficulty coping at 2 months postloss have significantly predicted the presence of higher levels of grief 2 years after the loss (Lasker & Toedter, 1991).

Perinatal loss also involves emotional distress. Bereaved parents can report depression (Garel, Blondel, Lelong, & Kaminski, 1994; Neugebauer et al., 1992), suicidal ideation (Defrain, Martens, Stork, & Stork, 1986), self-criticism (Giles, 1970; Herz, 1984), and anxiety (Cecil & Leslie, 1993; Thapar & Thapar, 1992).

Several factors are related to the intensity of grief and emotional adjustment following a perinatal loss. Gender is related to grief intensity as women, compared to men, tend to report higher levels of grief, guilt, and personal responsibility (Goldbach, Dunn, Toedter, & Lasker, 1991; Theut, Pedersen, Zaslow, & Rabinovich, 1988). However, it should be noted that in one study (Zeanah, Danis, Hirshberg, & Dietz, 1995), in 25% of participating couples, fathers reported more intense grief than mothers. Gestational age at the time of the loss is also related to the intensity of grief. Late losses are associated with more intense grief (Janssen, Cuisinier, de Graauw, & Hoogduin, 1997; Kirkley-Best, 1981; Lasker & Toedter, 1991; Theut et al., 1989; Toedter, Lasker, & Alhadeff, 1988) and more persistent active grief (Lasker & Toedter, 1991) than early losses. In one study, however, no differences were found in grief intensity in losses occurring after 20 weeks of gestation (Zeanah et al., 1995). Less intense grief has been associated with a strong marital relationship and sufficient social support (Lasker & Toedter, 1991), good premorbid mental health status (Janssen, Cuisinier, Hoogduin, & de Graauw, 1997; Lasker & Toedter, 1991; Toedter et al., 1989), and parents’ positive perceptions of their own physical health (Toedter et al., 1988). One factor that has received little attention is whether or not a subsequent pregnancy affects the mourning process.

**THE IMPACT OF A SUBSEQUENT PREGNANCY ON THE EXPERIENCE OF MOURNING**

Parents often wish to have another pregnancy soon after their loss (Cuisinier, Janssen, de Graauw, Bakker, & Hoogduin, 1996) and they express dissatisfaction with advice to wait, citing pressing concerns such as maternal age, infertility issues, and preferred spacing of children (in age) as reasons not to wait (Davis, Stewart, & Harmon, 1989). While a perinatal loss can impact upon a subsequent pregnancy causing it to be considered a stressful and joyless task of “keeping” the baby (Franche & Mikail, 1999; Phipps, 1985; Theut et al., 1989), it is possible that a reciprocal relationship exists in that a subsequent pregnancy also impacts upon the experience of mourning (Lin & Lasker, 1996; Theut et al., 1989).

It has been suggested that a speedy pregnancy can cause the mourning process to be discontinued or thwarted, possibly leading to problems in attachment to the subsequent baby (Bourne & Lewis, 1984; Lewis, 1979; Lewis & Page, 1978). Difficulties hypothesized to be related to chronic, unresolved grief include (1) the “vulnerable child syndrome” (Green & Solnit, 1964), where the couple may become overprotective of the subsequent baby possibly resulting in separation/individualization issues, infantilization, and/or preoccupation with somatic concerns (Phipps, 1985) and (2) the “replacement child syndrome” (Cain & Cain, 1964; Poznanski, 1972), where the parents perceive the subsequent child as a replacement for the baby lost. These syndromes are based primarily on clinical observations.
Theut and colleagues (Theut, Pedersen, Zaslow, et al., 1988) hold a somewhat alternative position. They suggest that a subsequent pregnancy may contribute to the resolution of perinatal grief by improving self-concept. For a woman, "pregnancy is an opportunity to mitigate her narcissistic loss and to assuage her guilt over the previous loss" (Theut et al., 1988, p. 291).

Few empirical studies have considered the impact of a subsequent pregnancy on the couple’s grief and emotional adjustment. In one study (Theut et al., 1989), participants completed the Perinatal Bereavement Scale during the eighth month of the pregnancy and 6 weeks postnatally. Results suggested that the birth of a healthy baby was a significant factor in the resolution of grief for couples with early or late losses.

In a recent longitudinal study (Cuisinier et al., 1996), 227 women who lost a baby early in their pregnancy were asked to complete the Perinatal Grief Scale at 2.5, 6, 12, and 18 months postloss. In this sample, 87% of the women had lost their baby within the first 16 weeks of gestation. The conception of a child and the birth of a living child following a perinatal loss were associated with a significant decrease in the total level of grief reported. Furthermore, a subsequent pregnancy decreased the severity of grief to the equivalent of the passage of 8 months of time after a loss. A speedy new pregnancy was seldomly found to be harmful.

