Grief following termination of pregnancy for fetal abnormality: Does marital intimacy foster short-term couple congruence?

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Acknowledgements
This study is part of the “Reproductive decisions and transition to parenthood following a pre- or postnatal diagnosis of fetal abnormality” research project, integrated in the Relationships, Development & Health Research Group of the R&D Unit Institute of Cognitive Psychology, Vocational and Social Development of the University of Coimbra (Pest-OE/PSI/UI0192/2011). Bárbara Nazaré and Ana Fonseca are supported by PhD Scholarships from the Portuguese Foundation for Science and Technology (SFRH/BD/43204/2008, SFRH/BD/47053/2008, respectively).
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Abstract

Objective: This study aimed to 1) compare women and men in congruent and incongruent couples regarding the intensity of grief responses and the prevalence of clinically relevant grief responses following a termination of pregnancy for fetal abnormality; and to 2) assess the role of marital intimacy in fostering couple congruence on grief responses.

Background: In spite of the detrimental effects of incongruent grief on the marital relationship, previous studies have seldom compared congruent and incongruent couples. Furthermore, little is known regarding the predictors of incongruent grief. Studying such topics will allow for the implementation of effective clinical interventions aiming at decreasing the negative consequences of incongruent grief.

Methods: 31 couples answered the Perinatal Grief Scale and the Personal Assessment of Intimate Relationships, one to six months after a termination of pregnancy for fetal abnormality.

Results: The majority of couples were found to display congruent grief reactions. Women had significantly more intense grief reactions than men in both groups. Women's scores were significantly higher in incongruent couples than in congruent couples, while no such difference was found for men. Clinically relevant grief symptoms were particularly prevalent in women in incongruent couples. Women's perception of marital intimacy, but not men's, positively predicted couple congruence.

Conclusion: Given the normativity of gender differences regarding grief responses, clinicians should foster couple communication and acceptance. As couple incongruence may signal difficulties adapting to the loss, psychological assessment is warranted. Marital intimacy is a resource for women which should be fostered in clinical interventions.
Keywords: couple congruence; grief responses; incongruent grief; marital intimacy; termination of pregnancy for fetal abnormality.
Introduction

Throughout pregnancy, couples may face several types of perinatal loss, including miscarriage, stillbirth, or termination of pregnancy for fetal abnormality (TOPFA; Public Health Agency of Canada, 2000). Grief responses such as sadness, disappointment, guilt, and anger are common following a perinatal loss (Kavanaugh & Wheeler, 2003), as this is often an unexpected event which entails several losses (e.g., the child, the parental role, the worldview, hopes and expectations; Callister, 2006; Sandelowski & Barroso, 2005; Wing, Clance, Burge-Callaway, & Armistead, 2001).

Moderate to strong positive associations between partners’ grief responses following such a loss have been found (Dyregrov & Matthiesen, 1987; Korenromp, 2006; Korenromp et al., 2005), showing both parents to be concomitantly affected by this event and underscoring the non-independence of their reactions (Kenny, Kashy, & Cook, 2006). This is understandable, considering that both lose a child (Beutel, Willner, Deckardt, von Rad, & Weiner, 1996; Korenromp et al., 2007). Furthermore, there is a mutual influence between partners (Kenny et al., 2006), as noticing the partner’s reaction to the loss can not only trigger similar reactions in oneself, but also generate distress due to the perceived inability to prevent the partner’s suffering (Beutel et al., 1996; Conway & Russell, 2000; Schwab, 1992).

