A COMPARISON OF GRIEF AS RELATED TO MISCARRIAGE AND TERMINATION FOR FETAL ABNORMALITY

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ABSTRACT

This study proposed that maternal bereavement in women who experienced miscarriage and women who terminated for fetal abnormality would differ related to the existence of a grief reaction, and to identify the factors that differentiated the two groups. There were no significant grief differences between the miscarriage group and termination group. The groups were then combined to analyze within group factors. Six fixed variables were found to be related to vulnerability for a grief reaction. Factors included: time since the most recent loss; intervention of counseling; employment outside the home; feeling responsible for the perinatal loss; age of the mother as related to guilt; and gestational length of pregnancy.

The loss of a wanted pregnancy in the second trimester because of miscarriage or termination for fetal abnormality causes a woman to mourn for both the possibly malformed baby she was carrying and the perfect baby she mentally anticipated. Perinatal loss is unique and troubling because there is usually no visible child to mourn, and no memories of shared life experiences. The death is sudden and often coupled with a lack of recognition by relatives and friends regarding the significance of the loss (Lee & Slade, 1996). Personal stories of women who miscarry or terminate a wanted pregnancy for fetal abnormality reverberate with feelings of loss and emptiness. In addition, women who terminate cite the added emotional pain of guilt for choosing to end a life. This guilt enters into and permeates the woman’s mourning process.
Each trimester of a pregnancy includes psychological tasks that are part of the
bonding process between mother and infant. The first trimester involves suspicion
and confirmation, resolving initial ambivalence, accepting the pregnancy, and
reviewing of one’s childhood and changing feelings regarding body image and
sexuality. During the second trimester, the mother begins to realize the fetus
is a separate individual, and bonding is facilitated by the quickening (fetal
movement) and viewing the fetus via ultrasound. She begins to picture the ideal
child (Benkendorf, Corson, Allen, & Ilse, 1990). In the third trimester, the
mother establishes a caretaking relationship with the fetus, and mentally prepares
for labor and delivery (Bliss-Holtz, 1991).

Following perinatal death, the mother begins to process the meaning of the
loss. Grief has been defined as “a painful, complex emotional state that changes
with time and a process of confronting the loss (e.g., by yearning for and
repeatedly reliving the lost relationship) in the service of gradual detachment
from the lost person or object” (Beutel, Deckardt, Von Rad, & Weiner, 1995,
p. 518). Normal grief is accompanied by a multitude of symptoms impacting
feelings, cognitions, and physical sensations (Worden, 1991). Difficulty in griev-
ing has been found to persevere at least six months. With uncomplicated grief,
these feelings wane in intensity and the person slowly returns to a subdued
interest in and ultimately a zest for life. A grief disorder is characterized by
intrusive images, extreme feelings of emotion, denial of the importance of the
loss to the self, and a general neglect of necessary adaptive actions both in
the workforce and at home (Horowitz, Siegal, Holen, Bonnanno, Milbrath, &
Stinson, 1997).

The loss of the infant during the second trimester because of miscarriage or
termination often results in grief as the mother may have completed many of the
psychological tasks, including accepting the pregnancy and bonding with the child
(Benkendorf et al., 1990). She mourns the death of the idealized baby but may not
receive sufficient emotional support because of a lack of social recognition of the

When applying current bereavement theory to perinatal loss, several factors
must be considered. A pregnancy is confirmed much sooner in today’s society
than in earlier times due to medical advances. This, combined with first trimester
sonograms, leads to an earlier bonding with the fetus in utero and the development
of a mental representation of the child. Also, lower infant mortality rates have
led to greater expectations regarding the success of pregnancy (Cecil, 1994).
Consequently, many women are not prepared for pregnancy failure. The process
of miscarriage and termination for fetal abnormality both contain factors includ-
ing a sense of biological failure, isolated grieving, a possible lack of perceived
support and no time for anticipatory grieving. The factors related to the two
types of pregnancy loss may either combine with other risk factors, or alone
be detrimental enough to increase susceptibility to a short-term grief reaction
leading to a grief disorder.
White-Van Mourik, Connor, and Ferguson-Smith (1992) separate grief factors specific to perinatal loss into three areas, each defining a component of self-esteem. The areas of loss include the loss of biological self-esteem, moral self-esteem, and social self-esteem. The first is the loss of what researchers define as a biological loss of self-esteem. The fact that the woman’s body produced an imperfect offspring is perceived, if only subconsciously, to be a reproductive failure. Loss in terms of biological self-esteem may result from feeling physically inadequate. For many women experiencing either miscarriage or fetal termination, this experience cannot be viewed as an exception because it may be determined that the same fetal malformation is possible in future pregnancies.