Finally, Lin and Lasker (1996) followed 194 bereaved parents (138 women and 56 men) over a period of 2 years. The Perinatal Grief Scale was administered at 3 months, 1 year, and 2 years following the loss. Variables related to a significant decrease in total grief intensity included subsequent birth, subsequent pregnancy, and the presence of other children. These three studies suggest that a subsequent pregnancy does reduce perinatal grief. However, it is unclear which aspects of grief are most significantly reduced. The present study was designed to examine the impact of a subsequent pregnancy on grief, emotional adjustment, and marital adjustment following a perinatal loss. Of particular interest was the impact of a subsequent pregnancy on the different components of grief. This study extends the literature as it is, to our knowledge, the first study that examines active grief, difficulty coping, and despair in association with subsequent pregnancy. Previous studies have examined the total score only of the Perinatal Grief Scale (Cuisinier et al., 1996; Lin & Lasker, 1996) or used a unidimensional measure of grief (Theut et al., 1989). Understanding the impact of a subsequent pregnancy on specific aspects of grief and emotional distress can help professionals address patients’ concerns in a more precise fashion.

METHOD

Participants

Women and their partners who had suffered a perinatal loss within the last 3 years were recruited to participate in the study. They were either pregnant for the first time since the loss (Pregnant Loss group) or were not pregnant and had not been expecting again since their loss (Loss group). Exclusion criteria included previous or current psychotic disorder, current substance abuse, and inability to speak or read English.

Procedure

Announcements concerning the study were posted in obstetrical clinics in a large Canadian university hospital. Recruitment for the Pregnant Loss group occurred between the 10th and 19th week of gestation, while recruitment for the Loss group occurred at their 6th week postpartum visit. Eligible women were asked by health-care staff if they were interested to learn more about the study. If interest was expressed, they immediately met with a research assistant who explained what participation involved. Partners were then encouraged, either by direct
contact or through the woman (if the partner was not present at the visit), to participate. Women and partners willing to participate were asked to complete a battery of questionnaires. Couples typically chose to complete the questionnaires at home and returned them by mail. They were then called by the research assistant for debriefing and to offer emotional support if appropriate. Eligible partners included husbands, common-law partners, and boyfriends, who were the father of the baby. All participants were able to contact the main investigator or the research assistant if they had any questions.

Of the patients who were approached, the acceptance rate was 88 and 100% for the Pregnant Loss and the Loss groups, respectively. Some participants from the Loss group, however, asked to be called several months later after the initial contact as they did not feel ready to participate. After consenting to participate, three couples in the Pregnant Loss group and five couples in the Loss group did not return the questionnaires. Some of them expressed that they found it too painful or unpleasant to think about their perinatal loss. The final sample consisted of 25 women in each group, 24 men in the Pregnant Loss group, and 18 men in the Loss group. Final participation rate of approached female patients was 78 and 83% for the Pregnant Loss group and the Loss group, respectively. For the men (who were eligible only if their wives/partners initially consented to participate), the participation rate was 86 and 60% for the Pregnant Loss group and the Loss group, respectively.

Participating men and nonparticipating men were compared using Chi-Square or t-tests (adjusted for unequal sample size) with respect to the following demographic and obstetrical variables: education, marital status, length of marital or common-law relationship, birthplace, family income, language spoken, number of losses, gestational age at time of loss, number of living children, and length of time since the loss. No significant differences were found. Maternal reports of marital adjustment, depressive symptomatology, grief symptoms, and anxiety were also examined. Couples in which the man did not participate had maternal reports of marital adjustment that were significantly poorer than couples in which both parents participated (t = 3.24, p < .011).

Sample Characteristics

The age of the participants ranged from 20 years to 41 years for mothers (M = 31.48, SD = 4.95), and 26 years to 51 years for fathers (M = 34.67, SD = 6.27). Participants were homogeneous with respect to ethnicity and spoken language; 96% were born in Canada, 42% spoke English only, and 50% spoke English and French. Eighty-two percent of the couples were married and 18% were living common-law. None of the female participants were single in this study. Total annual household income for 68% of the sample exceeded $40,000 (CAN). Length of maternal formal education ranged from 9 to 18 years (M = 14.44, SD = 2.60) and length of paternal education ranged from 12 to 18 years (M = 15.60, SD = 1.85).

