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PSYCHOLOGICAL REACTIONS AND CONSEQUENCES AFTER
A SPONTANEOUS ABORTION

by

PAMELA D. TRUNK

A dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the
requirements for the degree of Doctor of
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date

Dec. 15, 1994
date

Anderson J. Franklin
Chairman of Examining Committee

L. Gould
Executive Office

Anderson J. Franklin, Ph.D.

Laurence Gould, Ph.D.

Steven Tuber, Ph.D.

Supervisory Committee

The City University of New York

Abstract

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by

PAMELA DENYSE TRUNK

Advisor: Professor Anderson J. Franklin

The specific objectives of this study were to determine whether women who had experienced a spontaneous abortion and encountered specific barriers that prevent grief from reaching a normal resolution would manifest forms of pathological grief. Married adult females aged 25 -41 who had a spontaneous abortion within two years were studied. The study utilized a Barriers Questionnaire which inquired into the women's perception of the abortion experience, Beck Depression Inventory, The Schedule of recent Experience, Marital Satisfaction Inventory, and structured interviews. T-tests and Pearson correlations were used to determine if the variables were significantly related.

The spontaneous abortions were perceived as sudden and unexpected. In some cases the spontaneous abortions

were even seen as unreal. However, the women tended to report substantial social support, and few respondents were clinically depressed. Global dissatisfaction with their marriages and dissatisfaction with the non-verbal means of affectionate communication between husband and wife did increase following the spontaneous abortion. However, there were no significant correlations between depression and the post-abortion marital satisfaction scales. No significant relationships were observed between post-abortion depression and the respondents' perceptions of aspects of the experience.

DEDICATION

This work is dedicated to my husband Carl F. Trunk, Jr. who never let me despair when we encountered unbearable losses in our lives...

...and to my children, Nina Denyse, Claire Katherine and Dana Grace who constantly remind me that out of darkness can come glorious light.

ACKNOWLEDGMENTS

I wish to thank sincerely my supervisory committee for their encouragement throughout this long process. Dr. Anderson J. Franklin has given me unfailing support and guidance, not only on this project, acting as my chairperson, but also throughout my career as a graduate student. To Dr. Lawrence Gould, I am eternally grateful for his insisting I think "clinical," that is what made this research project come to life. I also want to thank Dr. Steven Tuber for agreeing to join the committee on short notice, and putting a great deal of time and thought into going over the work I had done.

My outside readers, Dr. Vera Paster and Dr. William King were encouraging of my efforts and provided interesting suggestions for enhancing the scope of my work. Thank you both.

I would like to thank the women who shared their experiences with me, who let me meet them, call them, and take up time in their lives. This project would not have been possible without them.

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CHAPTER I

INTRODUCTION

The area of female reproduction, its successful patterns and its abnormalities, has been studied from a physiological standpoint, but extensive research on the psychological impact of childbearing has been lacking. Exactly what are "normal" reactions to certain reproductive events have not been adequately defined. The appropriateness of psychological intervention cannot be determined unless we know if the observed behavior is a deviation from the norm. The entire area of reproduction has been treated as one event, beginning with conception and ending with the birth of a child. In reality, the birth of a child is the result of many separate occurrences, each one having the possibility of success or failure. The components that can be studied are: (1) conception, or its failure; (2) successful pregnancy or spontaneous abortion or stillbirth; (3) birth of a healthy child or a child with defects.

These failures and complications of the childbearing process are not new, but as more women postpone childbearing until their thirties or forties, the complications are receiving more attention. And it has been noted (Tupper & Weil, 1962; Berle & Javert, 1954) that a failure somewhere in the process can disrupt the

1954) that a failure somewhere in the process can disrupt the chain of events. For example, women who have had two or more spontaneous abortions are likely to repeat their past experiences, even when no physiological difficulties can be found psychological intervention can break the pattern of repeated spontaneous abortion (Tupper & Weil, 1962; Grimm, 1962). But of course it is necessary to know that a woman is reacting to a spontaneous abortion in a manner that is not healthy. Quite often the medical profession is not able to deal with the psychological complications of reproductive failure. A woman who has lost a child through a spontaneous abortion is often told by doctors that she can always have another one. This ignores the psychological ramifications of the event. Society often colludes with the medical establishment, ignoring the event, which provides the women with no acceptable outlet for her grief. This in turn can produce serious psychological consequences effecting subsequent attempts to have children.

It is the aim of this paper to look specifically at spontaneous abortion and the grief that accompanies it. Spontaneous abortion happens to 15 percent of obstetric patients (Seibel & Graves, 1986). What are the psychological implications for these women?

Statement of the Problem

As increasingly more women postpone childbearing until their thirties and forties the number of women experiencing spontaneous abortions is increasing. The loss of this baby causes women to grieve as they would grieve over the death of a spouse or another child. Yet this grief is not recognized or acknowledged because of the assumption that there is no attachment between the mother and the lost child. In fact, many barriers are placed in the way of the normal grieving process making the resolution of grief more difficult. The literature shows us that unresolved grief can frequently become pathological. It appears that this specific population, women who have had spontaneous abortions, is at high risk for encountering pathological grief.

This study will explore the relationship between barriers encountered by women who have had a spontaneous abortion and the resolution of their grieving process.

Significance

The recognition that women who have had a spontaneous abortion do grieve and face obstacles that prevent the normal resolution of grief is of importance for assessing the need for psychological intervention. Intervention and support can be offered immediately following the spontaneous abortion in many instances. In other cases psychotherapy can be helpful during the grieving process itself.

Specific Objectives

--To show that spontaneous abortion is followed by grief which is often not worked through because of certain barriers.

--To determine if women who have encountered many of these barriers have a harder time resolving their grief and therefore, will show signs of pathological grief.

--To determine if this pathological grief may be manifested in difficulties with interpersonal relationships with family and friends, difficulty in fulfilling the parental role and in somatic complaints, or in feelings of worthlessness and self-accusation.

To support these points it is first necessary to

look at the literature on spontaneous abortion, dealing both with its physical and psychological aspects. Then the literature on grief will be reviewed. A look at what barriers might impede grief from being resolved and cause it to become pathological in nature will be looked at. Finally, the paper will try to weave together all these threads to show the psychological impact of a spontaneous abortion on women.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter will look at the literature on maternal-infant attachment, spontaneous abortion, and the psychological and emotional responses to a spontaneous abortion. Various theories on grief and how it is resolved, as well as theories on pathological grief will also be discussed. Finally literature specifically on grief after a spontaneous abortion will be presented.

Maternal-Infant Attachment

In the literature on maternal-infant attachment various authors write of the attachment of the mother to her child while the baby is in utero. Deutsch (1945) was one of the first writers to address this. She noted that especially with quickening a woman directs her psychic energy inward. While Deutsch felt that this was marked by the mother's regression to the oral stage others saw the recognition of attachment differently.

Bibring (1961) also felt that the first fetal movements were the point in pregnancy where the mother becomes attached to the child as a person:

Under the impact of the marked physiological and anatomical changes of the first months of

pregnancy, the libidinal concentration on the self increases and leads to the integration of, and merging with, this foreign body, turning it into an integral part of herself--until the quickening disrupts this narcissistic process and undeniably introduces the baby as the new object within herself. From here on, to the delivery, the second task of adjustment sets in: within a state of growing self-cathexis, which is due to the pregnant woman's unique situation of extensive body changes and body functions, serving the growth within herself as if it were part of herself, an opposing trend simultaneously develops. This part of herself begins to move on its own, is recognized as the coming baby, begins to be perceived as if it were another object and thus prepares the woman slowly for the delivery and anatomic separation. (pp.15-16)

Davidson, (1977) says of the 15 mothers he studied "every one of the mothers had felt the baby from the moment they became aware of the pregnancy. With a growing commitment of emotion, they had formulated a mental picture of their wished-for child" (p. 269).

And Kirkley-Best (1984) in the study of 38 women who had experienced prenatal loss concluded that the attachment occurs early and that "women grieve at all

points to loss in pregnancy even though there is a discernible rise in intensity of reactions across the time of pregnancy" (p. 90).

Klaus and Kennell (1982) stated that technology, particularly amniocentesis might facilitate attachment to the baby in utero even more. While some parents felt that knowing the sex of the child from the tests results removed a good deal of mystery, "the tests have beneficial results by removing some anxiety about the possibility of any abnormality. We have noted following the procedure that the baby is sometimes named and the parents often carry around a picture of a very small fetus" (p. 15). These authors represent just a few who feel and/or have noted that attachment by the mother begins prior to the birth of the child. A spontaneous abortion is felt as the loss of a child that a woman has become attached to.

Spontaneous Abortion

Most of the literature on spontaneous abortion deals with its medical and physiological aspects. There is very little dealing the with psychological and emotional aspects of this loss. Medically, a spontaneous abortion is defined as the unintended ending of pregnancy before the time the fetus could survive outside the mother's womb. "Seventy-five

percent [of miscarriages] occur within the first twelve weeks, and about one half of these 'early' miscarriages are due to an abnormality in the embryo or in the process of its implantation in the uterus. In 'late' miscarriages (from the thirteenth to the twentieth week) the fetus is usually normal but there are problems in its attachment to the placenta or uterus. (Borg, 1981, p. 28).

Williams Obstetrics, 1985 written for medical students states the incidence of spontaneous abortion to be about 10% of all pregnancies but feels that is a low estimate because it does not include very early spontaneous abortions. Friedman & Gradstein (1982) say that approximately one woman in five has a miscarriage.

Miscarriage is a term used interchangeably with spontaneous abortion.

A miscarriage is a lay person's term for a spontaneous abortion, which means that there is a premature delivery of a fetus before it can survive on its own. In some hospitals such a premature delivery before the eighteenth week is called a spontaneous abortion; after that it is called a stillbirth if the fetus cannot live on its own. The World Health Organization defines spontaneous abortion as a premature delivery of a non-viable fetus before the twenty-eighth week. In either case we consider these

premature deliveries that result in a non-viable fetus to be spontaneous abortions. It is different from an elective abortion (induced abortion) in that it is not planned and not voluntary. It happens on its own without drugs, an operation, or any medical procedure. (Pizer and Palinsky, 1980, p.11)

Psychological and Emotional Responses to Spontaneous Abortion

Freud (1917) said that the loss that leads to grief is not necessarily the loss of a person, but can also result from the loss of a concept or abstraction. A woman who is pregnant is carrying a person within her. She is also carrying an abstraction. After such a loss a woman experiences the symptoms and feelings associated with grief but for a variety of reasons is not able to express them, resulting, in many cases, in pathological grief. Davidson (1977) states:

Every day, somewhere, a mother loses the child she has wished for. For some, it is the disappointment that their baby was of the opposite sex. For others, it is the birth of a defective child, either with some physical or mental retardation. No woman gives birth without first having formed a mental image of her idealized

baby. Part of the normal preparation for motherhood seems to be testing that image against all the fears of what can go wrong. And sometimes those fears are confirmed. (pp. 265-266)

Perhaps the mother-to-be has already created a physical space for the baby, repainted the nursery, purchased toys, selected a name, and even let her imagination go so far as to decide what college the child will attend. She and her husband have discussed who will care for the baby, should the mother stay home or work. If there are other children in the family the parents might have already prepared them for the arrival of their sibling. To suggest that the loss of a pregnancy is not serious is inconsistent with reality. From the moment a family knows that a baby is expected they regard the being in the uterus as real and incorporate it into their lives.

