

Review Article

Grief following pregnancy loss – Literature Review

Vidyadhar B. Bangal¹, Shalini Y. Sachadev², Manasi Suryawanshi³

¹Professor, Dept. of Obstetrics and Gynaecology (OBGY), Rural Medical College of Pravara Institute of Medical Sciences, (Deemed University) Loni, Maharashtra, India

²Associate Professor, Dept. of Obstetrics and Gynecology, Rural Medical College of Pravara Institute of Medical Sciences (Deemed University) Loni, Maharashtra, India

³Registrar, Dept. of Obstetrics and Gynaecology (OBGY), Rural Medical College of Pravara Institute of Medical Sciences, (Deemed University) Loni, Maharashtra, India

***Correspondence Info:**

Dr. Vidyadhar B. Bangal

Professor,

Dept. of Obstetrics and Gynaecology (OBGY),

Rural Medical College of Pravara Institute of Medical Sciences, (Deemed University)

Loni, Maharashtra, India

Email: vbb217@rediffmail.com

Abstract

Introduction: Pregnancy loss is a stressful situation where in there is termination of pregnancy with adverse fetal or neonatal outcome. The literature related to grief reaction following pregnancy loss was reviewed to find out the nature, incidence and various factors affecting grief process.

Methods: An electronic search of 46 published articles in the Medline, Pubmed and Psych Info databases was carried out covering a period from year 1982 to 2013, using the keywords pregnancy loss, miscarriages, spontaneous abortion, recurrent abortions, neonatal deaths, stillbirths in combination with grief and mourning.

Results: Majority of studies on the subject were reported from developed countries. A large percentage of women seem to experience a grief, with the actual incidence of grief unavailable. Women experienced feeling of guilt, sense of inadequacy, doubts about femininity, anger towards oneself, spouse, friends, depression, feelings of emptiness and sadness, uncontrollable crying, withdrawal from others and activities, jealousy, lowered self-esteem. Women with prior psychiatric symptoms, advanced gestational age and absence of living children at home are more predisposed to severe grief reaction after pregnancy loss.

Conclusions: There is a need for greater awareness among health care providers (Practitioners, counsellors, nursing staff, medical social workers) about the psychological reactions that may accompany a pregnancy loss. Health care providers need to spend extra time with the affected couples to understand their feelings following pregnancy loss, so as to find out solutions for their grief reaction. They need to be empathic, sensitive and supportive of couples faced with this type of loss.

Keywords: Emotional upset following miscarriage, Grief reaction following pregnancy loss

1. Introduction

The word 'Pregnancy' equates to the magic images of smiling, gurgling babies and a "glowing pregnant woman". It is a word that symbolizes joy, hope for the future, dreams and relationships yet to be realized, and perhaps, the next step on the ladder of life-- parenthood, For some people, it represents the fulfilment of a lifelong goal. Undoubtedly, there is utter frustration felt by couples when there is a pregnancy loss. Couples feel cheated out of a wondrous, natural experience that was to be theirs, Suddenly their dreams are shattered and their hope for a family, is lost, or temporarily put on hold. Feelings

of guilt, blame, and failure may also begin to surface.¹

Pregnancy loss is a condition where there is termination of pregnancy with adverse fetal or neonatal outcome. It leads to psychological and emotional upset to the couple and the close associates of the family. The sudden occurrence of unexpected event results into varied nature and severity of grief reaction.² It varies from individual to individual and depends on factors like duration of pregnancy, type of loss, history of similar incidences in past, presence of living issues in the family, duration of married life, bonding between spouses and support of family members, relatives and friends after the pregnancy loss. Pregnancy loss may be due to first and second trimester miscarriages, ectopic pregnancies, second trimester genetic terminations and natural losses, the demise of one baby in a multiple gestation, a full term stillborn, the death of a baby soon after it is born. Pregnancy loss occurs in almost 10-15 % of pregnancies³. The affected group is large, diverse and spares no one. All ages, religions, races, income levels and stages of life are represented. The effects are at times unrecognized, at times invisible, and at times denied¹. The purpose of this review was to find out the nature of grief following pregnancy loss, to determine the incidence, intensity, and duration of grief; and to identify the various factors that affect the grief process.

