Grief after pregnancy loss was predicted by length of pregnancy, neuroticism, psychiatric symptoms, and absence of other children


**Objective**

To determine the factors that predict grief intensity in women who have a pregnancy loss.

**Design**

Inception cohort of women followed for 18 months after a pregnancy loss.

**Setting**

The Netherlands.

**Patients**

2140 recently pregnant women recruited through a notice in a popular family magazine provided information on coping with normal pregnancy, delivery, and complications. 221 of the 227 women (10.6%) who subsequently reported spontaneous loss of the pregnancy were studied. 91% of the losses occurred at < 20 weeks of pregnancy; 97% of the women were married or in stable relationships, their mean age was 29 years, 32% had other children, and 41% had had a previous pregnancy loss. Follow-up was 94%.

**Main results**

All factors except previous pregnancy loss predicted grief intensity on univariate analysis. Multivariate analysis showed that grief intensity was higher for women who had been pregnant longer (P < 0.001), had preloss neurotic personalities (P < 0.001), had preloss psychiatric symptoms (P = 0.02), and did not have other living children (P = 0.01). The subscales of grief intensity showed similar results for these same risk factors (P < 0.02), except for the association between active grief and preloss psychiatric symptoms (P = 0.1). Grief intensity, active grief, difficulty coping, and despair decreased with time (P < 0.001).

**Conclusion**

Stronger grief responses in women who had a pregnancy loss were associated with a longer pregnancy, a more neurotic personality before the loss, preloss psychiatric symptoms, and the absence of other living children.

**Commentary**

Approximately 2.5% of pregnancies that are viable at 7 to 14 weeks are spontaneously lost by 28 weeks of gestation (1). Grief is almost universal; approximately 80% of women seek early loss counselling (2). Support, sympathy, and opportunity to see the baby are some of the interventions that appear to improve subjective grief responses (3, 4).

In this large, prospective study, it was possible to assess the effect of preloss neuroticism, psychiatric symptoms, and social support on grief without the recall bias that previous retrospective studies have had. The results add to our understanding of intensity of grief response after pregnancy loss, and implications for practice may arise.

The study confirms a decline in grief response with time after pregnancy loss for all women, regardless of preloss neuroticism or psychiatric symptoms; this may be reassuring to women and clinicians. The other main findings are that women who are neurotic have a stronger grief response early and that grief response increased with increasing duration of gestation at loss. The latter finding may be partly explained by the fact that women who lost their baby later in pregnancy had a shorter time before completing the first follow-up questionnaire. Will knowledge of risk factors alter how pregnancy loss is managed? Possibly. All women should be offered counselling and other supportive measures early, if available. A historical study of psychiatric symptoms or neuroticism could help clinicians decide which women might benefit most from longer-term support or psychiatric intervention. Lastly, these results cannot be extrapolated to the management of induced pregnancy loss without further information on the relative contribution of other factors (e.g., reasons for and method of termination) to grief response.

**Ruth Gilbert, MD**

Institute of Child Health
London, England, UK

**References**


**Author's response**

Our finding of a stronger response with increasing duration of gestation at loss both makes sense and endorses findings from previous retrospective studies. We do not think that Dr. Gilbert's alternative explanation (shorter time before completing questionnaire) is plausible because the interaction effect between time since loss and length of pregnancy at loss were not statistically significant.

**Marian C. Cuisinier, PhD**