Characteristics of the Pregnant Loss Group

The mean gestational age at which the pregnant group lost their child was 25.24 weeks (SD = 9.92, range = 10 weeks to 41 weeks). Eighty-eight percent of the couples lost their baby after 15 weeks of gestation. The mean duration of time since the pregnancy loss was 13.28 months (SD = 8.85, range = 4 to 36 months). The mean time between the loss and subsequent conception was 9.55 months (SD = 8.90, range = 1 to 31.5 months). Eighty-eight percent of the couples noted that their current pregnancy was planned.

Characteristics of the loss group. The mean gestational age at which the nonpregnant group lost their child was 27.72 weeks (SD = 9.29, range = 10 weeks to 42 weeks). Ninety-six
percent of the couples lost their baby after 15 weeks of gestation. The mean duration of time since the pregnancy loss was 5.76 months (SD = 4.82, range 2 to 19 months).

Participants were asked to complete the following questionnaires:

Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988). The total score of this 21 item measure of depressive symptomatology was used. Beck and colleagues (1988) reported an internal consistency of .86 and test-retest reliability ranging from .48 to .86 for varying time intervals. The BDI demonstrates moderate to good correlations with several other scales assessing depression (Dobson, 1985).

State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1984). The STAI is a self-report measure of state and trait anxiety levels. Only the State Anxiety subscale (STAI-S) was used in the current study. The STAI-S has a high degree of internal consistency, ranging from .83 to .92 (Spielberger et al., 1984).

Abbreviated Dyadic Adjustment Scale (ADAS; Sharpley & Rogers, 1984). The ADAS is a seven-item questionnaire assessing marital adjustment. Internal consistency was reported to be 0.76 (Spanier, 1976). The ADAS adequately discriminates between persons who in their perception were happy with their relationship and those who were not, as well as between married and divorced couples (Sharpley & Rogers, 1984).

Perinatal Grief Scale—short form version (PGS; Potvin et al., 1989; Toedter et al., 1988). The PGS scale was designed to assess general symptoms of grief as well as symptoms thought to be especially relevant to a perinatal loss. The three factors of Active Grief (PGS-AG), Difficulty Coping (PGS-DC), and Despair (PGS-D) are derived from a factor analysis of descriptors of perinatal grief generated by 194 bereaved parents (Lasker & Toedter, 1991). The short form version consists of three 11-item subscales corresponding to the three grief components. The total scale internal consistency coefficient is 0.95; for the subscales of Active Grief, Difficulty Coping, and Despair, the alpha coefficients are 0.92, 0.91, and 0.86, respectively. The three subscales also show adequate discriminant validity (Lasker & Toedter, 1991).

All participants completed a personal information form assessing basic demographics, circumstances of perinatal loss, and, if applicable, of present pregnancy.

RESULTS

Preliminary Analyses

Dependent variables were examined for potential multicollinearity. The three PGS subscales were highly correlated; however, they were kept in the analyses as they are meant to be examined jointly despite high intercorrelation (Potvin et al., 1988; Toedter et al., 1988) (see Table 1).

<table>
<thead>
<tr>
<th></th>
<th>Active Grief</th>
<th>Difficulty Coping</th>
<th>Despair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Grief</td>
<td>0.74</td>
<td>0.69</td>
<td>0.84</td>
</tr>
<tr>
<td>(p = .000)</td>
<td>(p = .000)</td>
<td>(p = .000)</td>
<td></td>
</tr>
<tr>
<td>Difficulty coping</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(p = .000)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
One-way analysis of variance (ANOVA) and Chi-square analyses were conducted to determine whether the two groups differed on variables that have been found to influence grief levels. A Chi-square analysis showed no group differences in marital status. One-way ANOVAs revealed no significant group differences in gestational age at the time of the loss, number of living children, income level, age of mother and father, and number of previous losses. However, a significant group difference was observed for the duration of time elapsed since the loss ($F = 28.12, p < .001$). The Loss group, compared with the Pregnant Loss group, had lost their baby more recently. As this variable may contribute to the intensity of emotional distress and grief, it was entered as a covariate, where applicable, in the main analyses examining group differences.

**Main Analyses**

A series of multivariate analyses of variance (MANCOVAs) and univariate tests were conducted to compare the levels of emotional adjustment and grief between the Pregnant Loss group and the Loss group. The analyses were conducted separately for men and women. A series of MANOVAs were then performed examining gender differences across the two groups for emotional adjustment and grief levels. Significant multivariate analyses were followed by univariate analyses using the Bonferroni correction. The mean scores and standard deviations for the BDI, STAIS, ADAS, and PGS for both groups are presented in Table 2.