2. Method of the Review

An electronic search of 46 published articles in the Medline, Pubmed and Psych Info databases was carried out covering a period from 1982 to 2013 using the keywords pregnancy loss, miscarriages, spontaneous abortion, recurrent abortions, neonatal deaths, stillbirths in combination with grief and mourning. Additional searches were conducted using references cited in the published literature on the subject. Pregnancy loss was considered when there was termination of pregnancy with adverse fetal or neonatal outcome. Grief reaction referred to affective, physiological and psychological reactions to the loss of an emotionally important figure^{4,5}.

3. Results of the Review

The loss of a planned or anticipated baby was usually accompanied by feelings of sadness, disappointment, doubt, confusion and even anger. It not only signals the end of a relationship between the developing baby and its parents but also lost are the dreams, hopes and wishes that are an integral part of the pregnancy. When embarking on a pregnancy the parents are "totally unprepared for death. It comes out of the blue"⁶. Miscarriage is the term used for a pregnancy loss before 20 weeks gestation. It includes ectopic pregnancy and blighted ovum as well as spontaneous abortion, incomplete abortion and IVF attempts. It is estimated that as many as 1 in 4 recognized pregnancies may end in miscarriage. It is estimated that about three-quarters of miscarriages occur in the first 12 weeks.⁷ Miscarriage can cause a woman the most acute sadness she has ever experienced. "It can stun parents with the intensity of its emotional impact"⁸. Because miscarriage usually happens very early in the pregnancy, there is often the misconception that the degree of loss experienced is in proportion to the length of the pregnancy. What seems far more relevant is the loss of an expected child. Attachment is based on the expectations, fantasies and hopes for the child⁹.

Women speaking of their miscarriages do so in very personal and relational terms - speaking of the miscarriage as the loss of a person¹⁰. They commonly show the same range of feelings reported in other bereavement situations and have been found to experience two phases of mourning: The initial phase, characterized by denial as a means of coping with the loss. The acute mourning period, characterized by an increase of feelings of anger, guilt, blame and jealousy.

"Soon after conception the psychological and physiological processes of pregnancy are set in motion."¹¹ The body and psyche gears up for motherhood. Therefore when a pregnancy is interrupted or does not yield a desired outcome, the woman is left in the state of physical and emotional readiness for a baby that will never be. The woman's focus is still centered on the lost baby for a time and she becomes very sensitive to those around her who either have young babies or who are pregnant. Something as simple as shopping may become very difficult, as everywhere she turns there are baby products, babies in advertising or other mothers with their babies and children. A pregnancy loss can have a profound effect on a parent's self-image. Many people prepare to become parents long before they actually do. They have some idea of themselves as parents somewhere in the future - it's part of their life goal - on the long term plan if you like. A parent's role traditionally centers on protecting and nurturing the child and parents usually do not expect to outlive their offspring. For many, the grief associated with the loss of a child may bring with it a profound sense of personal failure and guilt. Many women talk about feeling inadequate as a woman and a mother by not bringing a pregnancy to a complete and healthy outcome. They feel guilt for failing to meet the expectations of partners, children and parents. Loss of a first pregnancy may

raise considerable anxiety about future fertility¹.

Anger is another recognized part of the grieving process. It may be towards the partner, friends and oneself. The grieving woman may be concerned that she or others may not have done enough to prevent the loss. She may be dissatisfied that there is no apparent reason for the pregnancy loss and no definite answer or reassurance against the possibility of this happening again. Tension and conflict may arise in the parental relationship after a pregnancy loss because of the different degrees of bonding for men and women¹. The emotional attachment for the father tends to lag behind that of the mother. Hence the mother seems to experience a greater degree of grief that lasts longer because of the deeper attachment. A study reported that women were more likely to see the miscarriage as the loss of a person whereas men tended to perceive it as a sad event but not as a death¹¹. A book on "Motherhood and Mourning" suggest that society's expectations for men were to remain strong and suppress their emotions, whereas women were expected to express their sadness and grief.¹² Men all too often throw themselves into work in order to take their minds off their own grief and to avoid feelings of helplessness in the face of their partner's pain. For some women this apparent lack of grief can lead to feelings of isolation and bitterness, causing problems in the relationship. Where the level of the husband's support is evident, women usually fare better and the level of depression decreases¹³. This is also the case where there is active support from friends and relatives.