However, significant gender differences in responses to a perinatal loss (i.e., incongruent grief; Gilbert, 1989) have also been found. Specifically, women usually display more intense grief reactions than men (Abboud & Liamputtong, 2003; Brier, 2008; Dyregrov & Matthiesen, 1987; Korenromp, Iedema-Kuiper, van Spijker, Christiaens, & Bergsma, 1992; Korenromp et al., 2005, 2007; Lang, Gottlieb, & Amsel, 1996; Stinson, Lasker, Lohmann, & Toedter, 1992; White-Van Mourik, Connor, & Ferguson-Smith, 1992), a tendency of the great majority of couples presenting incongruent grief responses (Korenromp, 2006). Furthermore, four months after TOPFA, women were found to present a significantly higher prevalence of clinically relevant grief responses (i.e. scores
above the cut-off point, indicating the possible existence of pathological grief reactions) than men (9.70% vs. 2.40%, Korenromp et al., 2007), and only in a small percentage of couples (1.10%) both members simultaneously displayed clinically relevant grief responses (Korenromp, 2006). More studies are needed in order to assess whether incongruences within the couple may indicate the presence of grief responses demanding clinical attention.

Differences in grief reactions tend to be acknowledged by the couple (Desrochers, 2011; Dyregrov & Matthiesen, 1987), who may find it surprising (White-Van Mourik et al., 1992). Incongruent grief has consistently been found to have detrimental effects in the couple, namely marital conflicts (Gilbert, 1989), tension (Korenromp et al., 1992) and dissatisfaction (Vance, Boyle, Najman, & Thearle, 2002). Furthermore, feelings of isolation (Wallerstedt & Higgins, 1996), disappointment (Schwab, 1992), frustration, and anger towards the partner (Vance et al., 2002) may arise. Ultimately, the dissolution of the marital relationship may result, as couples facing a miscarriage or stillbirth have been shown to have a higher probability of divorce than those with healthy babies (Gold, Sen, & Ayward, 2010).

Furthermore, as in the great majority of incongruent couples women were found to display significantly more intense grief responses than men, short-term incongruence regarding grief responses has been identified as a risk factor for women’s difficulties in adjusting to the loss (Korenromp, 2006). Given the significant consequences of couple incongruence, it is important to assess couples’ short-term reactions to the loss. Doing so will allow for clinical interventions aimed at preventing subsequent marital distress to be implemented when needed. In addition, it is essential to identify factors contributing to this phenomenon, as this will enlarge the scope of clinical interventions, leading to an increase in its effectiveness.

In spite of the different meanings the loss may have for each parent, perinatal loss is shared by the couple (Gilbert & Smart, 1992). In order for individuals to share their
intimate experiences, it is necessary for them to perceive from their partners a sense of validation and acceptance, which are components of intimate relationships (Schaefer & Olson, 1981). Sharing intimate experiences fosters couple interdependency, that is, one member’s behavior significantly influences the partner, in multiple ways and for a long period (Brehm, Miller, Perlman, & Campbell, 2002). Considering this, couples with higher marital intimacy are expected to be more prone to display congruent reactions to a perinatal loss. However, the role of marital intimacy in fostering couple congruence in the context of perinatal loss, to our knowledge, has not been previously studied.

Additionally, most studies on couples’ grief responses to a perinatal loss focus on spontaneous losses. However, due not only to the advances in prenatal technology (Wyldes & Tonks, 2007) but also to the increase in maternal age at birth (which is associated with a higher probability of having an affected fetus; Hollier, Leveno, Kelly, McIntire, & Cunningham, 2000), increasingly more couples are facing a prenatal diagnosis of fetal abnormality. Consequently, the number of TOPFAs has been increasing (Wyldes & Tonks, 2007). Given its specificities, TOPFA deserves particular attention. On the one hand, as this is usually a shared decision (Korenromp et al., 2007), TOPFA may foster more congruent grief responses within the couple. Specifically, couple’s active role in determining the end of a wanted pregnancy tends to be perceived as a burden and may conflict with one’s values (Sandelowski & Barroso, 2005; White-Van Mourik et al. 1992), leading to intense feelings of ambivalence and guilt in both members of the couple (Desrochers, 2011; McCoyd, 2007). On the other hand, a considerable percentage of TOPFAs occurs in the second half of the pregnancy (Wyldes & Tonks, 2007). As it was suggested that higher gestational age predicts greater couple discrepancy in grief responses (Korenromp, 2006), couples undergoing TOPFA may be particularly prone to display incongruent reactions.