**Table 2.** Groups (Pregnant Loss vs. Loss) by Gender Means and Standard Deviations for the Dependent Variables

<table>
<thead>
<tr>
<th></th>
<th>Mothers (Pregnant Loss M(SD))</th>
<th>Mothers (Loss M(SD))</th>
<th>Fathers (Pregnant Loss M(SD))</th>
<th>Fathers (Loss M(SD))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Symptoms (BDI)</td>
<td>10.00 (6.36)</td>
<td>14.00 (8.66)</td>
<td>7.75 (7.43)</td>
<td>6.44 (4.57)</td>
</tr>
<tr>
<td>State-Trait Anxiety Inventory-State (STAIS)</td>
<td>43.32 (14.48) (70th percentile)</td>
<td>46.76 (13.30) (83rd percentile)</td>
<td>39.63 (14.27) (52nd percentile)</td>
<td>39.68 (13.30) (33rd percentile)</td>
</tr>
<tr>
<td>Dyadic Adjustment (ADAS)</td>
<td>24.44 (6.55)</td>
<td>25.52 (7.51)</td>
<td>24.71 (7.38)</td>
<td>26.00 (2.75)</td>
</tr>
<tr>
<td>Perinatal Grief Scale-Active Grief (PGS-AG)</td>
<td>36.32 (8.64)</td>
<td>39.64 (8.04)</td>
<td>32.09 (7.47)</td>
<td>32.22 (5.26)</td>
</tr>
<tr>
<td>Perinatal Grief Scale-Difficulty Coping (PGS-DC)</td>
<td>25.56 (10.26)</td>
<td>29.00 (10.42)</td>
<td>22.61 (7.64)</td>
<td>23.39 (6.57)</td>
</tr>
<tr>
<td>Perinatal Grief Scale-Despair (PGS-D)</td>
<td>21.76 (6.68)</td>
<td>25.72 (8.63)</td>
<td>19.96 (6.50)</td>
<td>19.50 (5.46)</td>
</tr>
</tbody>
</table>

Standard deviations are in brackets in all tables.
STAIS, or ADAS scores. However, a trend ($F = 4.47, p < .04$) was found for the Loss group to have higher scores on the BDI than the Pregnant Loss group. It should be noted however that levels of depressive symptomatology remained low for both groups. The mean BDI score for the Pregnant Loss group was within normal limits according to recommended guidelines (Beck et al., 1988), while the mean BDI score for the Loss group was in the minimal to moderate range of depressive symptomatology. As well, the ADAS scores for all groups were within 1 standard deviation of the mean for married couples (Sharples & Rogers, 1984).

A second MANCOVA compared levels of grief of mothers in both groups using scores on the PGS subscales as dependent variables—Active Grief, Difficulty Coping, and Despair. The effect of the time elapsed since the loss was partialed out. A significant multivariate group effect was found ($F = 2.91, p < .05$). Univariate tests (significance level, $p = 0.017$) revealed that scores were significantly higher for the Loss group as compared to the Pregnant Loss group on the Despair ($F = 8.58, p < .005$) and Difficulty Coping ($F = 7.76, p < .008$) subscales. A trend ($F = 4.33, p < .04$) in the same direction was found for the Active Grief subscale.

Given that later losses are typically associated with more intense and persistent grief, a post hoc analysis was conducted to determine whether the above group differences in despair and difficulty coping would remain significant in women with late losses. The MANCOVA was repeated in women whose losses had occurred at or after 20 weeks of gestation. There were 20 women in the Pregnant Loss group and 22 women in the Loss group. Despite the absence of a significant multivariate group effect, univariate tests were interpreted due to the exploratory nature of the analysis (Tabachnik & Fidell, 1983, pp. 250–251) and without the use of Bonferroni correction due to the small number of participants involved. Despair and Difficulty Coping subscales remained significant (see Table 3).

**Group differences for men.** For the fathers, two MANCOVAS were performed examining group differences in levels of grief and emotional adjustment. No significant group effects in emotional adjustment or intensity of grief were found.

**Gender differences.** Differences in emotional adjustment between women and men were examined using a MANOVA, with scores on the ADAS, BDI, and STAIS as the dependent measures. Results of the analysis revealed a significant multivariate gender effect ($F = 4.83,$...
Subsequent Pregnancy and Perinatal Grief

p < .004). Univariate tests (significance level, p = 0.017) revealed that women, compared to men, reported significantly higher levels of depression ($F = 12.23, p < .001$) and state anxiety ($F = 7.02, p < .009$).