The literature in regard to incidence rates, intensity, and duration of grief following miscarriage is limited. With regard to incidence rates, the literature is composed primarily of qualitative studies that lack a clear operational definition of grief and use varying time intervals, formats and measures. As a result, the incidence of grief reactions following pregnancy loss reported in these studies has varied widely. Thus, although a sizable percentage of women experience a grief reaction, the actual incidence of grief is unclear¹⁴⁻¹⁷.

Whereas many studies have examined factors that might moderate the intensity of grief following a miscarriage, three studies could be identified that focused on the overall, relative intensity of grief following a miscarriage. Roughly three fourths of participants reported moderate to intense grief reactions. Thus, based on this limited literature, when a grief reaction occurs following a miscarriage, it seems to be relatively elevated. Further, again suggestively, the intensity of grief following a miscarriage seems to be similar to the intensity of grief after other types of significant losses¹⁸⁻²⁰.

Several studies have attempted to answer the question: How long does grief endure following a miscarriage? using changes in the intensity of grief over time as a marker. The available data indicate that there is a significant reduction in the intensity of grief by about 6 months postmiscarriage, suggesting that the duration of grief following pregnancy loss is similar to the duration of grief after other types of significant losses^{3,19,21-23}. One variable that seems to affect the duration of grief following a miscarriage is a subsequent pregnancy. The women who had a subsequent pregnancy by the time of these assessments displayed a significant decrease in grief levels compared with women who as yet had not again conceived^{24,25}. Grief levels in women who became pregnant following a miscarriage were significantly lower than grief levels of women who had not become pregnant^{26,27}. Thus, these studies are somewhat consistent in indicating that the duration of grief following miscarriage is relatively shorter in women who became pregnant by the time of assessment compared with women who do not become pregnant. In addition, these studies suggest that key elements of loss following miscarriage include the loss of the roles of pregnant woman and mother so that when these roles are reestablished, symptoms of active grief lessen².

Eight research studies related to gender-specific difference in the intensity of grief following a miscarriage revealed that men experience significantly less intense grief following a miscarriage than women. The reason could be that woman carried the pregnancy biologically, has a greater psychological attachment and therefore, experiences the loss more powerfully²⁸⁻³⁵.

There have been few reports on the various factors that influence the grief reaction. The nature and intensity of individuals' reactions to pregnancy loss differ. The factors that are generally seen as influencing the direction and strength of the relationship of bereavement and grief include the nature of the relationship between the bereaved and the deceased, the specific needs and wishes the individual associates with the relationship, the extent to which the deceased is an important part of the bereaved individual's mental representation of the world, the way the individual deals with emotional challenges and expresses emotions typically, and the reactions of significant others to the loss³⁶.

Many factors have been evaluated to find out their role in influencing the intensity and duration of grief following miscarriage, few clear conclusions can be drawn. There is partial but inconsistent support for an association between perceiving the pregnancy as real and grief following miscarriage and inconsistent support for an association between

gestational age and grief when other forms of pregnancy loss are excluded from study and only miscarriage is considered. The absence of living children is suggestively but inconsistently associated with the intensity of grief following miscarriage. Somewhat consistent results are found when level of grief after miscarriage and the presence of prior psychiatric symptoms are studied, with preloss coping capacity seeming to be predictive of level of grief. Finally, the absence of studies on the effects of social support and religious participation on level of grief following miscarriage prevents any conclusions from being drawn³⁷⁻⁴⁵.

For hospital staff busy with their routine work may have little time for the mother or parents what they need most at this time - empathy, explanation, time and support.