Our study aimed to: 1) compare congruent and incongruent couples in the first six months following TOPFA regarding: a) women’s and men’s intensity of grief responses;
and b) women's and men's prevalence of clinically relevant grief responses; and to 2) assess the role of marital intimacy in couple congruence on grief responses. Considering the lack of previous studies on these topics, no hypotheses were advanced.

Methods

Procedure

This study is part of an ongoing longitudinal investigation entitled "Reproductive decisions and transition to parenthood following a pre- or postnatal diagnosis of fetal abnormality", which was approved by the Ethics Committee of Hospitais da Universidade de Coimbra, Portugal. Inclusion criteria included having terminated a pregnancy due to fetal abnormality one to six months earlier, being 18 years or older, and having a level of literacy that allowed the comprehension of the assessment protocol. From September 2009, to December 2011, all women who filled the inclusion criteria were contacted by telephone by the researchers (consecutive sampling), and the study goals were presented. Women who accepted to participate were mailed an informed consent for signing and two versions of the questionnaires (their own and the one for their partners), and were told that both spouses should complete the questionnaires separately and return it in a pre-stamped envelope provided by the researchers. Regardless of participation in the study, psychological counseling was available to all couples.

A total of 62 couples were contacted, from which seven (11.29%) refused to participate, and 18 (29.03%) did not return the questionnaires. Of the remaining 37 (59.68%), only those in which both members of the couple answered the questionnaires were considered. The final sample comprised 31 couples, that is, the participation rate for this study was 50.00%. For four of these couples, marital intimacy was assessed during pregnancy and before the diagnosis, due to their participation in another research project the authors were carrying out at the time.

Participants
Sociodemographic and clinical data for our sample of 31 cohabitating couples are presented in Table 1. Significant gender differences were only found regarding age (with men being older) and educational level (with women having studied for longer than their partners).

**Measures**

**Perinatal Grief Scale (PGS; Potvin, Lasker, & Toedter, 1989; Portuguese version: Rocha, 2004):** This 33-item measure assesses thoughts and feelings associated with a perinatal loss. Answers are based on a 5-point Likert scale ranging from 1 (*Strongly agree*) to 5 (*Strongly disagree*), with higher scores indicating more intense grief reactions (factor scores falling between 11 and 55). It is comprised of three factors: Active Grief (normative grief manifestations such as crying, sadness, and missing the baby), Difficulty Coping (difficulty performing usual activities and relating to others), and Despair (feelings of hopelessness and worthlessness). In this sample, Cronbach alphas varied from .90 (Difficulty Coping, Despair) to .92 (Active Grief) for women, and from .81 (Difficulty Coping) to .88 (Active Grief) for men. To identify clinically relevant grief responses, a cut-off score of 90 was considered (Davies, Gledhill, McFayden, Whitlow, & Economides, 2005).

**Personal Assessment of Intimacy in Relationships (Schaefer & Olson, 1981; Portuguese version: Moreira, Amaral, & Canavarro, 2009):** This 35-item measure assesses the perception of the intimacy level of a dyadic relationship. Answers are based on a 5-point Likert scale ranging from 0 (*Strongly disagree*) to 4 (*Strongly agree*), with higher scores indicating higher intimacy. The Portuguese version is comprised of three factors: Engagement (couple's sense of validation and acceptance by each other, regarding feelings and opinions, and emotional closeness), Communication (couple's ability to express opinions, feelings, and desires to each other), and Shared Friendships (couple's
relationships with others). Only the total score ($\alpha = .90$ for women and $\alpha = .87$ for men) was used in the present study.

Sociodemographic (age; educational level; professional status; marital status; relationship length) and clinical data (number of previous pregnancies; type of diagnosis; gestational age at TOPFA; time since TOPFA; decision-sharing by the couple) were collected.