A MANOVA was also conducted comparing levels of grief between women and men, with scores on the PGS-AG, PGS-D, and PGS-DC as dependent variables. Results of the MANOVA revealed a significant multivariate gender effect ($F = 5.15, p < .05$). Univariate tests (significance level, $p < .017$) showed that women reported higher levels of grief than men on the three PGS subscales and significantly so for Active Grief ($F = 15.94, p < .000$) and Difficulty Coping ($F = 8.04, p < .006$). There was a trend in the same direction for Despair ($F = 4.99, p < .028$).

DISCUSSION

Pregnant women with a previous perinatal loss experienced less despair and difficulty coping in their grief reactions than women who had a perinatal loss and had not subsequently become pregnant. In contrast, expecting bereaved fathers did not report lower levels of grief intensity, anxiety, or depressive symptomatology that those who were not expecting. Furthermore, mothers, compared with fathers, experienced higher levels of active grief, difficulty coping related to the grief, anxiety, and depressive symptomatology.

Lower levels of despair and difficulty coping are known to predict less chronic grief, better coping skills and improved self-esteem (Lasker & Toedter, 1991). Our findings suggest that a new pregnancy may be associated with a restorative effect for women with a previous perinatal loss. Indeed, a subsequent pregnancy may help to improve a woman’s perception of herself by moderating the narcissistic injury and despair. However, due to the study’s cross-sectional design, we cannot eliminate the possibility that women with initially lower grief intensity felt more ready to attempt a new pregnancy or, for psychophysiological reasons, were more physically able to conceive.

Results concerning women with losses occurring after 20 weeks suggest that the potential beneficial effects of a subsequent pregnancy also hold true for women with late losses. However, these results need to be considered with caution, as more relaxed criteria of interpretation were applied.

A common apprehension among professionals working with bereaved parents is that a subsequent pregnancy could lead to a suspension or discontinuation of the grieving process and to the development of a subsequent maladaptive parent–child relationship. The present data suggests that grief does continue despite a subsequent pregnancy. In pregnant mothers with a previous loss, although we observed a decrease in active grief, the grief remained high. Moreover, the additive score of the mean of the three PGS subscales remained above 60 (on a scale with a minimal score of 33) for both parents in both groups, which has been considered indicative of continued mourning (Lin & Lasker, 1996). Consequently, the grief process did not appear to be hindered by a subsequent pregnancy.

It is important to consider our results concerning couples in which the man chose not to participate: they suggest that these couples may have been less well adjusted than couples where both partners participated. One cannot eliminate the possibility that for a small group of parents, possibly those who choose not to participate to studies on perinatal loss, a subsequent pregnancy could represent a significant obstacle to continued mourning. In a previous study on perinatal loss, participants tended to be psychologically healthier than those refusing to participate (Zeanah et al., 1995).

A subsequent pregnancy was not associated with significant changes in levels of depressive
The severity of this anxiety response in pregnant and nonpregnant bereaved women may be due to the unexpected impact of their grief—they may feel overwhelmed by the magnitude of their reaction.

Despite similar levels of maternal state anxiety, the sources of that anxiety may vary. The anxiety of bereaved mothers who are not pregnant may be related to the fear of not becoming pregnant again. In contrast, studies have shown that following a perinatal loss pregnant bereaved mothers report more anxiety specifically concerning the outcome of their pregnancy than pregnant women with an unremarkable obstetrical history (Franche & Mikail, in press; Theut et al., 1988). However, in these studies, no significant differences were observed between pregnant women with and without a previous loss in terms of their high levels of state anxiety, measured between the 10th and 24th week of gestation (Franche & Mikail, in press) and trait anxiety, measured at 8-month gestation (Theut et al., 1988). These findings point to the distinct concepts captured by state-, trait-, and pregnancy-specific anxiety that may have very different relationships among each other in expecting, expecting and bereaved, and bereaved populations.