A loss of moral self-esteem may occur in women terminating for fetal abnormality. The female might personally confront her own morality in causing death (White-Van Mourik et al., 1992). The woman is aware of her own decision to end her child’s life, which may result in guilt. This feeling may be possible in other types of loss such as miscarriage, where the mother may blame her own inappropriate behavior such as excessive exercise (Mander, 1999). In terminating a pregnancy, however, there is no doubt as to how the life was ended.

One study found women who experienced miscarriage had more feelings of loss and grief, while women who had an induced abortion for reasons other than fetal abnormality had greater feelings of relief, guilt, and shame (Broen, Moum, Bodtker, & Ekeberg, 2004). Though the pregnancies in this study were terminated for fetal abnormalities, the act of abortion may still cause feelings of guilt which necessitates exploration of its impact on the grief process. Women who terminate often speak in support groups of the additional burden of guilt, as compared to the focus on the feelings of loss by women who miscarried (Magi, personal communication, 1999).

Zoja and Martin (1997) discuss the polar opposites of abortion within the United States culture. Diametrically opposed positions are fostered: pro-choice or pro-life. In reality, however, there is much overlap and middle ground. The woman who terminates may feel emotional pain generated by the controversy surrounding abortion and its implied immorality. Women may later dwell upon the decision or experience guilt (Ilse, 1995).

A loss of social self-esteem is also associated with perinatal death, as compared to the elevated social status often accorded to pregnant women (White-Van Mourik et al., 1992). Society does not attach great importance to pregnancy loss and does not encourage open grieving for this type of death. One indication of the lack of validity is that funeral observances are limited. No set grieving process within society for a perinatal loss exists. The female experiences a loss of self-esteem engendered by the lack of recognition by society of the importance of the death. This results in possible isolating tendencies. Successful completion of the grieving process is dependent upon resolution of factors associated with perinatal loss. Key factors include a sense of biological failure, feelings of isolation, and a perceived lack of support.
The three areas of loss of self-esteem—biological self-esteem, moral self-esteem, and social self-esteem—permit the factors associated with the experience of miscarriage and termination for fetal abnormality to be viewed in a concrete manner. The resultant breakdown analysis allows for the determination of which variables are most associated with a greater susceptibility for a grief reaction, while identifying variables that facilitate the grief process.

**HYPOTHESIS ONE**

This study proposed that maternal bereavement in women who experienced miscarriage and women who terminated a wanted pregnancy as a result of fetal abnormality should be examined and compared to determine if a difference in susceptibility to a grief reaction existed, to identify the factors that differentiated the two groups, and to address the needs of women in both circumstances.

**HYPOTHESIS TWO**

The second hypothesis of this study speculated that a greater number of variables would be significantly related to grief scores, and would attempt to identify those factors. Some examples of variables include number of living children, prior losses, and psychological interventions.

In this study, contributing factors were considered in conjunction with White-Van Mourik et al.’s (1992) concept of the three areas of loss (biological self-esteem, social self-esteem, and moral self-esteem) in order to evaluate the variables in a quantifiable manner. Variables associated with biological self-esteem included the age of the mother, previous pregnancy losses, length of the pregnancy and the presence of a fetal abnormality. Variables associated with social self-esteem included limited or no family or social support. Lastly, the variable associated with moral self-esteem was guilt.

It was hypothesized that females who terminated a wanted pregnancy would experience a greater vulnerability for emotional problems as evidenced by a depressive reaction (Beutel et al., 1995). The loss of moral self-esteem was theorized to have a greater negative effect upon women who terminated a wanted pregnancy than women who miscarried.

**METHODOLOGY**

**Subject Recruitment**

Questionnaire results were gathered through four different venues: 1) clinician participation in recruiting patients (3.5% of subjects); 2) New York based hospital support groups (23.5% of subjects); 3) World Wide Web support groups, Website
messages, and World Wide Web listserv recruitment (64.7% of subjects); and 4) advertisements in national perinatal support newsletters (8.2% of subjects).

Data collection began in August 1999 and ended in March 2000. The desired number of subjects for the miscarriage group \((n = 50)\) was not obtained because of a lack of response from miscarriage participants. The researcher attempted to enlarge the cohort base, because the specificity of requiring second trimester loss participants narrowed the subject pool considerably. The resultant 23 valid questionnaire response sets allow for hypothesis one to be addressed.

Sample

A total number of 23 women who experienced miscarriage and 62 women who terminated for fetal anomaly correctly completed the set of questionnaires. This totaled 85 participants.