**Statistics**

All data analysis was carried out on the Statistical Package for the Social Sciences, version 17.0. Data analyses were performed using the couple as a unit. The database was restructured in order to consider each couple as the subject of the analysis and each partner score as a different variable. Missing data were handled by case mean substitution (Fox-Wasylyshyn & El-Masri, 2005) as they were random and low level (<5%). Demographic and clinical data were not substituted.

Three indexes of couple congruence on grief scores were computed. The discrepancy between women’s and men’s scores on each variable was computed considering the absolute values for the difference. The discrepancy value was subtracted from 44 (the maximum possible difference), with higher values reflecting higher couple congruence. Based on the three congruence indexes, a K-means cluster analysis was run in order to classify couples as congruent or incongruent (two-cluster solution). Women’s and men’s grief scores were compared with Wilcoxon and Mann-Whitney U tests. Women’s and men’s prevalence of clinically relevant grief responses were compared with Fisher’s exact test. Pearson correlations between marital intimacy and the couple congruence indexes were calculated. The association between marital intimacy and the couple congruence indexes was explored with multiple linear regressions. The method Enter was used; for control purposes gestational age at TOPFA, time since TOPFA, and parity were entered in the first step, and the remaining variables were entered in the second step. Post hoc power calculations made for this analysis performed with a significance level of .05
and power >= .80 indicated that only large effects could be detected (Faul, Erdfelder, Lang, & Buchner, 2007).

Results

(Table 2 about here)

In our sample, 23 (74.19%) couples were classified as congruent, while eight (25.81%) were classified as incongruent. In the incongruent group, all women presented higher scores than their partners (data not shown). Gender differences were significant in the three grief dimensions (see Table 2). In the congruent group, significant gender differences were found for Active Grief and Difficulty Coping (see Table 2). Women in incongruent couples displayed significantly more intense grief responses than women in congruent couples (see Table 2), regarding Active Grief (Mann-Whitney U = 35.00, \( p = .010 \)), Difficulty Coping (Mann-Whitney U = 14.50, \( p < .001 \)), and Despair (Mann-Whitney U = 20.00, \( p = .001 \)). No group differences were found for men (see Table 2).

While in the congruent group no gender differences were found regarding the prevalence of clinically relevant grief responses, this prevalence was significantly higher for women than men in the incongruent group (see Table 2). A significantly (Fisher exact \( p = .006 \)) higher proportion of women with clinically relevant grief responses was found in the incongruent group compared to the congruent group (see Table 2). No such difference was found for men (see Table 2).

(Table 3 about here)

As Table 3 shows, only women's perception of marital intimacy was significantly associated with couple congruence on grief responses. Women perceiving higher levels of marital intimacy tended to display grief responses more congruent with their partners'.

(Table 4 about here)

All regression models were found to be significant (see Table 4). Women's perception of marital intimacy positively predicted couple congruence on grief responses,
while men’s perception was found not to be a significant predictor. Regarding Active Grief and Difficulty Coping, less time since loss predicted more couple congruence.

Discussion

The present study has several strengths which make it an important contribution to the current state of the art. First of all, our quantitative approach allowed us to classify and compare congruent and incongruent couples regarding grief responses which, to our knowledge, has not been done before. The present study was also the first to address the role of marital intimacy in fostering couple congruence on grief responses. Finally, we focused on a specific type of perinatal loss (i.e., TOPFA) which, despite its recent increase (Wyldes & Tonks, 2007), has received little attention from researchers.

Our study found the majority of couples to display congruent grief responses, which is consistent with previous studies showing partners’ grief responses to be associated (Dyregrov & Matthiesen, 1987; Korenromp, 2006; Korenromp et al., 2005). This is understandable, as perinatal loss has direct and indirect effects (through the partner’s reaction to the loss) on each member of the couple (Gilbert & Smart, 1992).