Expecting and nonexpecting bereaved parents reported levels of marital adjustment that were within the normal range. However, the generalizability of these results is limited by the fact that fathers who did not participate were in couples where maternal rating of marital adjustment was significantly lower than in couples where both partners participated. Participation of fathers was also much lower in the Loss group than in the Pregnant Loss group, suggesting that there may be differences in marital adjustment between expecting and nonexpecting parents, which the study did not capture. Current literature indicates that marital adjustment may be a relatively stable phenomenon, best predicted by previous marital adjustment. Previous research also indicates that perinatal loss is not a greater risk factor for marital distress than having a live healthy birth (Mekosh-Rosenbaum & Lasker, 1995) and that the best predictor of marital adjustment following a perinatal loss is the level of marital adjustment immediately prior to the loss (Gottlieb, Lang, & Ansel, 1996; Lang, Gottlieb, & Ansel, 1996). However, these studies may have suffered from the same bias as the one of the current study and couples who were distressed about their marital life may have been less likely to participate.

The finding that the subsequent pregnancy was not associated with any changes in the grief intensity of men, as it was for women, suggests that there are gender differences in how the subsequent pregnancy is perceived. It has been suggested that the lost baby is perceived by the mother as part of herself (Furman, 1978) and that grief is unique for a mother in that she is mourning part of herself. In contrast, for a father, the separateness of the baby from oneself is possibly more clearly distinguished (Furman, 1978; Leon, 1992; Theut et al., 1988). Accordingly, a new pregnancy may not restore men’s perception of self in the same way as it does for women (Theut et al., 1988).

Gender differences in levels of overall grief have been attributed to the different course of prenatal attachment to the baby in women and men. It is proposed that fathers’ attachment lags slightly behind mothers’ earlier during pregnancy and that the gap is gradually reduced as birth approaches (Goldbach et al., 1991; Peppers & Knapp, 1980). Gender differences have been documented in self-reported prenatal attachment (Weaver & Cranley, 1983; Zeanah, 1989) as well as in reported prenatal ability to interact with the fetus (Stainton, 1985).

Gender differences may be related to differences in socially sanctioned expressions of grief for women and men. The active expression of grief, such as crying about the loss, is more socially acceptable for women than for men. Men may tend to suppress or deny their grief (Zeanah, 1989), especially in the presence of their grieving partner. It is interesting that in our
Subsequent Pregnancy and Perinatal Grief

study, the most salient gender differences were for active grief and difficulty coping. These components of grief may be thought of as more readily observable components of perinatal grief than the despair component that refers to more covert beliefs.

Men may not express grief in the same manner as women. A previous study found that salient grief symptoms for mothers included sleep problems, depression, anorexia, weight loss, social withdrawal, guilt/anger/hostility, morbid preoccupation with baby, and psychosomatic symptoms; salient symptoms of grief for fathers included an inability to work, guilt, anger, hostility, denial of death, alcohol abuse, and social withdrawal (Tudehope, Iredell, Rodgers, & Gunn, 1986).

Gender differences may also be related to the limited availability of perinatal grief measures. The PGS was developed and validated on a sample comprised mainly of women (women, n = 138; men, n = 56), thereby limiting its sensitivity to men’s experiences of grief. The degree to which fathers’ lower grief scores after a loss are due to differences in attachment and/or to gender related differences in the expression of grief should therefore be further explored using a grief measure developed and validated on a larger sample of men.

Several shortcomings of this study require mention. The sample size was small, limiting the number of variables that could be considered for each analysis. The homogeneity of participants with respect to socioeconomic level, the relatively lower rates of participation in the Loss group, as well as the documented difference in marital adjustment of participants versus nonparticipants, limit the generalizability of the findings.

In addition, some of the measures used in this study limited the interpretations of the findings. The BDI, similar to other measures of depressive symptomatology, includes several items of somatic symptoms that can be signs of depression and normal physical changes associated with pregnancy. As well, norms for the PGS at this time are limited. Interpretation of scores on this scale would be improved by norms for gestational age at loss, time since loss, and gender.

The study’s cross-sectional design limited the ability to establish direction of effects between emotional health and ability or choice to conceive. Only a prospective longitudinal design, where intent and attempt to conceive were monitored, could provide additional insight into these questions.

The impact of a subsequent pregnancy following a perinatal loss remains an important issue in obstetrical care. The results of this study support the idea that, for most women, a subsequent pregnancy could have a significant positive impact on psychological adjustment, by helping to reduce grief intensity. While pregnant mothers continue to grieve their loss, a subsequent pregnancy is associated with lower levels of despair and difficulty coping, the components of grief associated with a more chronic and complicated form of grief. This information, offered to couples considering or beginning a pregnancy after a loss, may help to alleviate their anxieties about their level of readiness for a subsequent pregnancy and their fear of not adequately mourning the lost pregnancy.

REFERENCES


Subsequent Pregnancy and Perinatal Grief