The target period was up to two years post loss, with the majority of the women having experienced the loss less than one year prior to filling out the questionnaire. Consequently, longitudinal and short-term effects were addressed.

Participants were gathered from different pools. Patients who experienced miscarriages and terminations at Westchester County Medical Center (WCMC) in Valhalla, New York were administered the series of questionnaires. The questionnaire was mailed to the participants with a short cover letter asking for cooperation and two self-addressed stamped envelopes (SASEs) included. One letter regarded confidentiality and informed consent, and was returned by the participant separately to ensure anonymity. Each responder’s returned questionnaire was assigned an identification number to guarantee anonymity.

A World Wide Web listserv was also used for both groups from which equal numbers of participants were targeted. This was a moderated newsgroup where members posted messages that others read via e-mail and invited responses. As a closed list designed to protect privacy, a person sent a brief note to the monitor describing her experience and why she wanted to be on the list. The monitor screened each individual for his or her suitability for the group and authenticity of experience, thus attempting to ensure the truthfulness of each member (www.aheartbreakingchoice.com). Hygeia (www.hygeia.org), a Website dedicated to perinatal loss, posted a notice regarding the study, allowing selection from an even greater population.

The perinatal bereavement coordinator at Good Samaritan Hospital in Suffern, New York agreed to solicit the participation of women who miscarried in their hospital setting, women who participated in their support groups, and women who were referred to them for follow-up (P. Magi, personal communication, April 24, 1999). The same procedures as above were followed for questionnaire administration. Additional advertisements were placed in perinatal bereavement newsletters to solicit participants.
Coding ensured the results would differentiate between the internet participants, the support group participants, and the WCMC participants. Equal numbers of participants were targeted for both the miscarriage and the termination groups, allowing for monitoring of differences between each group.

**Questionnaires**

To accurately assess the three areas of loss experienced by the two populations, measures were used that looked at grief factors through the use of self-report questionnaires.

Three questionnaires were administered to participants. A combination of questionnaires was chosen to examine qualitative and quantitative aspects of the loss experience. Initial enthusiasm expressed by participant pools for this study indicated the 30-minute administration time was appropriate.

The Perinatal Grief Scale-Shortened (PGS-S) is a questionnaire that has been successfully used to quantitatively measure active grief, difficulty with coping, and despair (Potvin, Lasker, & Toedter, 1989). The developer gave permission to use this measure for this study. The results of 22 studies involving four countries show very high internal consistency reliability, as well as construct and convergent validity, and external validity (Toedter, Lasker, & Janssen, 2001). Support group participants and self-selected populations were found to have significantly higher scores.

The PGS-S examined three aspects of grieving: active grief, difficulty coping, and despair. Examination of these categories in relation to the length of time that had passed since the loss led to greater insight into the psychological ramifications of miscarriage and termination for fetal abnormality.

Active grief addresses sadness and missing or crying for the baby. As the most positive form of grief, it leads to less psychological difficulties. Questions concern sadness, missing the baby, and crying for the baby (i.e., “I feel depressed”) (Potvin et al., 1989).

Difficulty coping is evidenced in difficulties with both daily activities and interactions with other people (i.e., “I find it hard to get along with certain people”). This is an indicator of more severe depressive symptomatology because individuals scoring high on this scale withdraw from others and have trouble functioning on a daily level.

The despair subscale is a predictor of serious and long-lasting negative psychological effects (i.e., “I take medicine for my nerves”). A person feels as if part of her died with the baby, she cannot find anything funny anymore, or believes it is safer not to love.

The PGS-S has a limited number of questions pertaining to guilt (i.e., “I feel guilty when I think about the baby”), a factor indicative of the loss of moral self-esteem (White-Van Mourik et al. 1992). This generated a need for an additional measure.
The Perinatal Bereavement Scale (PBS) is a 26-item instrument that focuses on the thoughts and feelings experienced by parents after a loss (Theut et al., 1989). Thoughts and feelings regarding sadness, guilt, anger, and preoccupation with loss are included. Theut, Zaslow, Rabinovich, Bartko, and Morihisa (1990) developed the measure to examine the resolution of parental bereavement after a perinatal loss, and the subsequent birth of a healthy child. The authors granted use of the measure for this study. Since this scale has not been validated with the two sample groups, it could not singularly be used to examine factors. This scale contributed to the study as it has three questions assessing actual feelings of guilt about the fetal death (i.e., “I feel guilty when I think about my lost baby,” “I feel partially responsible for the loss of my child,” “I worry that I failed to take enough precautions during the previous pregnancy, i.e., with weight, diet, smoking, sex, drinking, activity, etc.”).