Nevertheless, both in congruent and in incongruent couples, women had more intense grief responses than men, which is consistent with the literature on TOPFA (Korenromp et al., 1992, 2005, 2007; White-Van Mourik et al., 1992). Such gender differences have been linked to women’s physical experience of pregnancy, which promotes a stronger bond to the child and, hence, a stronger sense of loss (Beutel et al., 1996; Brier, 2008; Dyregrov & Matthiesen, 1987; Lang et al., 1996). Supporting this hypothesis is the fact that more intense grief responses were found in men who have seen the baby in an ultrasound, compared to those who did not (Puddifoot & Johnson, 1999).

Differences regarding emotional expression have also been mentioned as accounting for incongruent grief. It has been suggested that most men are not given a chance to express their grief (McCreight, 2004) or, alternatively, choose to hide, repress, or internalize their feelings regarding the loss (Desrochers, 2011; Dyregrov & Matthiesen,
1987; Korenromp et al., 1992; McCreight, 2004; White-Van Mourik et al., 1992), as they find it necessary to provide support to their wives (Abboud & Liamputtong, 2003; Desrochers, 2011; Dyregrov & Matthiesen, 1987; Korenromp et al., 1992; McCreight, 2004), not to add to their spouses’ distress (Dyregrov & Matthiesen, 1987; Schwab, 1992), and/or not to display their emotions due to societal norms (Gilbert, 1989; White-Van Mourik et al., 1992).

On the other hand, while women have more need to talk about the loss (Beutel et al., 1996; Gilbert, 1989; Korenromp et al., 1992), men were found to have less positive attitudes about communicating their grief experience (Kamm & Vandenberg, 2001). Talking about the loss is seen as considerably less useful by men than women (Beutel et al., 1996), leading to men being less willing to discuss this topic (Abboud & Liamputtong, 2003). Consistently with these findings, women were found to seek social support (i.e., share their feelings) to deal with the loss more frequently than men (Feeley & Gottlieb, 1988; McGreal, Evans, & Burrows, 1997).

Finding the partner to be supportive and provide validation and acceptance are components of marital intimacy which allow for the sharing of intimate experiences (Moreira et al., 2009). Sharing thoughts, feelings, and ideas with the partner regarding the loss and perceiving support from the partner have been shown to predict less intense short- (Korenromp et al. 2007) and long-term grief reactions (Lang et al., 1996), particularly for women. Consistently, our results confirm marital intimacy to be a personal resource for women, as it promotes couple congruence. Belonging to a congruent couple may indicate the presence of more adaptive grief responses, as women in incongruent couples were found to display a higher prevalence of clinically relevant grief responses than those in congruent couples. Given that the intensity of men's grief responses was found not to vary according to couple's congruence level, it is understandable that their perception of marital intimacy was not found to predict couple congruence. Furthermore,
as we have discussed, the opportunity for emotional expression seems to be less valued by men, which may also contribute to these findings.

Several clinical implications derive from our results. First, couple congruence on grief responses should be carefully assessed, as belonging to an incongruent couple may signal difficulties adjusting to the loss. Moreover, although this does not seem to occur frequently (Korenromp, 2006), there is the possibility that both members congruently present clinically relevant grief responses.

Second, as our study confirmed that men tend to display less intense grief reactions than women following TOPFA, clinicians should stress the normativity of such differences. It should be underscored that although both partners lose a child there can be disparities in the meaning of the loss for each parent (Gilbert & Smart, 1992). It is important for clinicians to assess and discuss the reasons behind men's lack of overt manifestations, as women may interpret it incorrectly (e.g., that men do not care about the loss of the baby; Schwab, 1992). Couples who acknowledge and accept these differences have been shown to be more able to share their feelings with each other (Beutel et al., 1996; Schwab, 1992).