Women are usually discharged quickly from hospital and often go home in the state of shock. Many are confused - searching for answers and barely able to believe they are not still pregnant. There can be the tendency to want to shut out the world for a time - to pull the bedclothes over one's head and just stay there. Anxiety can be high, particularly about future pregnancies. Some will struggle alone with their feelings and reactions, not sure how they should be feeling or wondering whether what they are feeling is "normal". Many are hesitant to disclose these feelings and to ask questions. It is important to have all concerns addressed. It is helpful to write down any queries or concerns before seeing the doctor at a follow up visit. Counseling can help to normalize the feelings and reactions to this loss¹.

There are many psychological effects of pregnancy loss like feelings of disbelief ,guilt ,feelings of failure ,sense of inadequacy ,doubts about femininity ,feeling ,anger towards oneself, spouse, friends and towards those minimizing the loss or failing to recognize its significance ,depression, feelings of emptiness and sadness ,uncontrollable crying , preoccupation with the lost baby ,withdrawal from others and activities ,jealousy ,lowered self-esteem⁷.

Certain interventions have been shown to reduce the rate of psychological problems after a pregnancy loss. The best preventive is a "crisis debriefing" within the first 2-3 weeks after the incidence. This would include giving a woman an opportunity to discuss her feelings about what happened and making sure she has the correct factual information such as "it was not due to anything you did or did not do". Also, resources for emotional support should be identified at that time and if there are not many within the existing family or social structure, referring to support groups and recommending reading materials on common reactions to miscarriage and grief. There also should be some ongoing monitoring for depression or anxiety reactions in the next year to make sure the process is resolving .Some additional interventions are: acknowledging the loss and educating the woman about the natural grief response ,encouraging use of family, friends and support groups, providing reading materials, encouraging expression of feelings, including anger, in a non destructive manner, addressing guilt with reassurance about reasons for loss and future fertility, asking directly about suicidal thoughts, monitoring for excessive anxiety, depression, substance or alcohol use/abuse and referral to specialist, if present, monitoring for marital discord which is common after a pregnancy loss, monitoring for depression, anxiety, or grieving in subsequent pregnancy^{46,1}.

There is an insufficient evidence to demonstrate the superiority of psychological support over no intervention following pregnancy loss. Most of studies included in this review were not adequately powered. Furthermore, there was marked heterogeneity in the methods of the included trials. In settings where some form of psychological support is being formally provided to women with pregnancy loss, there no reason to change the current practice. The findings are equivocal and do not give a reason to alter the existing services in any way. Most of research, including the trials included in this review, has come from resource-rich settings. Even if future studies show evidence in favor of psychological follow-ups, there will be a need to replicate their effectiveness in under-resourced settings. Cultural variations may exist in the methods of coping with a loss and may have implications for the choice of components or the methods of follow-up. Another important issue which need to be considered in low- and middle-income countries is that of resource constraints, since these countries are still struggling with adequate coverage of basic health-care services (e.g. safe delivery, safe abortions, etc.). This is not to say that the psychological services after a pregnancy loss are not needed for women residing in under-resourced settings. Rather, the appropriate issues for discussion in this context would be identification and prioritization of these services for at-risk women and development of low-cost, effective models for follow-up as well as integration of such services with existing primary care services in the country. Families continue to serve as a major source of support in developing countries such as India. The extended families often provide the necessary care and emotional support, perhaps compensating for the deficits in the formal care services to a certain extent³.

4. Conclusion

There is a need for greater awareness among health care providers about the emotional and psychological reactions

that may accompany a pregnancy loss. Everyone concerned with this issue need to be empathic, sensitive and supportive to parents faced with this type of loss, providing them with information and resources to deal with their loss rather than leaving them with a silent sorrow.