The Pregnancy Loss Experience and Needs Assessment Questionnaire (PLENAQ) (Alderman, 1999) was used with the author’s permission to qualitatively address the experience of loss through miscarriage or termination for fetal anomaly. Contributing variables such as age, number of living children, etc., that contribute to a grief reaction were concurrently evaluated. This measure initially evaluated the miscarriage experience. Modified with the author’s permission to incorporate the word termination, the measure did not compromise its overall focus.

Alderman’s instrument assesses the woman’s experience of her miscarriage or termination, what her needs were at the time of loss, and if those needs were adequately met. The scarcity of available research necessitated the use of both qualitative and quantitative measurements.

The two quantitative questionnaires (the PGS-S and the PBS) identified those women who were currently experiencing grief complications. The qualitative questionnaire (the PLENAQ) allowed for an examination of the loss experience itself and fixed factors. The grief complicating factors were defined as the three areas of loss and included the loss of biological self-esteem, social self-esteem, and moral self-esteem. Variables associated with biological self-esteem included the age of the mother, previous pregnancy losses, length of pregnancy, and the presence of a fetal anomaly. Variables associated with social self-esteem included limited or no family or social support. Lastly, the variable associated with moral self-esteem was guilt.

A Bivariate Correlations procedure was first conducted to compare the PBS and the PGS-S to determine inter-measure reliability. A Pearson correlation of .827 was found between the two measures. This finding meant both measures assessed similar aspects of grief for each woman and could be used to concurrently examine grief.

Subscales to examine guilt as related to fixed characteristics of the sample were developed using questions present in both quantitative measures. The PGS-G-guilt
and PBS-guilt were developed through the identification of those questions related to guilt, and had an inter-item reliability of .883.

The analysis of the data attempted to determine the importance of each contributing fixed variable (age, income, presence of living children, number of losses, employment, ethnicity, marital status, education, and feelings of guilt or blame) and a mediating variable (counseling) on different aspects of grieving including the PGS-S subscales despair, active grieving, and difficulty with coping.

RESULTS

Questionnaire Response Rate

A total of 193 questionnaires were sent out, 90 being sent to clinicians to distribute to eligible patients, 57 to World Wide Web participants, 28 to support group participants, and 18 to participants recruited through perinatal bereavement newsletters. The return rate was 3.1% for clinician recruited women. A large number of questionnaires were sent to clinicians with the realistic expectation that only a small number would be returned. There was a return rate of 91% for support group recruited women, 91% for internet based women, and 97% for women recruited through advertisements. The total number of questionnaires returned was 95.

Ten questionnaire response sets were not included in the final analysis as the subjects’ perinatal losses did not match the required time period of study, or the women had experienced their most recent loss over two years prior to filling out the questionnaire. This resulted in 85 valid questionnaire response sets being examined in this study. The second trimester point of study focus was expanded at both the entry week of loss and the last acceptable week of loss for inclusion in the study to explore the changes in grief over time. The gestational loss range was 11 to 24 weeks.

Sample Characteristics

The women ranged in age from 18 to 47 years, with a mean age of 32.79 years. The majority of the sample was White, non-Hispanic (89.4%), followed by African American (3.5%), Hispanic (2.4%), Asian or Pacific Islander (2.4%), and other (2.4%).

Educationally, the majority of women completed an advanced degree (31.8%), followed by a four-year college degree (30.6%), some college (16.5%), some graduate school (8.2%), two-year college degree (8.2%), vocational school (1.2%), and some high school (2.4%). The preponderance of women had a total family income of $50,000 per year or higher (77.6%).

The geographical majority of the population resided in the Northeast portion of the United States (42.4%), followed by the West (21.2%), the South (18.8%), the Midwest (10.6%), and non-U.S. countries (5.9%).
Most (91.8%) of the women were either married or with a partner, 4.7% of them were single, and 3.5% listed other for their marital state. Slightly more than half (50.6%) of the women reported not having a living child, and 49.4% had living children. The number of losses ranged from 1 to 8.

The sample was categorized into two groups. The first group included women who experienced either singular or multiple miscarriages \((n = 23)\). The second group was comprised of women who primarily experienced a termination of a wanted pregnancy for fetal abnormality \((n = 62)\). Women who had experienced both a termination for fetal abnormality and miscarriages \((n = 5)\) were identified as part of the termination group because that is how they listed their primary loss. The miscarriage group was much smaller than the termination group. Women who miscarried tended to be younger, married for a longer period of time, had less income, and experienced a greater number of perinatal losses. It was not possible to completely match the two sample populations.