To lose this being produces in the woman feelings of melancholia, as Freud discussed it. With the loss of the child there is a fall in self-esteem, a feeling that one is biologically flawed and unable to function fully in a uniquely feminine way. Kennell, Slyter and Klaus (1970) did a study which dealt with 20 women who had lost babies through miscarriage, stillbirth, or neo-natal death. Using six indicators of grief (sadness, loss of appetite, inability to sleep,

increased irritability, preoccupation with the lost infant and an inability to return to normal activities) Kennell et al concluded the grief these mothers felt was the same as maternal grief over the death of older loved ones. "Strong affectional bonding appears to begin before physical contact and caretaking but is enhanced by these activities" (p. 344). Pizer and Palinski (1980) found that "feeling sad and depressed for weeks or months after miscarriage seemed to be the norm. Many women say they didn't get over their feelings of sadness until they were pregnant again" (p.112). And Corney and Horton (1974) say that these feelings are indeed a form of grief, "might these women [who have had spontaneous abortions] not represent examples of prolonged or distorted grief" (p. 826). Friedman and Gath (1989) conducted a study of 67 women shortly after they were released from the hospital after a spontaneous abortion. They found that many of the women also reported symptoms typically associated with grief. For example "40 of the women had feelings of emotional numbness. In the next few days this numbness was followed by being 'very upset' in half the women. Several women likened the distress to that following the death of a family member" (p. 811). This is also true with women who are ambivalent about their pregnancy. Neugebauer et al. (1992) reported that

"depressive symptoms levels were unrelated to the woman's attitude toward the pregnancy" (p.1337).

Another conclusion Kennell et al (1970) reached was that the length of the baby's life did not influence the depth of the mourning. Pepper and Knapp (1980) were particularly interested in the relationship between mourning and length of pregnancy and reasoned that if there was no relationship between length of life and mourning, might not this be true in the case of prenatal death. They expanded upon Kennell et al and added more indicators of grief: difficulty in concentration, anger, guilt, failure to accept reality, time confusion, exhaustion, lack of strength, depression and repetitive dreams of the lost child. They used self-reports from 65 subjects who had experienced involuntary fetal death six months to 36 years prior to participating in the study. "The results of this study have empirically demonstrated the similarity in the grief responses of mothers who have involuntarily lost babies in either the prenatal or postnatal period. The reaction to loss appears to be as great in the case of an early miscarriage or stillbirth as it is in the loss of a neonate" (p.157). Pepper and Knapp go on to state:

In developing the concept of maternal-infant bonding, Klaus and Kennell (1976) attempted

to document prenatal emotional attachment by studying the mourning responses of 20 mothers whose infants died from one hour to twelve weeks after birth. They reasoned that length and intensity of mourning is proportionate the closeness of the relationship prior to death. Observable grief in each of their subjects led them to the indirect conclusion that 'significant bonding had been established by the time of or soon after the birth of the child.' Our data provide direct evidence of prenatal attachment. Apparently the affectional ties develop very early in pregnancy. The suggestion that grief or mourning is proportionate to the closeness of the relationship leads many people to assume that the quality of a relationship is also associated with the length of time invested in it. Our data suggest that this is not the case, that the intensity of grief is as great in miscarriage as it is with the loss of a neonate. (p.158)

Neugebauer et al (1992) also reached the same conclusion, "In the miscarriage cohort, depressive symptoms were not associated with length of gestation; that is, women with early and late miscarriages, had

equally high levels of depressive symptoms"
(p. 1337).

Grief

Definitions

When one reads through the literature on grief three terms are used, sometime interchangeably: grief, bereavement, and mourning. Mourning should be understood as the cultural expression of a person's feeling of loss. In most cultures it is that which structures and perhaps facilitates the grief process. Grief can be understood as a process, or a series of steps or stages by which one actually experiences, physically and psychologically, a loss. Bereavement is the actual loss - defined by the American Heritage Dictionary: 1. to deprive of (life or hope, for example) 2. to leave desolate, especially by death. (p. 125).

DSM III R lists Uncomplicated Bereavement as "a normal reaction to the death of a loved one. A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia" (p.333).

In Uncomplicated Bereavement, guilt, if present, is chiefly about things done or not done at the

time of the death by the survivor; thoughts of death are usually limited to the individual's thinking that he or she would be better off dead, or that he or she should have died with the person who died. The individual with Uncomplicated Bereavement generally regards the feeling of depressed mood as normal. (p.333)

Psychoanalytic Theory

In his 1917 work Mourning and Melancholia Freud provided a psychoanalytic view of grief:

Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on...It is also well worth notice that although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as morbid condition and hand the mourner over to medical treatment. We rest assured that after a lapse of time it will be overcome, and we look upon any interference with it as inadvisable or even harmful. (p. 165)

Freud concluded that the work of mourning is through when the lost object is acknowledged by the libido as no longer existing and the ego is free to face reality.

Fenichel (1945) goes on in much the same vein stating that grief consists of two parts, introjecting the lost object and then breaking away from the introjected object. The introjection is the mourner's answer to the loss of the real object. He constructs a substitute object within himself, he regresses from love to incorporation, from object relation to identification" (p.394). But no object is the subject of love only. If the relationship with the object was one of ambivalence then mourning becomes more difficult, for the incorporation is now not only a desire to preserve the loved object, but also a chance to destroy the hated object. Fenichel (1945) summarized this by saying that "mourning is characterized by an ambivalent introjection of the lost object, a continuation of feelings toward the object, and the participation of guilt feelings throughout the process" (p.395). When the bereaved finally breaks away from the introject he is said to have completed a normal process of mourning.

Cognitive Theory

Bowlby (1980) uses a cognitive framework to understand grief. For him it consists of four phases, the first being one of "Shock and Numbness". This can be brief, lasting a few hours or a few weeks. During

this stage the survivor often has difficulty understanding that a loved one has died. Intense outbursts of anger or distress may erupt. During the second phase, one of "Yearning and Searching" for the deceased the bereaved finally comprehends that the loved one is really dead and "this leads to pangs of intense pining and to spasms of distress and tearful sobbing (p.86) Somatic complaints are common during this phase, along with restlessness, insomnia and continual thoughts of the dead person. Anger is again present in this phase. But what Bowlby found most striking about this phases was the actual searching for the deceased.

Another interesting observation Bowlby has made is that during this stage the bereaved is seeking to be reunited with the deceased and the type of help he desires from others is in finding the lost one, not in accepting the loss. Those who seek to comfort the bereaved by offering platitudes such as "He's at peace now" or "Her suffering is over" are in fact offering little comfort and might be subjected to the anger and hostility that the bereaved is feeling.

The next stage Bowlby speaks of is one "Disorganization and Despair". During this phase old patterns of thinking and old ways of acting are no longer appropriate; they no long have an object. The

bereaved despairs, it seems as if nothing remains that is not connected with the dead person, and yet all that is connected with the deceased has no bearing on life now. At this point it is necessary for the bereaved to "Reorganize" (Bowlby's fourth phase) his life - redefine his status, his way of functioning, his place in the world.

Behavioral Theory

Ramsay (1976) looks at grief from a behavioral point of view. He sees it as one form of depression and says that the symptoms of depression, as summarized by Beck (1967) can be seen.

They are " (a) sad, apathetic mood; (b) negative self concept (self reproach, self blame); (c) desire to hide, to stay away from others; (d) loss of sleep, appetite, and sexual desire; (e) change in activity level; becoming either lethargic or agitated" (p. 131)

Grief as a Process

In his work Symptomatology and Management of Acute Grief (1944) Erich Lindemann assessed 101 patients who had lost relatives during the course of treatment, or in a disaster (The Coconut Grove Fire). He notes observable symptoms of grief that are part of what he

calls a normal grieving process. For Lindemann the observable aspects were: (1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct.

It should be noted that all the above authors view grief as a process consisting of steps or stages and not as a static state. How well the grief process is resolved depends on how well the bereaved moves from one stage to the next. Stack (1982) points out that "the grieving person should be assured that illusory experiences, dreams, and episodes of unexplained sadness or crying are signs not of mental illness but of the normal grieving process. To allow these experiences to occur will facilitate healing and the pain will subside. The endpoint of grieving is not to forget the loved person, but to be able to remember without pain (p.273-274). But some people are not able to remember without pain, somewhere during the process of grieving something went wrong.

Barriers to the Normal Resolution of Grief

Speigel (1977) has listed a number of factors that might prevent grief from following its normal pattern:

- (1) opposition to giving oneself up: (2)
- undeveloped ability to mourn; (3) a succession of

losses; (4) external circumstances forcing the bereaved primarily to take care of his survival; (5) doubt about the reality of death; (6) ambivalent attitude toward the deceased; and (7) social and religious norms that demand the self control of the bereaved. (p.86)

Lindemann (1944) points out the "the intensity of interaction with the deceased before his death seems to be significant. The interaction does not have to be of the affectionate type; on the contrary, the death of a person who invited much hostility, especially hostility which could not be expressed because of his status and claim to loyalty, may be followed by a severe grief reaction in which hostile impulses are the most conspicuous feature" (pp. 146-147). Lindemann goes on to mention another factor that is very important in preventing grief from normally proceeding - grief is painful. Speigel (1977) notes that we can avoid the pain simply by distracting ourselves. Ours is a society that values activity and busyness. And by immersing ourselves in activity we can avoid the pain that accompanies grief. And finally, guilt, says Deutsch (1937) "toward the lost object may disturb the normal course of mourning" (p.12).

Bowlby (1980) lists a number of variables, grouped under five headings, that he studied to see if they

could lead to "disordered mourning." They are (1) the identity and role the deceased, (2) the age and sex of the deceased, (3) the causes and circumstances of the loss, (4) the social and psychological circumstances affecting the bereaved about the time of and after the loss, (5) the personality of the bereaved with emphasis on the ability to respond to stressful situations.

Under the first heading Bowlby says that there is agreement that the "relationships which precede disordered mourning tend to be exceptionally close" (p. 176). Yet the age or sex of the bereaved do not seem to have any direct bearing on whether grief will become disordered. The circumstances of the death, however, do appear to be of significance . A person who experiences the death of another as sudden and untimely not only shows "a greater degree of emotional disturbance - anxiety, self reproach, depression - but ...it persists throughout the first year and on into the second and third years, and also that it leads more frequently to a pathological outcome." (p. 180). Both Volkan and Stack believe that in many cases the cause of pathological grief is sudden and unexpected loss. Also, under the causes and circumstances of the loss Bowlby notes that having direct knowledge of the death reduces the tendency for disbelief which appears more frequently when the news of the death has to travel far

or is presented by strangers. And when the circumstances of the death are such that blame is assigned to someone the outcome for disordered mourning is greater.

Bowlby and Speigel cite "multiple stressors" or a succession of losses in a short period of time as a barrier to the resolution of grief. The most significant factor under social and psychological circumstances was whether "families, friends and others play a leading part either in assisting the mourning process or in hindering it" (p. 191). Reporting on his work done in (1977) Raphael says that when women who were widowed were encouraged to talk about their past life, freely express their sadness, guilt or anger they had a much higher chance of successful adjustment than those who were told by family and friends to forget the past, to bear up, and move on.

In regard to Bowlby's fifth variable, the personality of the bereaved is a factor that can lead to disordered mourning. This type of mourning is more likely to occur in couples whose relations were extremely ambivalent. "Included also are individuals who, whilst protesting emotional self-sufficiency, show plainly that it is precariously based. In all such persons relationships are likely to be suffused with strong ambivalence, either overt or latent" (p. 212).

Pathological Grief

That the process of grieving can go wrong and not be completed in a normal manner is established in the literature. Goin, Burgoyn and Goin (1979) say of grief "the successful psychological adaptation and pathological adaptation have more in common than has been previously emphasized. The existence of an intraphysic attachment to a loved one is present in both. It is the nature of this attachment and the interference it causes with ego functioning that separates pathological from successful adaptation" (p. 989).