References

1. Seigerman A. The emotional impact of pregnancy loss- in book *Parenthood lost; healing the pain after miscarriage, stillbirth and infant death*. Caregivers views -Greenwood publishing group, USA, 2001. Page number 89-93
2. Brier N, Grief following miscarriage: A Comprehensive Review of the literature. *Journal of Women's Health* 2008;17(3): 451-64
3. Mehta M, Pattanayak RD. Follow-up for improving psychological well-being for women after a miscarriage: RHL commentary (last revised: 1 January 2013). *The WHO Reproductive Health Library*; Geneva: World Health Organization.-
4. Covington SN. Pregnancy loss. In: Barnes LH, Covingtons SN, eds. *Infertility counseling: A comprehensive handbook for clinicians*. New York: Pantheon, 1999:227.
5. Prigerson HG, Jacobs SC. Caring for bereaved patients. *JAMA* 2001;286:1369.
6. Lothrop, H. *Help, Comfort & Hope after Losing Your Baby in Pregnancy or the First Year*. Fisher Books. USA. 1997.
7. Neville A -The emotional and psychological effects of miscarriage. *Opendoor counseling and educational services*. link-Inc. Opendoors.com.all/pregnancy.htm
8. Overs, M., *Coping with Miscarriage*. Health Book. Gore & Osment Publications, Sydney. 1995
9. Nichol, M., *Loss of a Baby: Understanding Maternal Grief*. Ban, Harper Collins Publishers (Australia) Pty Ltd, 1997
10. Reinharz, S. (1988), What's missing in miscarriage?. *J. Community Psychol.*, 16: 84–103. doi: 10.1002/1520-6629(198801)16:1<84::AID-JCOP2290160110>3.0.CO;2-G
11. Friedman, R. and Gradstein, B., *Surviving Pregnancy Loss*. Little Brown Book Limited. (America). 1982
12. Peppers, L.G. and Knapp, P.A., *Motherhood and Mourning*. Perinata; death .New york .Praeger. Special studies. 1980
13. Witzel, P.A. *The unrecognized psychological impact of miscarriage*. Canada's Mental Health. March 1989.
14. Leppert PC, Pahlka BS. Grieving characteristics after spontaneous abortion: A management approach. *ObstetGynecol* 1984;64:119.
15. Turner MJ, Falnnelly GM, Wingfield M. The miscarriage clinic: An audit of the first year. *Br J Obstet Gynaecol* 1991;98:306.
16. Zaccardi R, Abbott J, Kozial-McLain J. Loss and grief reactions after spontaneous miscarriage in the emergency department. *Ann Emerg Med* 1993;22:799.
17. Beutel M, Deckardt R, von Rad M, Weiner H. Grief and depression after miscarriage: Their separation, antecedents, and course. *Psychosom Med* 1995;57:517.
18. Paton F, Wood R, Bor R, Nitsun M. Grief in miscarriage patients and satisfaction with care in a London hospital. *J Reprod Infant Psychol* 1999;17:301.
19. Nikcevic AV, Snijders R, Nicolardes KH, Kupek E. Some psychometric properties of the Texas Grief Inventory adjusted for miscarriage. *Br J Med Psychol* 1999;72:171.
20. Hutti MH, dePacheco M, Smith M. A study of miscarriage: Development and validation of the Perinatal Grief Intensity Scale. *J Obstet Gynecol Neonat Nurs* 1989;27:547.
21. Deckardt R, Beutel M, Schaudig K. Long-term psychological sequelae of spontaneous abortion: Do medical management, recent pregnancy and delivery really help in coping with grief? *Geburtshilfe Frauenheilk* 1994;54:347.
22. Beutel M, Willner H, Volkl K, von Rad M, Weiner H. Assessment of grief after pregnancy loss: Development and initial results of the validity of the Munich Grief Scale. *Psychother Psychosom Med Psychol* 1995;45:295.
23. Maciejewski PK, Bahoui Z, Block SD, Prigerson HG. An empirical examination of the stage theory of grief. *JAMA* 2007;297:716.
24. Klier CM, Geller PA, Ritsher JB. Affective disorders in the aftermath of miscarriage: A comprehensive review. *Arch Womens Ment Health* 2002;5:129.