**HYPOTHESIS RESULTS**

**Hypothesis One**

An analysis of the data was performed with the three areas of loss (loss of biological self-esteem, social self-esteem, and moral self-esteem) as between-group factors and the number of contributing variables as within-subjects factors. An Independent Samples \(T\)-Test using Levene’s test for equality of variances was performed to assess the quantitative scores of the PGS-S and the PBS in order to compare the results of the miscarriage and termination groups.

This was accomplished using the general linear model (GLM) univariate procedure which provided a regression analysis and analysis of variance by one or more factors and/or variables (SPSS for Windows, 1999). This allowed for an examination of the relationship between multiple independent variables and the dependent grief scores.

The analysis identified the specific fixed variables that contributed to the significant overall effect of complicated grief between and within each group using an independent \(t\)-test analysis between one independent variable and the dependent variable of the grief scores. Additionally, the variable of guilt was examined in relation to grief scores in women who terminated as compared to women who miscarried. The analysis of the data attempted to determine the importance of each contributing fixed variable (age, income, presence of living children, number of losses, employment, ethnicity, marital status, education, and feelings of guilt or blame) and a mediating variable (counseling) on different aspects of grieving including the PGS-S subscales despair, active grieving, and difficulty with coping.

The first hypothesis of this study was that females who terminate a wanted pregnancy would experience a greater vulnerability for grief complications. An
Independent-Samples T-Test compared mean scores of the quantitative measures for both groups and found no significant differences between the miscarriage group and termination group as related to the PGS-S or PBS total scores. The results may be viewed in Table 1. No significant differences were discovered, thus a combination of the two groups was used to make one total sample \( (n = 85) \) so as to explore the relationship between fixed independent factors and grief scores. This combination of groups replicated Alderman’s study (1999), which reported similar non-significance in a miscarriage group with a resultant focus on within group results.

No differences were found between the hospital, support group, and World Wide Web-based subject pool responses. Women who experienced both miscarriage and termination did not differ from those who had either a termination or miscarriage(s).

**Hypothesis Two**

A greater number of fixed variables was hypothesized to be significantly related to grief scores as reflected on the PGS-S and PBS. An Independent-Samples T-Test procedure analyzed fixed nominal and ordinal variables related to PGS-S or PBS scores. A GLM Univariate procedure provided a regression analysis and analysis of variance for one dependent variable by one or more factors and or variables (SPSS for Windows, 1999). The results allowed for several factors to be analyzed together in relation to PBS or PGS-S scores to explore the interaction of several independent variables. The qualitative experiences of both groups found

### Table 1. Mean Scores for Miscarriage and Termination Groups on Perinatal Grief Measures as Related to Total PGS-S and PBS Scores, and for Guilt Subscales

<table>
<thead>
<tr>
<th>Measure</th>
<th>Type of loss</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGS-S</td>
<td>Miscarriage</td>
<td>101.6954</td>
</tr>
<tr>
<td></td>
<td>Termination</td>
<td>103.3509</td>
</tr>
<tr>
<td>PBS</td>
<td>Miscarriage</td>
<td>69.8261</td>
</tr>
<tr>
<td></td>
<td>Termination</td>
<td>71.4915</td>
</tr>
<tr>
<td>PGS-S guilt</td>
<td>Miscarriage</td>
<td>6.8261</td>
</tr>
<tr>
<td></td>
<td>Termination</td>
<td>6.7258</td>
</tr>
<tr>
<td>PBS guilt</td>
<td>Miscarriage</td>
<td>9.0870</td>
</tr>
<tr>
<td></td>
<td>Termination</td>
<td>9.4426</td>
</tr>
</tbody>
</table>
on the PLENAQ proved to be more involved and will be reported in a separate study. Results from the PLENAQ that support quantitative findings are reported in this study (see Table 2).

Six key fixed variables related to PBS and PGS-S scores: time since the most recent loss, the intervention of counseling, employment outside the home, feeling responsible for the perinatal loss, age of the mother as related to guilt, and the gestational length of pregnancy. Significantly, time was the only variable found to interact with other fixed independent variables in relation to the dependent PBS and PGS-S scores. Correlational information for all variables may be viewed in Table 3.

A significant relationship was found between time since the most recent loss and the PBS total score (.044), time since the most recent loss and the PGS-S total score (.040), and time since the most recent loss and the active grief subscale of the PGS-S (.001). Time was further categorized into four sections: one to three months post loss, three to six months post loss, six to twelve months post loss, and one year post loss on to explore the impact of the passage of time on grief scores. A univariate analysis of variance found the number of perinatal losses, time, and the presence of living children significantly related to the difficulty with coping subscale of the PGS-S (.050). Time and face-to-face counseling were significantly related to lowered PBS total scores (.019).