Freud (1917) distinguished between mourning and melancholia which both spring from the same cause, but differ in that the melancholiac also suffers from a lowering of self-esteem, experiences guilt and expects to be punished. Melancholia persists longer than grief, it might last forever. Speigel (1977) amplifies on this by saying that the melancholiac is one, who unlike the mourner, never frees himself from the introject. He sees pathological grief not only as distinct from normal grief, but in itself broad enough to encompass two separate areas: prolonged grief and distorted grief. Prolonged grief is grief that is not completed but gets stuck in one of the first three

stages (shock, control, or regression).

Distorted grief, as defined by Lindemann (1944) produces symptoms which are a direct cause of unresolved grief. The symptoms that might surface are overactivity which the person does not connect with loss, the formation of certain psychosomatic conditions, a change in the person's relations with loved ones, hostility directed against specific persons (such as the doctor), an inability to socially interact, the engaging in activities that are socially or economically detrimental to the person's existence, and "straight agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment" (p. 146).

Corney and Horton (1974) state "pathological grief has a predictable symptomatology and characteristics of its own. The chief among these are an inability to consciously mourn the deceased, the presence of a transitional 'linking' object, chronicity of normal grief symptoms, repetitive dreams in which the deceased is alive, and a peculiar inability to 'bury' the lost one" (p. 285). In addition, Corney and Horton feel that there is delayed grief, which is a specific type of pathological grief which they cite as " a postponement of the mourning process. When symptoms do

occur, they may be those of typical grief or may represent a distortion of mourning" (p. 285).

Volkan (1970) feels that the absence of normal grief is a symptom of pathological grief, "the patients with pathological grief reactions usually have a history suggesting the lack of symptoms of acute normal grief such as the ones described by Darwin, Lindemann, Clayton et al at the time of the loss" (p. 237). This echoes Deutsch (1937) who also felt that under the heading of pathological grief was the absence of grief. This results when the ego is too weak to cope with the loss. For Stack (1982) pathological grief, delayed grief, incomplete grief are all part of grief that has not been resolved:

These syndromes may include a persistent memory of events surrounding the loss; and an anniversary grief experience; persistence of intense affect, such as anger or sadness, when discussing the loss; a splitting of the cognitive and affective recognition of the loss, often manifested by verbalizations as if the lost person were still present; an inability to cry; emotional and irrational hanging on to linking objects; the presence and persistence of a variety of physical complaints, such as headache, fatigue, dizziness, and increased susceptibility to real

injury, illness, morbidity, and death; and flooding with intense disproportionate emotion at the time of subsequent loss or crisis. (p. 271)

Grief Reactions After a Spontaneous Abortion

Women who have had a spontaneous abortion encounter many, if not all of the barriers previously listed. In fact, Stack (1980) says:

Delayed unresolved and pathological grief reactions are common and often unrecognized occurrences following spontaneous abortion. The loss is frequently not appreciated, so the woman may not have the opportunity to work out her grief reaction...Spontaneous abortion is an experience that occurs when a woman is psychologically vulnerable. She may undergo a loss that is more profound than is recognized by others or even herself. She is subject to the grieving process and to prolonged, pathological or unresolved grief reactions.

(p. 99)

Speigel's (1977) previously listed seven factors that can prevent grief from proceeding normally (1) opposition to giving oneself up; (2) undeveloped ability to mourn; (3) a succession of losses; (4) external circumstances, forcing the bereaved to take

care of her own survival; (5) doubt about the reality of death; (6) ambivalent attitude toward the deceased; and (7) social and religious norms that demand self-control, all relate to spontaneous abortion (with the exception of the second factor) specifically in the following ways.

The opposition to giving oneself up is very apt both physically and psychologically. The child the woman has lost is very much a part of herself. The experience of women who have miscarriages during the later stages of their pregnancy is very much like giving birth. The fetus is pushed out through contractions of the uterus. While this is biologically natural, many women fight against the contractions for they know that delivery will result in a dead child.

Psychologically, the giving up of oneself involves a bit more. Volkan (1970) says "introjection does not aim at being like the object; its aim is to continue a relationship with the object, this time in the inner 'world'" (p.244). It is easy to understand why women may not be able to move beyond this step. The lost object is incorporated, but the breaking away from the introjection does not take place because the woman wants to continue the relationship with child.

Moscarello (1989) says:

During the third trimester there is psychological

preparation for the physical and psychological separation of the baby from the mother through labour and delivery. Immediately following the physical separation the baby is intro-psychically reattached to the mother's self. The psychological separation process between mother and child takes place slowly over years. It is never complete, as the child has a special life-long place with the mother. Herein lies one very important aspect of perinatal loss which must be acknowledged and resolved. Inadequate opportunity for intra-psychic reattachment of the baby to the mother's self-image is experienced by the mother as loss of part of the self (as if it were an amputation). The resulting feelings experienced by the mother include inadequacy as a woman, intense self-blame and guilt, lost of self-esteem and self worth. (p.13)

The third factor Speigel speaks of, a succession of losses is of significance to the woman who has encountered multiple spontaneous abortions. If each spontaneous abortion is looked upon as a non-event, as if there were no loss then the woman has many losses over which she has been unable to grieve. Speigel's fourth factor, with slight modification, also applies to women who have spontaneous abortions. While Speigel

concentrated on the survival of the bereaved being paramount and not permitting time to carry out the mourning process, with women it might not only mean her literal survival, but the pressing duties she must attend to day after day in order to insure the functioning of her family and her household. Society regards the woman as if she has no reason to grieve, and offers her no support, so the woman allows herself to succumb to the demands of children, family, and friends, who often tell her not to worry, she will have another baby. If the woman wants time to herself, if she wants to discuss her feelings, she is lost. She is not given the comfort that one is given if they had lost a spouse or a parent (Stack, 1980, Davidson, 1977).

Doubting the reality of death, Speigel's fifth factor is also applicable to women who have spontaneously aborted. When the baby is lost the woman does not see it; it is quickly taken away from the woman by hospital personnel. There is no tangible process of saying goodbye, no funeral. There is no chance to see the baby, to actually see the loss. For many women this doubt about the reality of death can last until she has some tangible proof that the child is gone, either a dilation and curettage, the onset of menstruation, or the failure of her body to continue

growing.

Ambivalent attitudes toward the deceased, Speigel's sixth factor, has been touched on earlier in this paper.

The final factor the Speigel mentions is perhaps one that is most ignored. There are prescribed social and religious norms to mourn death, yet none of these apply to the death of a child not yet born. The woman has no support from outside, perhaps with the exception of her husband. And even then he is coping with his own fears and disappointment, and may not be totally supportive of his wife (Pizer and Palinsky, 1980). In fact, each might be blaming the other for the loss of the child. Lasker and Toedter (1991) in their work on grief and pregnancy loss note that "a perceived lack of support from one's family is...a risk factor [in developing depressive symptomatology] in the long run, even though support from friends appears to be more important in the short run" (p.520).

Although not mentioned in his seven factors that complicate the resolution of grief, another factor that can cause grief to go awry is the suddenness of death. According to Speigel (1977): "I can say that the more unexpected the death, the more acute and disturbing the grief" (p. 834). Spontaneous abortion can take one day or two weeks (Pizer and Palinsky, 1980), but the onset

is sudden. Women who are pregnant do not expect to lose their baby. Even problem pregnancies do not prepare a woman for the possibility of loss. Volkan (1970) says in his study of 23 patients with pathological grief reactions "sudden loss can be experienced even after a period of prolonged illness on the part of the lost one" (p. 232). I feel that this can apply to the woman who is told after suffering cramps and bleeding that she is in the process of having a spontaneous abortion, and therefore knows what is happening. The loss is still experienced as sudden.

Stack (1980) working from a medical and cognitive framework lists 12 factors which he feels explain the development of delayed and pathological grief reactions following a spontaneous abortion. Many of his factors are the same as Speigel's. Stack's twelve factors are:

- (1) People usually do not even know that the woman was pregnant.
- (2) The woman is often embarrassed to mention that she has lost a baby.
- (3) She has frequently not resolved the ambivalence that is typical of the early narcissistic stage of pregnancy.
- (4) she has not identified the fetus as a new person, but rather has considered it part of herself.

Grieving for the loss of one's self is often different and more difficult than grieving for

the loss of an outside love object. (5) The woman is not able to identify with the 'lost person' even to the extent of having felt fetal movement and has recognized that 'someone else' was there. (6) She rarely sees the baby she has lost. She can only fantasize about the sex, size and personality of this person who was never to be. (7) There is no funeral. (8) There is rarely recognition by caregivers that a significant event has occurred. (9) Caregivers, family and friends often encourage denial and intellectualization. They rarely encourage the woman to cry, talk about her loss or assume the role of the bereaved person. (10) Miscarriage is usually sudden and unpredictable, it does not allow the woman a period of anticipatory grieving and preparation for loss. (11) Guilt is a nearly universal feeling experienced by women who have had a miscarriage. (12) A sense of helplessness occurs when the woman is bleeding and neither she nor her physician can do anything to stop it. As had been demonstrated by Seligman, helplessness is a cause of despair and depression. (p. 101)

One brief case report by Corney and Horton (1970)

illustrates several of the above factors. The patient came to see them at the urging of her husband. She was suffering from sleep disturbances. She said that she was not feeling depressed and she had no previous psychiatric history. She said that she felt as if there had been a death in the family, and during the interview it was discovered that she had a spontaneous abortion during her fourth month of pregnancy. "Almost immediately after it was indicated that there had indeed been a recent death in the family, she recognized what was bothering her" (p. 826). This patient's experience with miscarriage sums up the experiences of many women. She had been visiting out of town when the spontaneous abortion occurred. She was treated by a strange doctor, put in an overcrowded hospital, in the hall of the maternity ward. After the miscarriage, she heard the doctor tell the nurse to take the fetus away to the science lab. She never saw what she regarded as her child. Her husband was away and since she was in a maternity ward, she felt that her crying would depress the other patients. She was looking forward to a visit from her father; she was very close to him and felt that she could tell him her true feelings and cry in his arms. When her father arrived he came with a family friend, so the patient put on a cheerful face and said nothing about how she

felt.

One of the hardest things that women endure when they have had a spontaneous abortion is the lack of socially acceptable ways of expressing their grief, and I should add that this applies to fathers also. The lack of funeral rites is not a way to ease the parents' feelings, but rather a handicap. Volkan (1970) says that these rites do not seek to avoid grief but to aid it, and therefore, the bereaved should be allowed to indulge in them. Speigel (1977) concurs: "the ritual is an expressive act which in the ideal case aids the implementation of the process" (p. 10).

Women who have miscarried in the early stages of their first trimester usually do not produce anything other than clots of blood and tissue. But from the fourth month on the fetus is identifiable as an infant. Bowlby (1980) describes a woman whose baby died after a premature delivery. The mother was permitted to see the infant and encouraged to hold it. She picked him up, stripped his body naked and covered it with kisses. She then proceeded to walk the baby through the corridors of the hospital. Finally, she returned the dead child to the doctors. And Parrish (1980) says, "Mothers or parents of the spontaneously aborted fetus, may also have a need to view the fetus. The need will obviously be dependent on the length of pregnancy and

the usual variables" (p. 36).

When the woman that Corney and Horton (1970) reported on returned home she did not discuss her feelings with her husband who had been less than enthusiastic about the pregnancy. This woman's experience is not uncommon. Even with husbands who are happy about the impending birth, they are not always able to lend support to their spouses:

My husband said it was so hard to be supportive because he had such strong feelings. Anger: "God damn that woman! How could she have done that!" And misery - he wanted to crawl into a corner - and self doubts: "Can I have any children at all?" Maybe if we could have talked about it during the days I was beginning to miscarry, we could be less tense now. (Boston Women's Health Book Collective, 1976, p. 323).