25. Cuisinier M, Janssen H, DeGraauw C, Baker S, Hoogdiun CA. Pregnancy following miscarriage: Course of grief and some determining factors. *J Psychosom Obstet Gynecol* 1996;17:168.
26. Nikcevic AV, Tunkel SA, Kuczmierczyk AR, Nicolaidis KH. Investigation of the course of miscarriage and its influence on women's psychological distress. *Br J Obstet Gynaecol* 1999;106:808.
27. Franche R. Psychological and obstetric predictors of couples' grief during pregnancy after miscarriage or perinatal death. *Obstet Gynecol* 2001;97:597.
28. Goldbach KRC, Dunn DS, Toedter LJ, Lasker JN. The effects of gestational age and gender on grief after pregnancy loss. *Am J Orthopsychiatry* 1991;61:461.
29. Stinson KM, Lasker JN, Lohman J, Toedter LJ. Parents' grief following pregnancy loss: A comparison of mothers and fathers. *Fam Relations* 1992;41:218.
30. Beutel M, Willner H, Deckardt R, VonRad M, Weiner H. Similarities and differences in couples' grief reactions following a miscarriage: Results from a longitudinal study. *J Psychosom Res* 1996;40:245.
31. Alderman L. The psychological experience of miscarriage on women and their families. *Dissertation Abstracts International: Section B: Sciences and engineering*. 1996;57(4-B):2853.
32. Alderman L, Chisholm J, Denmark F, Seilbod SC. Bereavement and stress of a miscarriage: As it affects the couple. *Omega: J Death Dying* 1998;37:317.
33. Barragan T, Antonio J. Miscarriage: Grief reaction differences between Mexican Americans and Euro-Americans on the Perinatal Grief Scale. *Dissertation Abstracts International: Section B: Sciences and engineering*. 2005;66(3-B):1706.
34. Swanson KM, Wojnar D, Petras A, Hsien-Tzu C. Gender differences in grief, depression and satisfaction with support after miscarriage. Paper presented at the 16th International Nursing Research Congress, Renew Nursing through Scholarship, July 14–16, 2005, Hawaii.
35. Serrano F, Luisa ML. Recurrent miscarriage: Psychological and relational consequences for couples. *Psychol Psychother* 2006;79:585.
36. Shaver PR, Tancredy CM. Emotion, attachment, and bereavement: A conceptual commentary. In: Stroebe MS, Hansson
37. Stroebe W, Schmit H, eds. *Handbook of bereavement research: Consequences, coping and care*. Washington, DC: American Psychological Association, 2001:63.
38. Muller ME. A critical review of prenatal attachment research. *Scholarly Inquiry Nurs Pract* 1992;6:5.
39. Hutti MH. Parents' perceptions of the miscarriage experience. *Death Stud* 1992;16:401.
40. Theut SK, Pedersen FA, Zaslow MJ, Rabinovich BA. Pregnancy subsequent to perinatal loss: Parental anxiety and depression. *J Acad Child Adolesc Psychiatry* 1988;27:289.
41. Stroebe W, Schmit H. Risk factors in bereavement outcome: A methodological and empirical review. In: Stroebe MS, Hansson RO, Stroebe W, Schmit H, eds. *Handbook of bereavement research: Consequences, coping and care*. Washington, DC: American Psychological Association, 2001:349.
42. Janssen HJ, Cuisinier MC, deGraauw KP, Hoogdiun KA. A prospective study of risk factors predicting grief intensity following pregnancy loss. *Arch Gen Psychiatry* 1997;54:56.
43. Neugebauer R, Kline J, Shrout P, et al. Major depressive disorder in the six months after miscarriage. *JAMA* 1997;277:383.
44. Adolfsson A, Bertero C, Larsson P. Effect of a structured follow-up visit to a midwife on women with early miscarriage: A randomized study. *Obstet Gynecol* 2006;85:330.
45. Lasker JN, Toedter LJ. Predicting outcomes after pregnancy loss: Results from studies using the Perinatal Grief Scale. *Illness Crisis Loss* 2000;8:350.
46. McKintosh DN, Silver RC, Wortman CB. Religion's role in adjusting to a negative life event: Coping with the loss of a child. *J Pers Soc Psychol* 1993; 65:812.
47. Jelovsek FR. The Emotional Effects of Miscarriage in Womens health resource, <http://www.wdxcyber.com/nmood07.htm> (accessed february19,2008)