Counseling was significantly related to both the PBS total scores (.003) and the active grieving subscale of the PGS-S (.022), with the intervention of counseling reported by 65.9% of the respondents. Interventions received in order of frequency included: social worker/counselor (27.1%), support group (24.7%), psychologist/psychiatrist (15.3%), other (5.9%), hospital nurse (2.4%), ob-gyn (2.4%), and a hospital nurse (2.4%). Of the women who had received counseling, 57.6% stated that it was beneficial. Women listed multiple sources of counseling support, and perceived counseling interventions differently on an individual basis. This precluded an analysis of the impact of different counseling venues on grief.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBS total</td>
<td>.766</td>
</tr>
<tr>
<td>PGS-S total</td>
<td>.604</td>
</tr>
<tr>
<td>PBS guilt</td>
<td>.509</td>
</tr>
<tr>
<td>PGS-S guilt</td>
<td>.866</td>
</tr>
</tbody>
</table>
The third fixed variable found to significantly relate to grief scores was employment outside the home. An important relationship was found between employment outside the home and the PBS-guilt subscale (.030), and employment outside the home and the PBS total score (.012). Fifty-seven women were currently employed outside the home when answering the questionnaire, and 25 women were not employed outside of the home. Women who worked outside the home (mean score = 9.69) achieved scores on the PBS Guilt subscale representative of less guilt related to the perinatal loss than women who did not work outside the home (mean score = 8.58).

The fourth fixed variable found to be significant was feeling responsible for the loss. Feeling responsible for the loss was related to both the PGS-S and the PBS total scores (.009 for each), the difficulty with coping subscale (.034), and the PBS-guilt subscale (.047). When questioned if the participant felt accountable for the loss, 54.1% of women stated they felt responsible for the loss and 52.9% stated the reason for the guilt was some action on their part. Of important note, 37.6% of the total number of women felt they could have prevented the loss.
Participants who felt responsible for the perinatal loss (mean score = 96.88) achieved scores indicative of greater grief, difficulty with coping and despair than women who did not feel responsible for the perinatal loss (mean score = 109.84). The mean score for women who felt responsible for the loss was 36.82 and the mean score for women who did not feel responsible for the perinatal loss was 43.13. Age was significant as related to guilt concerning the perinatal loss (PGS-S Guilt Subscale and age of mother related at .025). Lastly, a significant relationship was found between the greatest gestational age of all the perinatal losses and the PBS total (.018).

**Examination of Termination Within Group Differences**

No significant relationship was found between the grief scores and whether the women saw the deceased child, whether they belonged to an World Wide Web-based support group, or if they believed they had made the correct decision. A significant relationship was found between physical attendance at a support group and the PBS total score (.036). Supporting this, results approaching significance were found between women who physically attended a support group and the active grief subscale of the PGS-S (.051).

**DISCUSSION**

**Comparison between the Miscarriage and Termination Groups**

The loss of a wanted pregnancy in the second trimester due to miscarriage or termination for fetal abnormality causes a woman to mourn both for the possibly malformed baby and the perfect baby she had mentally anticipated. Such loss impacts the woman both physically and psychologically. This study investigated the psychological experience of miscarriage and termination of a wanted pregnancy for fetal abnormality to gain a greater understanding of the similarities and differences between the two groups.

The multidimensional aspects of pregnancy loss were examined in a concrete manner. White-Van Mourik, Connor, and Ferguson-Smith (1992) provided the research base in that perinatal death involves a loss of self-esteem in three areas: a) biological self-esteem, b) moral self-esteem, and c) social self-esteem.

**Loss of Biological Self-Esteem**

Loss of biological self-esteem was similar between women who miscarried and women who terminated a wanted pregnancy for fetal abnormality. A greater number of losses per person were reported in the miscarriage population. The miscarriage population had a mean of 2.36 losses and the termination population
had a mean of 1.66 losses. No significant relationship was found in differences between the two groups and grief scores as related to loss of biological self-esteem (.44). Loss of biological self-esteem was evidenced in the percentage of women (54.1%) who felt responsible for the loss.

Loss of Social Self-Esteem

As was expected, no differences were found between the two groups in the loss of social self-esteem (.641). Increased or decreased association with friends and family following loss, moving from where they were living, changing jobs, or experiencing a decrease or increase in sexual desire were not related to grief scores.