The Impact of Pathological Grief

Pathological grief following a spontaneous abortion can have an impact on many areas of a woman's life. Her relationships with family members, particularly her spouse, and friends can suffer. Her treatment of children already born and those that are born after the spontaneous abortion might be altered in a negative fashion. She herself might experience a

variety of somatic complaints. And finally, her feelings about herself, her self esteem, might suffer and she might blame herself for what has happened.

Difficulties in the relationship with the spouse often occur because one or both partners are fearful of discussing their feelings. One partner may actually blame the other. Friedman and Gradstein (1982) say "pregnancy loss can strain even the best relationships. Couples who have relatively stable and long-standing relationships may find themselves arguing, feeling misunderstood, resenting one another, or withdrawing completely"(p. 127). Sexual intimacy which previously bound couples together might be abandoned at this time. As Berezin (1982) says in her book After A Loss in Pregnancy, the sexual act is now a reminder of the loss and might be avoided. Couples might feel guilty that sexual activity during pregnancy resulted in the miscarriage, and there might be medical restrictions on resuming intercourse after a spontaneous abortion. All these factors can impede marital relationships.

Reactions to existing children have been explored in cases of mothers having a stillbirth, though not specifically a spontaneous abortion. However, the pathological grief reactions of these women are the same. Lewis (1979) says "children born after a stillbirth where there has been a failure to mourn the

stillbirth, can have severe emotional difficulties. Many mothers have mothering difficulties with the child born subsequently" (p. 303). And Tooley (1975) talks of how the surviving children may be scapegoated, in some instances actually blamed for the stillbirth, and how they may be unfavorably compared to the idealized lost child. Even if neither of these situations occurs, if the mother is withdrawn and unavailable for the children this will certainly have a negative impact on them. Kirkley-Best and Kellner (1980) say:

The most common variant of delayed or absent grief among this group of mothers [those who had stillbirths] may be to rush into another pregnancy, usually within a year of the loss. Cain and Cain described a 'replacement child syndrome' occurring in reaction to any bereavement a mother might experience...The problems, both for mothers and children, are painfully evident: the mother, never having worked out her original grief, searches for her lost child and 'finds' it in the replacement child. The replacement child, however, is constantly compared with the idealized deceased child and therefore lives in the shadow of the dead child, often incapacitated by death phobias and fears of abandonment. (p. 423)

Theut, Pederson, Zaslow et al (1989) note "the majority

of women who experience a perinatal loss become pregnant within 2 years of the loss. Clinical reports suggest that a mother's unresolved grief can affect her emotional investment in a relationship to a subsequent baby" (p.635).

Somatic complaints seem to be a common indicator that grief has not been resolved and taken a pathological turn. Stack (1982) and Lindemann (1944) are two of many authors who have noted that the depressed person will complain of fatigue, insomnia, loss of appetite, and other physical ailments. Often the women are not even aware that they are in a state that is different from their normal functioning.

Finally pathological grief can be seen in feelings of guilt and worthlessness. Berezin (1982) talks of one woman who had successive miscarriages. Her husband began to refer to her as a "defective incubator" and she said that ultimately she began to regard herself as he did. Many women search over the entire pregnancy trying to pinpoint what one thing they did wrong, or could have prevented. Self esteem is extremely low as women wonder why they cannot do the one thing they were specifically designed to do from a biological viewpoint. Also, many woman are upset by the loss of control over their bodies.

Because of the effect that pathological grief can

have on a women and those who are close to her it is important to recognize pathological grief when it occurs and help the women come to some sort of resolution.

Conclusions and Areas for Research

After reading the literature both on grief and grief after a spontaneous abortion it was apparent that the first was full, built on case studies and systematic research, while what was available linking spontaneous abortion and grief was less complete. Pepper and Knapp, working with 65 women relied on self reports about the women's reactions to perinatal or neonatal loss in some cases occurring 36 years prior to the study.

Stack's work is experiential and the 12 factors he suggests cause pathological grief are the same as, or overlap with Speigel's factors. These can be used to form a correlation between barriers to grieving and pathological grief. It is important to understand what might prevent grief from proceeding to resolution after a spontaneous abortion and to remove these barriers. Those who come in contact with women who have suffered a spontaneous abortion can facilitate instead of hindering their return to normal and healthy functioning. They can do this by removing barriers that

prevent women from grieving over their lost child.

Hypotheses

Four hypotheses form the core of this paper (1) Women who have had a spontaneous abortion will experience grief as a normal reaction to this personal loss. (2) Women who have had a spontaneous abortion confront barriers or experiences that inhibit their resolution of depression or grief. (3) Women who have encountered a large number of barriers preventing the resolution of normal grief reactions will show signs of depression and will have a greater risk for developing pathological grief. (4) Women who develop pathological grief from unresolved reactions to a spontaneous abortion will experience difficulties in their roles as wives and mothers.

CHAPTER III

METHODS

Because of the large number of scales and questionnaires being used, and because only married women and women without extensive psychiatric histories were being sought the mailing of materials was done in two stages. The goal of the first mailing was to gather information about the subjects' marital status, their age, the number of miscarriages they had, and their past psychiatric history. In the first mailing the women received a letter explaining the purpose of the research, (Appendix I) the Demographic Questionnaire, (Appendix II) Beck Depression Inventory, (Appendix III) and the Barriers Questionnaire, (Appendix IV) plus five scales form the Marital Satisfaction Inventory: the Global Distress Scale, the Affective Communication Scale, the Time Together Scale, the Dissatisfaction with Children Scale, and the Conflict over Childrearing Scale. (Appendix V).

The Demographic Questionnaire asked for the subject's name, address, phone number, age, occupation, religion, marital status, and date of marriage. In addition it asked the subject the number of spontaneous abortions she had, in which trimester they occurred.

The subject was asked how many children she had, how old the children were, and were they born prior to or after any of the spontaneous abortions. The questionnaire also asked if the subject had a psychiatric hospitalization and if they had been in therapy for the treatment of depression.

The Beck Depression Inventory was completed following the standard directions, "After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling in the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice."

The Barriers Questionnaire had 14 items to be completed in a narrative form. This was constructed to allow a woman to subjectively describe her feelings about the experience of the spontaneous abortion.

The Marital Satisfaction Inventory is a True/False questionnaire. The subject was instructed to "read each statement and decide whether it is true or false when applied to you. If a statement is true or mostly true when applied to you circle the letter T. If a statement is false or not usually true when applied to you, circle the letter F. Answer each item to the best

of your ability." There was no fixed order in which the subjects had to fill out the questionnaires.

Based on the responses to the Demographic Questionnaire unmarried women and women who had had a spontaneous abortion more than 2 years prior to participating in the research were eliminated. Because subjects who met the selection criteria were to be contacted again this was not a blind mailing. All subjects had to give their name, address and phone number. From the beginning all subjects were advised that they might be contacted again and asked to supply more information, as well as be interviewed.

The purpose of the second mailing was to determine if the subjects had encountered any events in their lives other than a spontaneous abortion that might produce signs of depression and grief. For this the Schedule of Recent Experience (Appendix VI) was used. In addition, the role of the women as wives and mothers was looked at from the point of view prior to having had a miscarriage. To do this the subject was again given the five scales from the Marital Satisfaction Inventory, but instructed to fill them out retrospectively, as they might have responded prior to having their last spontaneous abortion. A consent form (Appendix VI) was included in this mailing. Over 200 initial packets were distributed. After the second

mailing was completed 5 subjects were contacted and agreed to be interviewed. The purpose of the interviews was to encourage the women to describe how they experienced the events surrounding the spontaneous abortion. The interview consisted of asking the subjects the same questions on the Barriers Questionnaire, allowing them to elaborate upon their responses in a personal, but structured manner. And because each subject interviewed was asked the same set of questions it was possible to see if any trends emerged.

Sample

Selection

Subjects were recruited in a variety of ways. Some women responded to ads placed in community and religious newspapers. Several gynecologists handed out packets of questionnaires in their offices, and a support group at a local hospital also made the packets of questionnaires available to members. Women were also contacted through mailings to graduate school students and to members of a professional association.

The women who participated in this study have had a spontaneous abortion within the two years prior to their participation. All subjects were adult women, 21 years of age or older. All subjects were married

prior to the onset of the last pregnancy that ended in a spontaneous abortion.

Although Bibring (1959) suggests the later in the pregnancy the loss occurs the more intense the grief, other authors (Neugebauer & Kline, 1992) feel that this is not influential on the intensity of the grief.

This study included subjects who experienced a spontaneous abortion at different stages of pregnancy. Women were also screened to determine if they had experienced any major stressful life events, such as the death of a family member during the past year. Such persons were excluded from the sample. This was done to ensure that symptoms of grief would not be from events other than the spontaneous abortion.

Women who also had a psychiatric hospitalization, or who have been in psychotherapy for the treatment of a chronic or recent acute disorder were not used.

Four of the subjects were psychologists, two were social workers, one was a teacher, one was an investment banker, one was an engineer and one was an operations manager.

Four of the subjects had doctoral degrees, three had masters degrees, two had completed college and one had completed high school and had some years of college. Family income ranged from \$50,000 to \$200,000 with a mean of \$98,660.

Four of the subjects were Jewish, three were Catholic, one was protestant, one was an Agnostic and one did not indicate a religious affiliation.

Four of the ten women responding indicated that they did have children. One subject had two children, one born prior to her first spontaneous abortion, and the second child was born after the first spontaneous abortion. This subject had five spontaneous abortions in all. The second subject had two children prior to her spontaneous abortion. The third subject had one child prior to having a spontaneous abortion. The fourth subject had one child who lived for only five days, prior to her spontaneous abortion.

The women reported from one to five spontaneous abortions each. Seven of the women having had only one. Three women were pregnant at the time of the study. None had ever been hospitalized for psychiatric problems, but two had been in therapy. The demographic characteristics of the women are summarized in Table 1.

Table 1

Demographic Characteristics of the Sample (N=10)

<u>Variable</u>	<u>Range</u>	<u>Mean</u>	<u>S.D.</u>
Age	25-41	33.6	3.6
Age at marriage	23-36	28.4	3.2
Years married	2-18	5.3	3.4

<u>Variable</u>	<u>N</u>	<u>%</u>	<u>Variable</u>	<u>N</u>	<u>%</u>
<u>Religion</u>			<u>Education</u>		
Jewish	4	40	High School	1	10
Protestant	1	10	College	2	20
Agnostic	1	10	Masters	3	30
Catholic	3	30	PhD	<u>4</u>	<u>40</u>
Missing	<u>1</u>	<u>10</u>	Total	10	100
Total	10	100			

<u>Variable</u>	<u>N</u>	<u>%</u>	<u>Variable</u>	<u>N</u>	<u>%</u>
<u># of Children</u>			<u># of Spontaneous Abortions</u>		
0	6	60	1	7	70
1	2	20	2	1	10
2	<u>2</u>	<u>20</u>	4	1	10
Total	10	100	5	<u>1</u>	<u>10</u>
			Total	10	100

Research Instruments

The following materials were used to gather information about the research questions. A questionnaire was devised to gather demographic information about the subjects and to aid in screening out inappropriate subjects. The Barriers Questionnaire was specifically developed for this study to evaluate how women perceived the experience of abortion. The Schedule of Recent Experience was used as a further screening tool. It allowed the researcher to see if any of the subjects had experienced major losses other than the spontaneous abortion, that would produce signs of grief or pathological grief. The Beck Depression Inventory was used to determine if subjects were experiencing depression, and if so how severe was the depression. The Marital Satisfaction Inventory was used to see if the subjects had experienced a change in their relationship with their spouse and children after the abortion and if so was there a relationship between grief, and the changes in their relationships.