For couples to be able to share their feelings regarding the loss, they need to be capable of expressing their opinions as well as of listening to the other's. Expressing feelings regarding the loss may be particularly difficult for men (Dyregrov & Matthiesen, 1987; Korenromp et al., 1992), who may not find it as useful as women (Beutel et al., 1996). As such, developing communication skills may be particularly important in this context. Couple communication was identified as an important resource when dealing with a stressor such as perinatal loss (White-Van Mourik et al., 1992), while low levels of communication may lead to partners feeling withdrawn from each other (Dyregrov & Matthiesen, 1987), in a time when many couples feel socially isolated (Gilbert, 1989).

Given that intimacy is a continuous process (Schaefer & Olson, 1981), it is likely that not only a more intimate relationship leads couples to share loss-related feelings and
makes them more competent at this task (as they feel that the partner accepts their feelings and opinions and, as a result, they are more prone to express them), but also that this sharing strengthens the couple's perception of marital intimacy. Furthermore, fostering marital intimacy will likely increase not only marital satisfaction (Kamm & Vandenberg, 2001), but also adaptation (Korenromp et al. 2007; Lang et al., 1996), particularly for women. In fact, perceiving more support from the partner at TOPFA has been shown to predict less intense responses of grief, depression, and trauma, for both genders (Korenromp et al. 2007). Considering the ambivalence and guilt that is often reported by couples regarding the decision to terminate the pregnancy (Desrochers, 2001; McCoyd, 2007), support from the partner may be a helpful resource in order to decrease feelings of doubt regarding TOPFA.

Some limitations of our study should be acknowledged. First, given our small sample, the power of the present study only allowed us to detect large effects. As such, small to medium effects concerning the relationships between the study variables may exist, which we were not able to detect. Second, as this study had a cross-sectional design, couples were assessed only once, which may be insufficient in order to fully capture the influence of marital intimacy on couple congruence. Third, marital intimacy was assessed at different times (prior to or after TOPFA). However, as intimacy is a stable, albeit dynamic, process (Schaefer & Olson, 1981), we believe the reliability of our data not to have been compromised. Finally, it was not explored whether or not our assessment of couple congruence is consistent with couples' subjective perception of this variable, which should be explored in future studies.

In conclusion, our work underlines the importance of considering both members of the couple and focusing on relationship variables when studying topics regarding pregnancy and family. Further investigations are needed in order to identify other important factors influencing couple congruence.
References


Relationships Scale (PAIR) to the Portuguese population: A study of its psychometric properties. *Psychologica, 50*, 353-373.


Table 1

*Sociodemographic and Clinical Data*

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
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<td>34.16 (5.83)</td>
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<tr>
<td>Educational level (years)</td>
<td>13.23 (4.33)</td>
<td>11.32 (4.05)</td>
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</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>χ²</td>
<td>p</td>
</tr>
<tr>
<td>Currently employed</td>
<td>28 (90.30)</td>
<td>29 (93.50)</td>
<td>1.02</td>
<td>.601</td>
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<tr>
<td>No living children</td>
<td>18 (58.10)</td>
<td>16 (51.60)</td>
<td>0.26</td>
<td>.610</td>
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<td>Coupl-shared variables</td>
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<td></td>
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<tr>
<td>Relationship length (years)</td>
<td></td>
<td>7.10 (4.23)</td>
<td></td>
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<tr>
<td>Gestational age at TOPFA (weeks)</td>
<td></td>
<td>20.93 (5.07)</td>
<td></td>
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<tr>
<td>Time since TOPFA at assessment (months)</td>
<td></td>
<td>2.35 (0.88)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>n (%)</td>
<td></td>
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<tr>
<td>Fetal diagnosis of chromosomopathy</td>
<td></td>
<td>12 (37.50)</td>
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<tr>
<td>Decision to terminate shared by the couple</td>
<td></td>
<td>31 (100.00)</td>
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### Table 2