Loss of Moral Self-Esteem

No significant correlation between the miscarriage and termination groups related to the PGS-S or PBS scores of loss of moral self-esteem were reported (.44). Results indicate women who miscarried blamed themselves for the loss, even though they did not actively terminate the pregnancy. A qualitative exploration found reasons related to the loss of moral self-esteem cited by the miscarriage group included not reducing stress, working too hard, not taking vitamins, and not taking enough care of their bodies. The ambiguity surrounding the reason for the miscarriage results in women internalizing blame for the loss, and subsequently experiencing a loss of moral self-esteem.

The key reason related to the loss of moral self-esteem cited by the termination group included statements referring to deciding to end the pregnancy. Although the causes of loss cited by the two groups tended to differ, the resultant grief scores were the same. The number of losses experienced by the miscarriage population was greater than the number of losses experienced by the termination population.

Overall, grief scores representative of the two populations did not show significant differences. Lasker and Toedter (1991) found that age and income were not significant predictors of grief scores, and their results were substantiated in this study. The high grief scores found in this study may replicate Toedter, Lasker, and Janssen’s (2001) findings of higher scores in women attending support groups and list-servs. The number of losses experienced by women, and time married, may prove to be more important variables in the grief process.

Predictors of Grief

The combination of the three measures allowed for an examination of varying aspects of the grief process. As no significant differences in grieving were discovered between the two groups, the responses of women who miscarried and women who terminated a wanted pregnancy could be combined to examine the relationship of fixed factors to the grieving process. The combination of the two
groups was based on the Alderman study (1999) finding similar results in a gender study of miscarriage. Six fixed variables were found to be significantly related to the grieving process in this study: time since the most recent loss, the intervention of counseling, employment outside the home, feeling responsible for the perinatal loss, age of the mother as related to guilt, and the gestational length of the pregnancy.

**Time Since the Most Recent Loss**

The amount of time that had passed since the most recent loss was significantly related to the PGS-S and PBS total scores. The acuity of grief lessens over time. The subscale of the PGS-S influenced significantly by time was active grieving. This measures grief as evidenced by sadness, and missing or crying for the baby. Results indicate that the process of active grief begins to occur soon after loss and resolves itself over time if no complicating factors are present.

Time was found to interact with other factors in the grieving process. The number of perinatal losses, time, and the presence of living children were related to the difficulty with coping subscale of the PGS-S. Women whose loss had occurred closer to the time when they filled out the questionnaire, had greater numbers of perinatal losses, and no living children experienced greater difficulties. Evidence of difficulties were reflected in accomplishing daily activities, and dealing with other people. They may be withdrawing from others and having trouble functioning on a daily level.

**The Intervention of Counseling**

Time was related to the intervention of counseling and the PBS total score. Counseling was related singularly, without the added variable of time, to the active subscale of the PGS-S and the PBS total. The intervention of counseling was listed as being received by the majority of the respondents. Respondents were able to list more than one source of counseling, which precluded a comparison of differing counseling venues with grief scores. The interventions received in order of frequency include: social worker/counselor, support group, psychologist/psychiatrist, other, hospital nurse, ob-gyn, and a hospital nurse.

Of the women who had received varying types of counseling, 57.6% stated that it was beneficial. One complicating factor is that the concept of counseling is an individualized one, with some women viewing an internet support group as counseling and others not. The statistic is representative of the individual’s perception of whether she received counseling or not. Of the remaining 43.4% of women who did not list counseling as being beneficial, no clear cut definition of counseling was used and may have influenced their response. The actual percentage of those who found counseling to be beneficial may actually be higher.

Counseling, as reported by respondents, was found to help with thoughts and feelings regarding sadness, guilt, anger, and preoccupation with the loss.
The intervention of counseling was significantly related to the active grief subscale. Thus, counseling facilitates the process of grief work, and leads to less psychological difficulties. Women who get some form of counseling may be better able to process the loss and experience less severe grief symptomatology.

**Employment Outside the Home**

Women who worked outside the home experienced less sadness, guilt, anger, and preoccupation with the loss than women who were not employed outside of the home. The impact of added activities on the amount of time available to spend dwelling on the loss was reported by working women to influence grief scores. The importance of this factor as it relates to perinatal loss may be related to task-oriented coping.

**Feeling Responsible for the Perinatal Loss**

Women who felt responsible for the loss had scores reflective of greater amounts of grief, difficulty coping, and despair. This is an important finding as despair is a predictor of serious and long lasting negative psychological effects. Women reported feeling as if part of her died with the baby, that she cannot find anything funny anymore, or that she believes it is safer not to love. This is reflected in the perinatal loss literature (Potvin et al., 1989).