Measures

Schedule of Recent Experience

The Schedule of Recent Experience (Amundson, M.E., Hart, C.A. and Holmes, T.H., 1981) gathers information about

42 life events. The edition used asked how many times each event occurred during the past year. The types of events included are: a major change in financial state, death of a close friend, gaining a new family member, sexual difficulties, pregnancy, marital problems including separation from spouse. Values are assigned to items on the schedule. The values come from the Social Readjustment Rating Scale, (Holmes, T.H. and Rahe, R.H., 1967) and are in the manual of the Schedule of Recent Experience. Experiencing trouble with one's in-laws is given a mean value of 29, while experiencing the death of a close family member has a mean value of 63. These values are multiplied by the number of times the event occurred, with a maximum of four occurrences used for scoring, yielding Life Change Units (LCU). The higher the number of units the greater the chance of illness in the near future. There is a 30% chance of illness in the near future if the subject has less than 150 Life Change Units. 150 to 299 Life Change Units suggests a 50% chance of illness in the near future, and 300 or more Life Change Units correlates with an 80% chance of illness. Amundson, Hart and Holmes, 1986 state "the reported change in health must occur within the 2-year period following the occurrence of a cluster of life changes." (p.4). For this study the nature of each event that has occurred is very important. For example, a woman could have experienced the death of a close relative, which

is given a value of 63. Another subject might have experienced a less traumatic event such as trouble with in-laws, given a value of 29. If a woman reports that she has had trouble with her in-laws 4 times that would yield a score of 116. The second woman's Life Change Units are higher than the first woman's, yet the nature of the stressful event she has experienced might not produce symptoms of depression.

Beck Depression Inventory

Beck Depression Inventory (Beck & Steer, 1987) was used because grief and depression share similar symptoms, and this measure rates the severity of depression, both in adolescents and adults. Twenty one symptoms and attitudes are listed. They include, mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusations, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image change, work difficulty, insomnia, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido. Under each of the twenty one statements are four responses. Each response has a number from 0 to 3. The subject was instructed to read the response in each group and circle the number next to one statement in the group that best described the way they were feeling during the past week. If they felt that several statements were appropriate they

were allowed to circle each one that applied. Beck categorizes the scores in four ways. Scores ranging from 0 to 9 are within the normal range and considered asymptomatic. Scores from 10 to 18 are indicative of mild to moderate to depression. Moderate to severe levels of depression are reflected in scores ranging from 19 to 29, and scores of 30 to 63 indicate that the subjects are experiencing extremely severe levels of depression.

Barriers Questionnaire

This questionnaire was developed to have subjects recall events immediately surrounding the spontaneous abortion. "Did you feel that the loss of your baby was sudden?" was asked because the suddenness of loss was seen as a cause of pathological grief (Stack, 1982, Speigel, 1977, and Volkan, 1970). "Did the loss of your baby seem unreal?" was used because Speigel (1977) stated that doubting the reality of death is a factor often present when grief has not been resolved. In addition, question three "Were you able to hold and/or see your baby?" was directly related to question two. A woman who answered yes to question three was not likely to have doubts about the death of her child.

Inquiring into whether the doctor or hospital staff encouraged the woman to discuss her loss was related to Stack's 1980 work on spontaneous abortion and pathological

grief. He said family physicians were in a unique position to facilitate normal grieving and to help prevent or detect a delayed or pathological grief reaction after a spontaneous abortion. "It is helpful to encourage the woman and her partner to talk about their experience, to ask questions and discuss such issues as cause, blame and guilt." (p.102). Consequently questions four; "Did your doctor or the hospital staff encourage you to talk about your loss?" was based on these factors.

"Did you and your spouse discuss your loss?", "Was there a family member you talked with about the loss of your baby?", and "How did friends approach you about the loss of your baby?" (questions five, six and seven) were based on the work done by Stack (1982, 1980) and Bowlby (1980). They both stated that caregivers, family and friends often encourage a form of denial that any significant loss has occurred. The woman is not encouraged to mourn or to assume the role of the bereaved.

Question eight, "Did you in any way feel responsible for the loss of your baby?" was used because a woman was more apt to encounter difficulty in resolving grief if she felt responsible for the baby's death. Deutsch (1937) noted that feelings of guilt may alter the course of mourning, preventing it from reaching a normal resolution.

Because Lindemann (1944) and Stack (1980) both said that an ambivalent attitude toward the deceased can cause

severe grief reactions, question nine, "Did you feel ambivalent about this pregnancy?" was in the questionnaire.

The last three questions: "Did you feel that others sympathized with you over your loss?", "Did you choose a name for your baby?" and "Did you have a memorial service or a funeral service for your baby? were included to see if a lack of a ritualized form of mourning made it more difficult for grief to be resolved. Much of the literature supports this concept.

In addition to gathering information that could be quantified, all subjects were encouraged to elaborate on their responses. This provided anecdotal material about how the women actually perceived the experience surrounding the loss of the baby.

It was hypothesized that women who encountered many of the barriers preventing the resolution of normal grief reactions would show signs of depression and will have a greater risk for developing pathological grief.

Marital Satisfaction Inventory

The Marital Satisfaction Inventory (Snyder, 1981) which consists of 11 scales, is designed to be a multidimensional measure of marital interaction. The marital relationship is looked at along several dimensions and each spouse, through self-report, provides information of their perception of the relationship which identifies the nature and extent of the

distress. The MSI is completed by each spouse separately, and still yields substantial clinical information about the relationship even if only one spouse completes it. The subject answers True or False to each question. The raw scores are then converted to T scores.

The **Global Distress Scale** was used because its 43 items assess overall marital satisfaction. Questions on this scale were of the type " I have important needs in my marriage that are not being meet" and "If it weren't for fear of hurting my mate, I might leave him." Low scores, (below 50T) indicate that the partner is committed to the marriage and that the difficulties present in the relationship are not divisive. T Scores of 50 to 65 signal dissatisfaction with the relationship and elevated scores of 65 or over "reflect strong feelings of alienation and anger towards one's spouse" (p. 25). This helped identify if the marriage in general was satisfactory prior to the spontaneous abortion, and if it continued to be so after the spontaneous abortion.

The **Affective Communication Scale** "deals with the process, rather than the content of verbal and nonverbal communication" (p. 26). This scale was used because it was theorized that a lack of empathy and an inability to share one's fears and sadness could be the result of unresolved grief. How did the woman relate to her husband, how did she feel he related to her prior to the spontaneous abortion.

Had that pattern changed? Was either partner more withdrawn or did the woman feel that her husband was closer and more supportive after the spontaneous abortion? Representative of the types of questions on this scale were "Just when I need it most, my spouse makes me feel important" and "My spouse doesn't take me seriously enough sometimes: and "My spouse feels free to express openly strong feelings of sadness." As with **Global Distress Scale** T scores of 50 or below suggest indicate that a couple feels close and intimate with one another. T scores in the moderate range of 50 to 65 suggest a level of distress and T scores of 65 or over reveal "extensive isolation and negative affect" (p. 26).

The **Time Together Scale** contained items that reflected how the subject felt about the content of leisure time she spent with her husband. It asked such questions as "My spouse and I don't have much in common to talk about" and "My spouse seems to enjoy just being with me." T scores of 50 or below suggest that couples enjoy spending their leisure time with each other and share various interests in common. Scores in the moderate range, 50 to 65 indicate a lack of common pleasurable pursuits, and T scores in the elevated range of 65 or over suggest that use of leisure time for common pleasurable pursuits has been severely interrupted. While this interruption can result from child care needs and the demands of a job, elevated scores on the

woman's part show a discontentment with the marriage that is so severe that a desire for separation or divorce is present.

Ancillary information about the effect of the spontaneous abortion on children was obtained by using two additional scales. The **Dissatisfaction with Children Scale** was designed to look directly at how much satisfaction a parent derives from their relationship with their children. In this study the scale was used to see if the way the mother viewed her existing children changed after the spontaneous abortion. Questions such as "My children rarely seem to care how I feel about things" and "I frequently get together with one or more of the children for fun or recreation at home" were on this scale. T scores of 50 or below point to a positive relationship with children. Scores in the moderate range of 50 to 65 could suggest dissatisfaction with either the childrearing role of the children themselves. Elevated scores of over 65 indicate that the children might be need of professional help.

The last scale to be used, **Conflict Over Childrearing**, showed if the wife felt the couple's roles as parents had changed since the spontaneous abortion. Questions such as "My spouse and I rarely argue about the children" and "My spouse doesn't spend enough time with the children" are on this scale. Again, T scores of 50 or below indicate that the wife viewed her husband's participating in childrearing

positively. Scores of 50 to 65 indicate that the wife feels that responsibility for childrearing is not equally shared and scores over 65 indicate deep dissatisfaction by the wife toward her husband's involvement with children. These two scales were completed for the three subjects who had children. The fourth subject with a child did not fill out these scales because her son had died five days after birth.

In summary, the major hypotheses to be tested are

1. Women who have had a spontaneous abortion grief will experience grief as a normal reaction to this personal loss.
2. Women who have had a spontaneous abortion confront barriers or experiences that inhibit their resolution of depression or grief.
3. Women who have encountered a large number of barriers preventing the resolution of normal grief reactions will show signs of depression and will have a greater risk for developing pathological grief.
4. Women who develop pathological grief from unresolved reactions to a spontaneous abortion will experience difficulties in their roles as wives and mothers.

CHAPTER IV

RESULTS

The study reported here was designed to investigate a woman's experience of grief and its resolution and consequences following a spontaneous abortion. Participating women were measured on the Beck Depression inventory, the Schedule of Recent Experience, and several scales of the Marital Satisfaction Inventory. The women also completed a background and demographic data form and a questionnaire concerning aspects of their experience with the spontaneous abortion. The results of the study have been organized under four headings: (1) measured depression and stressful life events; (2) respondents' perceptions of the experience of the spontaneous abortion; (3) relationships between measured depression and respondents' perceptions of the experience of the spontaneous abortion, and (4) marital satisfaction pre and post spontaneous Depression and Stressful Life Events

Hypothesis I is that women who have had a spontaneous abortion will experience grief as a normal reaction to this personal loss. Scores on the Beck Depression Inventory (BDI) ranged from 0 to 23, with a mean of 8.3 (SD = 7.5). Scores ranging from 0 - 9 indicate no signs of depression are present; from 10 - 18 mild to moderate levels of depression; from 19 - 29 moderate to severe levels of

depression, and from 30 to 63 extremely severe depression.

Three of the 10 women in the sample had scores above the threshold core of 9 signifying mild to moderate depression. Of these, one individual with a score of 14 was classified as mildly depressed, and two women, one with a score of 20 and the other with a score of 23, were classified as moderately depressed.

Life Change Units (LCU) scores on the Schedule of Recent Experience (SRE) ranged from 0 to 897. LCU's over 300 indicate an 80% chance of illness in the near future. LCU's of 150-200 suggests a 50% change of illness and LCU's less than 150 suggest only a 30% chance of illness. All but three of the respondents had SRE scores that were sufficiently high as to categorize the respondent as having a 80% or better chance of a stress-related illness during the next year. These seven women had scores of 432 LCU's, 518 LCU's, 548 LCU's, 667 LCU's, 669 LCU's, 725 LCU's and 897 LCU's.

Thus the women generally appear to have experienced a large number of stressful life events during the previous year (including the spontaneous abortion) but none of these events was on the magnitude of losing a husband, family member or friend, or getting a divorce; events which would also be considered able to induce depression. Although the women did have high levels of stress, relatively few manifested clinically relevant levels of depression as

supported by the scores on the Beck Depression Inventory.

The Experience of the Spontaneous Abortion

Hypothesis II stated that women who have had a spontaneous abortion confront barriers or experiences that inhibit their resolution of depression and grief.

Table 2 presents frequency distributions of responses to questions concerned with the experience of having a spontaneous abortion. The data in the Table indicate that 80% of the respondents experienced the loss of the baby as sudden and unexpected, and 60% experienced it as unreal. None of the respondents reported being able to see and/or hold the baby.