**Grief Scores: Gender Comparisons and Couple Congruence**

<table>
<thead>
<tr>
<th></th>
<th>Congruent couples $(n = 23)$</th>
<th>Incongruent couples $(n = 8)$</th>
<th>Couple congruence $M (SD)$</th>
</tr>
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<tr>
<td></td>
<td>Women $M (SD)$</td>
<td>Men $M (SD)$</td>
<td>$Z$</td>
</tr>
<tr>
<td>Active Grief</td>
<td>31.22 (8.16)</td>
<td>27.96 (8.99)</td>
<td>-2.30</td>
</tr>
<tr>
<td>Difficulty Coping</td>
<td>21.17 (5.31)</td>
<td>19.48 (5.25)</td>
<td>-1.95</td>
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<tr>
<td>Despair</td>
<td>18.96 (5.92)</td>
<td>18.61 (5.47)</td>
<td>-0.61</td>
</tr>
<tr>
<td>Total PGS &gt; 90</td>
<td>4 (17.40%)</td>
<td>1 (4.30%)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Active Grief</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>-----</td>
<td>--------------</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.65***</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>.28</td>
<td>.34</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>.77***</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
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** *p < .01. *** *p < .001.
Table 4

Multiple Linear Regressions with Marital Intimacy as a Predictor of Couple Congruence

(Final Models)

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<th>B (SE)</th>
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<th>t</th>
<th>p</th>
<th>F</th>
<th>p</th>
<th>R²</th>
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<td></td>
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</tr>
<tr>
<td>Gestational age at TOPFA</td>
<td>-0.04 (0.23)</td>
<td>-.03</td>
<td>-0.19</td>
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<td></td>
<td></td>
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<tr>
<td>Time since TOPFA</td>
<td>-3.44 (1.48)</td>
<td>-.37</td>
<td>-2.33</td>
<td>.029</td>
<td>48</td>
<td>.006</td>
<td>.48</td>
</tr>
<tr>
<td>Parity^a</td>
<td>3.18 (2.14)</td>
<td>.23</td>
<td>1.49</td>
<td>.151</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIR - Total (Women)</td>
<td>8.68 (3.32)</td>
<td>.53</td>
<td>2.61</td>
<td>.015</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PAIR - Total (Men)</td>
<td>0.36 (3.60)</td>
<td>.02</td>
<td>0.10</td>
<td>.921</td>
<td>4.36</td>
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<td>.48</td>
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<tr>
<td><strong>Difficulty Coping (PGS)</strong></td>
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<td></td>
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<tr>
<td>Gestational age at TOPFA</td>
<td>0.01 (0.22)</td>
<td>.01</td>
<td>0.07</td>
<td>.949</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since TOPFA</td>
<td>-2.44 (1.42)</td>
<td>-.29</td>
<td>-1.71</td>
<td>.099</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity^a</td>
<td>-0.04 (2.06)</td>
<td>-.00</td>
<td>-0.02</td>
<td>.984</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIR - Total (Women)</td>
<td>8.09 (3.20)</td>
<td>.54</td>
<td>2.53</td>
<td>.019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIR - Total (Men)</td>
<td>0.33 (3.47)</td>
<td>.02</td>
<td>0.10</td>
<td>.924</td>
<td>3.57</td>
<td>.015</td>
<td>.43</td>
</tr>
<tr>
<td><strong>Despair (PGS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational age at TOPFA</td>
<td>0.28 (0.23)</td>
<td>.23</td>
<td>1.27</td>
<td>.217</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time since TOPFA</td>
<td>-2.34 (1.45)</td>
<td>-.28</td>
<td>-1.61</td>
<td>.120</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity^a</td>
<td>1.08 (2.10)</td>
<td>.09</td>
<td>0.51</td>
<td>.613</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAIR - Total (Women)</td>
<td>6.02 (3.26)</td>
<td>.41</td>
<td>1.85</td>
<td>.077</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PAIR - Total (Men)</td>
<td>1.33 (3.53)</td>
<td>.09</td>
<td>0.38</td>
<td>.711</td>
<td>2.83</td>
<td>.038</td>
<td>.37</td>
</tr>
</tbody>
</table>

^a 0 = no living children, 1 = living children; based on women's data, as two men had children from previous relationships.