Women blaming themselves for the loss indicates an intervention of some type of counseling would be appropriate. Counseling is shown in this study to facilitate active grief, and avoid more maladaptive grieving later on. Counseling could help with feelings of responsibility and guilt, and lessen possible negative psychological aftereffects.

**Age of the Mother**

Older women blamed themselves more for the loss. Some questionnaire responses indicative of age as a predictor of grief concerned the mother being too old, or that she should have conceived earlier in life. Feelings of responsibility or guilt are found to be linked to more serious grief complicating factors in this study.

**Gestational Point of Loss**

A significant relationship was found between the greatest gestational length of all the pregnancy losses and the PBS score. This is evidenced in one woman’s situation where she experienced four miscarriages, one termination, and had one live four-year-old child. Given that the five perinatal losses occurred at eight weeks, four weeks, nineteen weeks, twelve weeks, and six weeks, the greatest gestational age reached was nineteen weeks. The full-term birth of the live child would not be counted.
Women who experienced pregnancy termination displayed less negative effects on short-term psychiatric health than women who experienced a late spontaneous abortion or perinatal death (Salvesen, Oyen, Schmidt, Malt, & Eik-Nes, 1997). The length of the pregnancy might have contributed to the non-significant differences in short-term psychiatric health between the miscarriage and termination groups. This study and Lasker and Toedter’s (1991) research found the length of the pregnancy to be an important predictor of the grief response.

The length of the pregnancy indicates that the longer the woman is pregnant, the more time she has to bond with the unborn child. This results in a greater degree of grief. Women who experienced a longer pregnancy had more sadness, guilt, anger, and preoccupation with the loss.

**Summation of Discussion**

Women who experience a miscarriage and women who undergo a termination of a wanted pregnancy for a fetal abnormality do not experience significant differences as related to measures of grief. Although there were some minor differences between the two groups, the findings indicate that both groups mourn the loss of a child in utero equally.

Factors found to influence grief include: time since the most recent loss, employment outside the home, feeling responsible or guilty for the perinatal loss, the age of the mother as related to guilt, length of the pregnancy, and the intervention of counseling. The results are in keeping with, and build upon, general findings in the current literature.

Factors not related to grief for both groups include age as related to general grief scores, suddenness of the loss, perceived support, experiencing a significant loss within the past year, feeling fetal movement, knowledge of a problem prior to pregnancy, being given a reason for the loss, changing doctors following a loss, the doctor and staff being comforting, and seeing the deceased baby. At this point, it is unknown both within this study and in the current literature why this is the case. Only one question was related to religion/spirituality. Using a measure specifically targeted toward religion/spirituality with multiple questions may have found different results.

**Within Group Differences of the Termination Sample**

In studying the termination group alone, no significant relationships were found between grief scores and the cause of termination, whether the abnormality was compatible or incompatible with life, and if the woman thought she made the correct decision for herself. The significant relationship found between the PBS total score and attending a support group indicates that this type of counseling facilitates the processing of thoughts and feelings regarding sadness, guilt, anger, and preoccupation with the loss. This is supported by the near significant
relationship between the active grief subscale of the PGS-S and attendance at a support group.

Counseling as related to positively facilitating the grieving process is a key result. The study findings support routine screening for women following a perinatal loss and referring for counseling when indicated.

LIMITATIONS OF THE STUDY

One of the major problems in conducting research with bereavement in general is the lack of available information about the premorbid status of the person before their loss. This lack of information allows the researcher to only infer the person’s level of functioning prior to and after their loss.

The fact that the two comparison groups could not be matched according to demographic information confounds the results for the first hypothesis. Another limitation of this study is that the participants volunteered to fill out the questionnaires and consisted primarily of people who responded to advertisements, or were part of an established support network. It is possible that the people who responded were affected differently than people who did not respond.

Lastly, the study participants were not representative of the national population as a whole. Minority populations, lower-class, and middle-class populations were underrepresented.

FUTURE RESEARCH

The participants in this study consisted mainly of middle-class, educated Caucasian women. Further research including individuals from different ethnic and socioeconomic status backgrounds would allow for the validation of these factors on the experience of perinatal loss.

Further investigation is needed with matched sampling to gain a better understanding of the relationship between the two types of perinatal losses and the resultant grief experience. Factors that have been found in this study to relate to the grieving process need further investigation, and those that were not found to be related, in order to best help women who experience a perinatal loss. The importance of counseling and the characteristics of the women who choose to pursue counseling are in need of further study. The result will allow for a greater understanding of the role of counseling in facilitating the grieving process as well as to identifying those characteristics in women more likely to pursue counseling.

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