Half of the sample (50%) said that the hospital staff did encourage them to talk about the abortion, and all of the respondents indicated that they had discussed the loss with their spouse. More than half (70%) indicated that they had been approached by friends regarding the loss, and 90% indicated that they did have a family member with whom they could talk. On balance, then it appears that most of the women had some type of social support.

Only three of the women (30%) indicated that they felt responsible for the abortion, and only one respondent (10%) indicated that she had been ambivalent about the pregnancy. All of the respondents indicated that the baby had been wanted. Nine of the respondents (90%) felt that others had

been sympathetic about the event.

Table 2Perceptions of the Experience of a Spontaneous Abortion

<u>Variable</u>	<u>Value</u>	<u>N</u>	<u>%</u>
Was the loss of the baby sudden and unexpected?	Yes	8	80
	No	2	20
Did the loss seem unreal?	Yes	6	60
	No	4	40
Were you able to see/hold the baby?	Yes	0	0
	No	10	100
Did hospital staff encourage you to talk about your loss?	Yes	5	50
	No	3	30
	Other	2	20 ¹
Did you and your spouse discuss the loss?	Yes	10	100
	No	0	0
Did you discuss the loss with a family member?	Yes	9	90
	No	1	10
Did friends approach you sympathetically about your loss?	Yes	7	70
	No	1	10
	Other	2	20 ²
Did you feel responsible for the loss?	Yes	3	30
	No	6	60
	Other	1	10 ³
Did you feel ambivalent about the pregnancy?	Yes	1	10
	No	9	90
Did you feel others sympathized with you about your loss?	Yes	9	90
	No	1	10
Did you chose a name for your baby?	Yes	4	40
	No	6	60

Table 2 (continued)

Did you have a memorial service for your baby?	Yes	0	0
	No	9	90
	Other	1	10 ⁴
Was this a wanted baby?	Yes	10	100
	No	0	0

¹does not apply, subjects were not in hospital

²friends did not know subjects were pregnant

³one subject reported feeling some responsibility about the
loss

⁴the husband of one subject baptized the baby

Fewer than half of the subjects (40%) indicated that they had chosen a name for the baby, and none reported having held a memorial service for the baby (although one woman reported that her husband had baptized the child).

Relationships Between Depression and Other Measures

Hypothesis III stated that women who have encountered a large number of barriers preventing the resolution of normal grief reactions will show signs of depression and will have a greater risk for developing pathological grief.

In order to determine whether depression was related significantly to the women's perceptions of events surrounding the abortion, a series of independent t-tests were carried out. The results of these tests are presented in Table 3. Note that not all of the perception variables are included in this table. This is because there was little or no variability on some of these perception variables. For example, all respondents reported discussing the loss with their spouse, and none reported having a memorial service. Only those perception measures are included in Table 3 where there were at least 3 individuals in the smallest response group.

The tests presented in Table 3 were all nonsignificant. However, the statistical power of these tests was quite low, due to the very small sample size.

Table 3Abortion Depression by Selected Perceptions
of the Experience of Abortion

<u>Variable</u>	<u>N</u>	<u>Yes</u>		<u>Response</u>			<u>t</u>
		<u>Mean</u>	<u>SD</u>	<u>N</u>	<u>Mean</u>	<u>SD</u>	
Staff encouraged talk	5	5.80	9.68	3	10.33	3.21	-0.76
Did you feel responsible	3	8.67	12.50	6	7.67	8.12	0.13
Did you choose a name for the baby	4	11.0	12.19	6	6.00	5.25	0.91

involved. The mean difference on the BDI scores between those respondents who were and were not encouraged to talk about their spontaneous abortion appears large enough to warrant further study. It possibly suggests that encouragement by hospital staff to talk about the loss immediately may alleviate potential depression related to the experience of abortion.

Changes on Marital Satisfaction Inventory Scales

Hypothesis IV states that women who develop depression or pathological grief from unresolved reactions to a spontaneous abortion will experience difficulties in their roles as wives and mothers. Pearson Correlations were obtained between scores on the BDI and post abortion scores for Global Dissatisfaction, Dissatisfaction with Affective Communication, and Dissatisfaction with Time Together. These correlations were $-.10$, $-.13$, and $-.12$ respectively. None of these correlations was significant. These findings suggest no relationship between depression and the measured aspects of marital satisfaction.

Respondents completed five scales of the Marital Satisfaction Inventory (MSI) twice. The first time they completed the MSI they were given instructions to read each statement and if it was true or mostly true circle the letter T. If a statement was false or not usually true when

applied to you, circle the letter F. Answer each item to the best of your ability. When the subjects received the MSI a second time, within three weeks, the instructions were the same, but now they were asked to complete the scales as they would have responded prior to their last spontaneous abortion. Thus retrospective pre-abortion scores could be compared to post-abortion scores on the same scales.

Table 4 presents the results of correlated sample t-tests carried out to compare scores on the MSI scales referring to before and after the abortion. These tests were significant for both Global Dissatisfaction ($t = 2.03$, $df=9$, $p < .05$) and Affective Communication ($t = 2.15$, $df = 9$, $p < .05$). In each case, dissatisfaction was greater following the abortion than it was prior to the abortion. These findings suggest that the occurrence of a spontaneous abortion may indeed have an adverse impact on marital satisfaction. This finding is interesting in view of the fact that few of the women were categorized as depressed according to the BDI. One is led to suspect that the negative effect of the abortion on marital satisfaction is not a function of increased depression on the part of the wife; the wife does not experience more feelings of depression but rather experiences dissatisfied feelings with her relationship to her husband in general, and specifically with the way they relate to each other.

Table 4Marital Satisfaction Inventory Scales Prior to And
After the Spontaneous Abortion (N=10)

<u>Scale</u>	<u>Before Abortion</u>		<u>After Abortion</u>		t
	Mean	SD	Mean	SD	
Global Dissatisfaction	47.8	7.48	53.1	11.5	2.03*
Affective Communication	47.8	9.21	51.1	9.30	2.15*
Time Together	49.5	8.78	53.4	11.78	1.28

*(p <.05, one-tailed)

CHAPTER V

DISCUSSION

A summary of the findings of this study and implications will be discussed in this chapter. In addition anecdotal material from the five interviews based on the Barriers Questionnaire will be included to add to our interpretation of the results.

The limitations of this study, as well as areas for future research will also be discussed.

Hypothesis I, women who have had a spontaneous abortion will experience grief as a normal reaction to this personal lose was not supported by the results of this study. This finding does not support the literature which indicates that grief, as manifested by symptoms of depression, is to be expected after a spontaneous abortion (Pizer and Palinski, 1980; Kirkley-Best, 1984; Friedman and Gath, 1989). Only three of the ten women had scores on the Beck Depression Inventory that indicated they were experiencing depression. Of these three women, one was in the mild - moderate range of depression, and two were in the moderate - severe range. These women did not suffer any other losses, such as the death of a family member or close friend, or experience any sort of major illness that would account for the signs of depression.

The three women who did report levels of depression on

the Beck Depression Inventory reported some degree of difficulty in relating to other people. All three reported being sad, two saying they were sad all the time and unable to snap out of the feeling. All three reported negative feelings about their physical appearance ranging from feeling older and unattractive to believing that "I look ugly."

It is possible that the number of women experiencing depression was small because of the support and sympathy the women received from family members, other than their husband, and friends. The ability to talk to someone about the loss of the baby may be a significant factor in facilitating the grief process. To talk to others acknowledges that a loss occurred and removes the spontaneous abortion from the realm of a "non-event."

The second hypothesis studied was: Women who have had a spontaneous abortion confront barriers or experiences that inhibit their resolution of depression or grief. The specific barriers that this study inquired into were formulated on the works of Stack (1980, 1982), Spiegel (1977) and Volkan (1970), they were: 1 - suddenness of the death, 2 - doubting the reality of the death, 3 - lack of concern and meaningful discussion about the loss from the immediate caregivers such as doctors, midwives and other hospital personnel, 4 - lack of discussion between the husband and wife about the loss of the baby, 5 - lack of

support from other family members and friends, 6 - a feeling of being responsible for the death or having been able to prevent it in some way, 7 - ambivalent attitude about the deceased, in this case an ambivalent attitude about being pregnant, and 8 - lack of recognized and/ or ritualized forms of mourning. This hypothesis was partially supported. As a group the women encountered four of the barriers: the loss of the baby was sudden and unexpected, the loss seemed unreal, there was little or no support from those who came in contact with doctors, or hospital staff, and there was no ritualized form of mourning for the majority of the women. The fourteen questions on the Barriers Questionnaire addressed these eight barriers. The subjects, in addition to answering yes or no, were able to elaborate their responses to probes that encouraged them to express their feelings. In addition, this questionnaire was used to interview five subjects.

For all the women the abortions were perceived as sudden and unexpected. In some cases the spontaneous abortions were seen as unreal. During the interviews Subject 1, who had a total of four miscarriages said "I just assumed, I mean I was always healthy and had pretty normal periods in my whole life so I really didn't think I'd have a miscarriage. I mean I know a little about them, we were fearful after the first one, but they were unexpected because we didn't know what the problem was. My doctor told

me it was very common and very unlikely that I'd have another one and that's why it was a surprise, I really didn't think I had a problem. The fourth was also very unexpected...in the sense that I didn't think it could happen again.

Subject 3 said "I felt it was unexpected and sudden. I had been spotting but I had been to the doctor's two weeks before and everything was fine. The doctor sent me for a sonogram just to make sure. The radiologist seemed very aloof, you know New York snippy attitude. I asked to see the baby when the vaginal sonogram was done after nothing was seen on the other sonogram. The woman (probably a technician) left the room and the radiologist came back and had to break the bad news to me." Subject 5 responded "I just didn't believe that two things like this [the subject had given birth to a son who had lived for 5 days] would happen in a row. Subject 10, who had five miscarriages and two children said "by the 4th and 5th miscarriages I was nervous, apprehensive and fearful, but the loss was still difficult."

While the women did not doubt that they had a spontaneous abortion, 7 of the 10 did feel that the experience was "unreal". Subject 9 said " I was carrying twins. I didn't know I was carrying two and then it was over." Subject 3 said "It's hard to explain...the idea that you're pregnant and then all of a sudden with no gore, or warning, you're

not!"

When asked if a doctor or midwife or any member of the hospital staff talked with the women about their loss, 5 women were not in the hospital and the replies from the 5 who were hospitalized varied. Subject 4 said no one at the hospital talked with her, and subject 9 gave the same response. Subject 7 said "They told my husband and myself about group therapy sessions. We never went." and Subject 11 replied "a nurse talked to me and asked if I wanted to see a chaplain." Most distressing was the response of Subject 10 who said no one talked with her and "in addition having the D & C done in the labor and delivery unit of the hospital may be efficient, but it is hard on the patient to hear other people giving birth."

While all of the subjects reported talking with their husbands about the loss of the baby, the quality of the perceived support from the spouses varied. Subject 1 said her husband was very supportive, " he felt very bad because he was away [while the subject had her first spontaneous abortion]. He wanted to have a baby and we just knew we'd have a baby, we assumed it." Subject 2 responded yes on the Questionnaire when asked if she discussed the loss with her spouse. When interviewed however, she said: My husband doesn't do well in illness, another person's suffering he doesn't handle well...he didn't handle this well... it was just much more removed." Subject 3 was surprised by her

husband's support. "Bill, both his parents are alcoholics, he's really closed up. I was surprised he was very supportive. He let me know he was willing to talk as much as I needed to. Both of us went to therapy after this. I felt it was time to clean house. I had to find out what I wanted to do..." While subject 5 said she talked with her husband but "not as much as I would have liked. I got support from groups and social workers. He doesn't deal with...he deals with his problems by just forgetting about them instead of discussing them. I need to talk about them, go to groups and talk to other people who have experienced it where he would rather never talk about it. Whenever I needed to cry he was there with his shoulder, but he never discussed his feelings about it, and I guess I just didn't discuss it too much because I just didn't get the response I needed from him." Subject 7 had a similar response. She reported talking about it with her husband, but added " I think it was easier for me to talk about it than him. It still bothers him if I bring the subject up. Subject 10 replied "We shared the pain."

While the amount of support the subjects received from their husband's varied, there was a high degree of support from family members. Nine of the ten subjects reported getting support from family members, with 5 of the nine specifically mentioning their mothers as being particularly supportive. Subject 7 said " I spoke to my family more

than anyone." Subject 1 said "I talked to my mother... mostly my mother. She was very supportive." In addition, brothers, sisters and fathers were specifically named. The only subject who did not speak with family members was Subject 10, who seems to have had a high degree of empathetic support from her husband.

Also, most of the women did receive support from friends. Two women did not reveal that they were pregnant, and did not discuss the loss with friends after it happened. Subject 3 said her friends were "...very bad. They acted like nothing happened. This made things even worse for me." Subject 5 made the point that talking with friends was very important. She spoke mostly with friends from her support group. "Those were the ones who I was really comfortable talking with, because they didn't feel uncomfortable mentioning it. People who haven't gone through it feel that if I'm not talking about it then I'm not thinking about it. But they don't realize that it really helps to talk ." Subject 7 said "They were concerned for me, people expected me to fall apart. Some people would say you'll have more, but if I do, that will not replace what I lost. That's what you do, deal with, the loss." Subject 9 said of her friends "They said they were sorry to hear the news and that it probably was for the best. It's God's will."

Seven of the women did not in any way feel responsible for the spontaneous abortion. Subject 9 said " I felt

somewhat guilty for not stopping work and resting more." and Subject 10 said "not directly, but I have a feeling God might be testing me or punishing me and that's the reason for my miscarriages. That's related directly to my religious beliefs." and Subject 11 when asked if she felt responsible for the spontaneous abortion said "yes, in that I felt my body was inadequate to hold the child."

Only one subject reported feeling ambivalent about being pregnant. All of the women answered yes when asked if they wanted to be pregnant. When asked what the loss meant at this time in her life Subject 1 said "I felt more pressure than I would have in my twenties. I just felt like what's going to happen if I can't carry a baby? That was unreal, the idea that I might not be able to have a baby." Subject 5 responded "It was devastating. I had lost my son and my future plans only eight months before. When I became pregnant I felt it was a new start. I wasn't really thinking about miscarriage because I knew I could carry a baby full term. When the doctor told me I would miscarry (the 8 week sonogram showed no development, no heartbeat, and I was spotting: I was in shock. Not this baby too. It was just as painful as before. My future was gone. What was wrong with me I don't drink, smoke, take drugs. I eat very healthy and consider the pregnancy as my first priority in anything. So why can't I have baby?"

As to the last barrier, lack of recognized and/ or

ritualized forms of mourning, none of the women had any ceremony or memorial service for the baby, but one subject, who is Catholic, reported that her husband baptized the baby. From a religious point of view that would allow the baby to enter heaven. Subject 5 said "what I do is they [Methodist Hospital] have a memorial service every year and I go every year. I also belong to an organization called Penparents which is people who write to each other and on the birthday they always put both names so in the March issue they put Matthew [her son who died after 5 days] and baby boy Smith [Subject's name has been changed]. And I also light a candle for him at the memorial service."

In all the subjects encountered four of the eight barriers. They did experience the spontaneous abortion as sudden and unexpected event, and many felt it to be an unreal experience, two of the barriers that can be obstacles to the resolution of grief. Of those who were hospitalized most did not talk in depth with a doctor or hospital professional, another obstacle. While all of the women and their husbands talked about the loss of the baby, the answers indicate that the talks were not always as empathetic as the women would have liked. However the women all received support from family members and friends. The women as a group did experience a high degree of social support, so lack of support was not an obstacle. Few of the women felt responsible for the spontaneous abortion, another

barrier not encountered. And only one was ambivalent about being pregnant. Most of the women did not have any ritualized form of mourning, another barrier that makes grief difficult to resolve.

It is possible that the women as a group had few signs of depression because they did not encounter most of the barriers that would impede the resolution of grief. The three women who did have scores on Beck that indicated depression all reported discussing the loss with their spouse, two discussed the loss with family members, however, support from friends appeared to be lacking. One did not tell anyone that she was pregnant, another felt only one friend was supportive but the others were not and the last said her friends sympathized, but she did really feel any comfort from any source. While the women as a group did not suffer from depression this finding supports, in part, the literature that suggests support from family and friends can facilitate the resolution of grief. Stack (1980), feels that the role of family and friends in helping the women through her grief is essential. He said if they "encourage denial and intellectualization" of the loss resolution is grief is farther complicated. It is possible that receiving support from friends should be looked at as separate from having support from family.

Hypothesis III, Women who have encountered a large number of barriers that prevent the resolution of normal

grief reactions will show signs of depression and will have a greater risk for developing pathological grief, was not supported by this study. Seven of the ten women showed no signs of depression, one was in the mild - moderate range and two were in the moderate - severe range.

The final hypothesis, pathological grief can cause difficulties for a woman in her role as wife and/or mother was not supported. However, even though there were no signs of pathological grief, there was global dissatisfaction with their marriages and dissatisfaction with affective communication following the spontaneous abortion. This finding is in an agreement with the research of Friedman and Gradstein, (1982) and Berezin, (1982) who found that even the best marital relationships were strained after a spontaneous abortion.

This suggests that a spontaneous abortion can influence the marital relationship. For example, Subject 7's pre **Global Dissatisfaction** T scores was 46, indicating a close relationship with her spouse. After the spontaneous abortion her T score on this scale was 72 indicating feelings of anger and alienation. Responses to statements such as "I have never thought of myself or my spouse as needing marital counseling" and " I am quite happily married" changed from True to False.

This same subject's pre and post T score on the **Time Together** scale changed significantly from a pre T of 52 to a

post T of 72. Her responses to "My spouse and I don't have much in common to talk about" and "My spouse sometimes seems to spend more time with his friends than with me" changed from False on the pre scale to True on the Post scale.

Subject 2's pre T score on the **Global Dissatisfaction** scale was 51, her post T score was 60. Her response to the statements "I believe our marriage is reasonably happy" and "My mate rarely does things that make me angry" changed from True to False. Responses to the statements " I have important needs in my marriage that are not being met" and "My marriage is less happy than the very successful ones" changed from False to True.

The change on subject 10's **Affective Communication** scale, while remaining within the range indicating a close relationship with one's spouse did increase from a pre T score of 41 to a post T of 47. Her response to statements "Sometimes my spouse just can't understand the way I feel" and "My spouse and I communicate very little simply through the exchange of glances" went from False on the pre scale to True on the post scale. There was no change among the three subjects who had children on the **Conflict over Childrearing Scale** and the **Dissatisfaction with Children Scale**.

Limitations of the Study

The size of the sample and the heterogeneity of the group was limited. Over 150 questionnaires were mailed to

psychologists and graduate students. Questionnaires were also given to three obstetricians and one hospital based bereavement group. In addition, advertisements were placed in local community papers. The small response size might be attributable to the fact that the subjects had to identify themselves. In addition the women who responded did not represent a broad strata of society. Indeed, most of the women were in the middle to upper-middle class and well educated. This population generally has access to support groups and psychological interventions which might have helped ameliorate feelings of depression.

In addition, many of the women were mental health professional and might have been familiar with the measures used. This knowledge might have influenced the way the women responded to the questions.

The Barriers Questionnaire, while proving to be a valuable tool for structured interviews, was not normed or standardized and was created solely for this study based on an amalgam of the works of other researchers. It might be more useful if this questionnaire was further refined to let women respond more specifically to each question by incorporating a scale with meaningful categories across a designated range.

Conclusions

Women who have a spontaneous abortion did not necessarily show signs of grief that can be measured by depressive symptoms. However, the information obtained from the Barriers Questionnaire and the interviews revealed that a spontaneous abortion is a devastating event.

And the consequences of the loss of the baby, while not leading to pathological grief, for many of the women lead to profound changes in their lives. One subject reported that because of this loss "both of us [she and her husband] went to therapy after this. I felt it was time to clean house. I had to find out what I wanted to do. I spoke of being artistically inclined, I don't really like banking [her occupation at the time] ...My mother said I'd never really make money being an artist. She really discouraged me. I'm thinking of trying to change jobs, but I'm making good money so it's hard." For this woman, the spontaneous abortion prompted a reevaluation of her life.

Women do encounter a reluctance or inability on the part of medical personnel to offer psychological support. Many of these subjects reported that the loss had and "unreal" quality, it was treated like a "non-event." If women were encouraged to view the spontaneous abortion as a death and if they were given "permission" by medical personal to mourn this might legitimize the loss. The fact that those immediately involved in the loss act as if

nothing happens might suggest to the mother that she has no real reason to feel sad or grieve. This finding suggests that hospital personnel, doctors, nurses in offices as well, all those who are the first ones to tell a woman she has had a spontaneous abortion, need to be encouraged to provide emotional support immediately.

It appears that support from family members and friends is very therapeutic and eased the women's loss and provided them with a needed outlet for their feelings. A significant person for the woman experiencing a spontaneous abortion turned out to be her mother. Most women responded that they talked with their mother and most felt significant comfort from her. Also, siblings, even brothers, were a source of comfort.

All the women felt that their husbands offered support, however most felt the support was not the kind of support the women felt they needed or wanted. Indeed, the most significant finding of the study was that the women felt more dissatisfied with their marriages after the spontaneous abortion, and felt that the intimate and affectionate way in which they and their husbands communicated with each other had changed for the worse.

It seems that while most of the women talked to their husbands about their feelings, they did not talk "with" their husbands. The women wanted the husbands to feel comfortable in initiating the conversation. Also, it

appears that most of the women felt they were engaged in a monologue, that the husbands were uncomfortable expressing their feelings, and also the women wanted their husbands to feel the same way the women did. The spontaneous abortion revealed the complexity of the relationship between husband and wife. The responses to the **Affective Communicaton** scale, the Barriers Questionnaire and the interviews revealed that the impact of the spontaneous abortion subtly manifested inself in significant ways. It was apparent from this material that intervention for both husband and wife, as a couple, following the spontaneous abortion may well lessen any ensuing estrangement.

Suggestions for Further Research

Further studies need to separate women into larger groups divided along more precise time lines. Women should be looked at 3 months after loss, 6 months, 12 months and at least 2 years later. While this study had women in all those groups the sample size was too small.

In addition, it would be helpful to determine if there is a difference between receiving support from family members and receiving support from friends. While husbands were supportive of their wives, it often appeared not to be enough support. Research into what type of communication and intimacy women feel would be helpful is needed.

APPENDIX IRESEARCH MATERIALS

Pamela D. Trunk
153 Underhill Avenue
Brooklyn, N.Y. 11238
(718) 638-7541

Dear Colleague:

I am a doctoral candidate in the Psychology program at the City University of New York. I am doing research on the relationship between spontaneous abortion (miscarriage) and the reactions a woman has afterward. This letter is to request your participation in this study.

The purpose of this study is to gather information about women's reactions after a spontaneous abortion. Some women feel they have no one to share their experience with. The study will allow women to share some of their experiences and reactions to a spontaneous abortion. This information will provide helpful insight and interventions for professionals working with women who might have a spontaneous abortion.

If you, or someone you know, has had a spontaneous abortion within the last two years, and are interested in participating in this study please fill out the enclosed questionnaires and return them to me. You might be contacted again to provide additional information. This can be done through the mail or during an interview. All information will be kept confidential, no women will be individually identified. Your participation in this project will be greatly appreciated.

Sincerely,

Pamela D. Trunk, M.A.
Researcher

A. J. Franklin, Ph.D.
Supervisor
(212) 650-6604

APPENDIX II

DEMOGRAPHIC QUESTIONNAIRE

Name:

Address:

Telephone Number :

Age:

Occupation:

Religion:

Marital Status:

Date of marriage:

Family Income:

Highest level of education completed:

How many spontaneous abortions have you had?

What was the date of your last spontaneous abortion?

In which trimester were you when you had your most recent spontaneous abortion?

How many children do you have?

Please list the ages of your children:

Did you have any children prior to your first spontaneous abortion?

If so, how many?

Did you have children after any of you spontaneous abortions?

If so, after which spontaneous abortion?

Have you ever been hospitalized for a psychiatric illness?

Have you ever been in therapy for treatment of depression?

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**Appendix III
Pages 88-89**

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APPENDIX IV

BARRIERS QUESTIONNAIRE

1. Did you feel that the loss of you baby was sudden and unexpected?
2. Did the loss of your baby seem unreal?
3. Were you able to hold and/or see your Baby?
4. Did the hospital staff encourage you to talk about your loss?
5. Did you and your spouse discuss your loss?
6. Was there a family member you talked with about your experience?
7. How did friends approach you about the loss of your baby?
8. Did you in any way feel responsible for the spontaneous abortion?
9. Did you feel ambivalent about the pregnancy?
10. Did you feel that others sympathized with you over your loss.
11. Did you choose a name for your baby?
12. Did you have a memorial or funeral service for your baby?
13. Was this a wanted pregnancy?
14. What did the loss of your baby mean to you at this time in your life?

APPENDIX V

MARITAL SATISFACTION INVENTORY

Name _____ Date _____
 {Retrospectively}

This inventory consists of numbered statements. Read each statement and decide whether it is true or false when applied to you. If a statement is true or mostly true when applied to you circle the letter T. If a statement is false or not usually true when applied to you, circle the letter F. Answer each item to the best of your ability.

1. I believe our marriage is reasonably happy. T F
2. My spouse almost always responds with understanding to my mood at a given moment. T F
3. I have never thought of myself or my spouse as needing marital counseling. T F
4. My spouse and I don't have much in common to talk about. T F
5. It is sometimes easier to confide in a friend than in my spouse. T F
6. I am quite happily married. T F
7. My spouse and I enjoy doing things together. T F
8. I have never felt better in my marriage than I do now. T F
9. Sometimes my spouse just can't understand the way I feel. T F
10. My mate rarely does things that make me angry. T F
11. I wish my spouse would confide in me more. T F
12. There are some important issues in our marriage that need to be resolved. T F
13. My spouse and I spend a good deal of time together in many different kinds of play and recreation. T F
14. I am quite satisfied with the amount of time my spouse and I spend in leisure. T F
15. My spouse and I seem to have little in common when we're not busy with social activities. T F

MARITAL SATISFACTION INVENTORY (continued)

- | | | |
|--|---|---|
| 16. I've gotten more out of marriage than I expected. | T | F |
| 17. My spouse feels free to express openly strong feelings of sadness. | T | F |
| 18. At times I have very much wanted to leave my spouse. | T | F |
| 19. My mate and I seldom have major disagreements. | T | F |
| 20. My spouse and I frequently sit down and talk about pleasant things that happened during the day. | T | F |
| 21. I have important needs in my marriage that are not being met. | T | F |
| 22. My spouse can usually tell what kind of day I've had without even asking. | T | F |
| 23. I am fairly satisfied with the way my spouse and I spend our available free time. | T | F |
| 24. I have wondered, on several occasions, whether my marriage would end in divorce. | T | F |
| 25. My spouse has never taken pleasure in hurting me personally. | T | F |
| 26. My spouse is so touchy on some subjects that I can't mention them. | T | F |
| 27. My marriage has been disappointing in several ways. | T | F |
| 28. My spouse and I rarely go for walks together. | T | F |
| 29. It is unusual for my spouse to openly express strong feelings of tenderness. | T | F |
| 30. There are some serious difficulties in our marriage. | T | F |
| 31. Whenever I'm feeling sad, my spouse makes me feel loved and happy again. | T | F |
| 32. My marriage could be much happier than it is. | T | F |
| 33. The future of our marriage is too uncertain to make any serious plans. | T | F |
| 34. Our daily life is full of interesting things to do together. | T | F |

MARITAL SATISFACTION INVENTORY (continued)

35. My marriage is less happy than the very successful ones. T F
36. My spouse can always be trusted with everything I tell him. T F
37. Even when I'm with my spouse I feel lonely much of the time. T F
38. The unhappiest moments of my life are often caused by my marriage. T F
39. My spouse doesn't take enough time to do some of the things I'd like to do. T F
40. My spouse and I communicate very little simply through the exchange of glances. T F
41. I have never felt our marital difficulties were piling up so high that we could not overcome them. T F
42. It seems that we used to have more fun than we do now. T F
43. There have been moments of great happiness in my marriage. T F
44. My spouse and I argue nearly all the time. T F
45. I wish my spouse shared a few more of my interests. T F
46. My spouse does many different things to show me he loves me. T F
47. I might be happier if I weren't married. T F
48. Sometimes I feel as though my spouse really doesn't need me. T F
49. I get pretty discouraged about my marriage sometimes. T F
50. The recreational and leisure life of my spouse and myself appears to be meeting both our needs quite well. T F
51. My spouse does many things to please me. T F
52. Sometimes I wonder just how much my spouse really does love me. T F

MARITAL SATISFACTION INVENTORY (continued)

53. My spouse and I are happier than most couples I know. T F
54. I feel free to express openly strong feelings of sadness to my spouse. T F
55. I am thoroughly committed to remaining in my present marriage. T F
56. My spouse likes to share his leisure time with me. T F
57. Whenever he is feeling down, my spouse comes to me for support. T F
58. I usually feel that my marriage is worthwhile. T F
59. My spouse and I enjoy the same types of amusements. T F
60. My mate rarely does things that make me unhappy. T F
61. I'm not sure my spouse has ever really loved me. T F
62. I am certain our decision to get married was the right one. T F
63. When I'm upset, my spouse usually understands why even without my telling him. T F
64. I have known very little unhappiness in my marriage. T F
65. I sometimes avoid telling my spouse things that put me in a bad light. T F
66. My marriage is as successful as any I know. T F
67. I spend at least one hour each day in an activity with my spouse. T F
68. The good things in my marriage seem to far outweigh the bad. T F
69. My spouse and I have never come close to separation or divorce. T F
70. My spouse sometimes seems to spend more time with his friends than with me. T F
71. We seem to do more arguing than a couple should. T F

MARTIAL SATISFACTION INVENTORY (continued)

- | | | |
|---|---|---|
| 72. Just when I need it most my spouse makes me feel important. | T | F |
| 73. About the only time I'm with my spouse is at meals and bedtime. | T | F |
| 74. I believe that our marriage is as pleasant as that of most people I know. | T | F |
| 75. If it weren't for fear of hurting my mate I might leave him. | T | F |
| 76. My spouse and I sometimes enjoy just sitting down and doing things together. | T | F |
| 77. I think my marriage is less happy than most others. | T | F |
| 78. I am apt to hide my feelings in some things, to the extent that my spouse may hurt me without his knowing it. | T | F |
| 79. My marriage is an unhappy one. | T | F |
| 80. I have often considered asking my spouse to go with me to seek marital counseling. | T | F |
| 81. We just don't get the chance to do as much together anymore. | T | F |
| 82. My spouse doesn't take me seriously enough sometimes. | T | F |
| 83. Frankly, our marriage has not been successful. | T | F |
| 84. My spouse seems to enjoy just being with me. | T | F |
| 85. There are many things about my marriage that please me. | T | F |
| 86. There is a great deal of love and affection expressed in our marriage. | T | F |
| 87. My marriage has been very satisfying. | T | F |
| 88. Somethings are too upsetting to discuss even with my spouse. | T | F |
| 89. Two married persons should be able to get along better than my mate and I. | T | F |
| 90. My spouse keeps most of his feelings inside. | T | F |

MARITAL SATISFACTION INVENTORY (continued)

Name _____

If you have had a child, or children, before any of your spontaneous abortions continue to answer the following items.

- | | | |
|---|---|---|
| 88. Having children has increased the happiness of our marriage. | T | F |
| 89. My spouse and I nearly always agree on how to respond to our children's requests for money or privileges. | T | F |
| 90. For the most part our children are well behaved. | T | F |
| 91. Our children often manage to drive a wedge between my spouse and me. | T | F |
| 92. Raising children is a nerve wracking job. | T | F |
| 93. Our children seem to fight among themselves more than other children. | T | F |
| 94. My spouse and I rarely disagree on how much time to spend with the children. | T | F |
| 95. My children and I don't have very much in common to talk about. | T | F |
| 96. My spouse doesn't assume his fair share of taking care of the children. | T | F |
| 97. Having children has not brought all the satisfactions I had hoped it would. | T | F |
| 98. A large portion of arguments I have with my spouse are caused by the children. | T | F |
| 99. I wish my children would show a little more concern for me. | T | F |
| 100. My children have learned that if they can't get something from me they can often get it from my spouse. | T | F |
| 101. Having children has not kept my spouse and me from doing as much together as we used to. | T | F |
| 102. My spouse doesn't spend enough time with the children. | T | F |

MARITAL SATISFACTION INVENTORY (continued)

- | | | |
|--|---|---|
| 103. Our children don't seem as happy and carefree as other children their age. | T | F |
| 104. Most of the work involved in caring for the children falls on my shoulders. | T | F |
| 105. Our marriage might have been happier if we had not had children. | T | F |
| 106. My spouse and I rarely argue about the children. | T | F |
| 107. My children rarely seem to care how I feel about things. | T | F |
| 108. Quite frequently my children come and talk with me about routine events in their daily lives. | T | F |
| 109. My spouse and I decide together what rules to set for our children. | T | F |
| 110. Having children has interfered with the pursuit of my own career. | T | F |
| 111. My spouse and I assume equal responsibility for rearing the children. | T | F |
| 112. Words don't seem to have any impact on kids these days. | T | F |
| 113. The children and I often work together in the yard or on projects around the house. | T | F |
| 114. My spouse shows a great deal of enthusiasm in our children's interests and accomplishments. | T | F |
| 115. I sometimes think my spouse and I should have waited longer before having children. | T | F |
| 116. Our marriage has never been in difficulty because of the children. | T | F |
| 117. Our children rarely fail to meet their responsibilities at home. | T | F |
| 118. Sometimes my spouse really spoils the children. | T | F |
| 119. I frequently get together with one or more of the children for fun or recreation at home. | T | F |
| 120. My spouse and I always try to support each other when one of us praises or punishes our children. | T | F |

MARITAL SATISFACTION INVENTORY (continued)

121. Our children do not show adequate respect for their parents. T F
122. My spouse doesn't display enough affection toward the children. T F
123. My children's value systems are very much the same as my own. T F
124. My spouse and I seem to argue more frequently since having children. T F
125. Before having children, I didn't realize how much of a burden raising a family could be. T F
126. My spouse and I nearly always agree on what our children's responsibilities at home should be. T F
127. My children consider me an important part of their lives. T F
128. My spouse and I rarely disagree on when or how to punish the children. T F

END

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**Appendix VI
99-100**

University Microfilms International

APPENDIX VII

RELEASE

I hereby grant to Pamela Trunk, the right to record her conversation with me concerning the subject of spontaneous abortion and to use the material as part of her Doctoral Dissertation on the same subject.

Dated:

Signed:

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