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

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

3  
4   **Abstract**

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

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

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

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

23   Conclusion: Given the normativity of gender differences regarding grief responses,  
24   clinicians should foster couple communication and acceptance. As couple incongruence  
25   may signal difficulties adapting to the loss, psychological assessment is warranted. Marital  
26   intimacy is a resource for women which should be fostered in clinical interventions.

27 Keywords: couple congruence; grief responses; incongruent grief; marital intimacy;  
28 termination of pregnancy for fetal abnormality.  
29

30           **Introduction**

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

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

48           However, significant gender differences in responses to a perinatal loss (i.e.,  
49 incongruent grief; Gilbert, 1989) have also been found. Specifically, women usually display  
50 more intense grief reactions than men (Abboud & Liamputtong, 2003; Brier, 2008;  
51 Dyregrov & Matthiesen, 1987; Korenromp, Iedema-Kuiper, van Spijker, Christiaens, &  
52 Bergsma, 1992; Korenromp et al., 2005, 2007; Lang, Gottlieb, & Amsel, 1996; Stinson,  
53 Lasker, Lohmann, & Toedter, 1992; White-Van Mourik, Connor, & Ferguson-Smith, 1992),  
54 a tendency of the great majority of couples presenting incongruent grief responses  
55 (Korenromp, 2006). Furthermore, four months after TOPFA, women were found to  
56 present a significantly higher prevalence of clinically relevant grief responses (i.e. scores

57 above the cut-off point, indicating the possible existence of pathological grief reactions)  
58 than men (9.70% vs. 2.40%, Korenromp et al., 2007), and only in a small percentage of  
59 couples (1.10%) both members simultaneously displayed clinically relevant grief  
60 responses (Korenromp, 2006). More studies are needed in order to assess whether  
61 incongruences within the couple may indicate the presence of grief responses demanding  
62 clinical attention.

63 Differences in grief reactions tend to be acknowledged by the couple (Desrochers,  
64 2011; Dyregrov & Matthiesen, 1987), who may find it surprising (White-Van Mourik et al.,  
65 1992). Incongruent grief has consistently been found to have detrimental effects in the  
66 couple, namely marital conflicts (Gilbert, 1989), tension (Korenromp et al., 1992) and  
67 dissatisfaction (Vance, Boyle, Najman, & Thearle, 2002). Furthermore, feelings of isolation  
68 (Wallerstedt & Higgins, 1996), disappointment (Schwab, 1992), frustration, and anger  
69 towards the partner (Vance et al., 2002) may arise. Ultimately, the dissolution of the  
70 marital relationship may result, as couples facing a miscarriage or stillbirth have been  
71 shown to have a higher probability of divorce than those with healthy babies (Gold, Sen, &  
72 Ayward, 2010).

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

82 In spite of the different meanings the loss may have for each parent, perinatal loss  
83 is shared by the couple (Gilbert & Smart, 1992). In order for individuals to share their

84 intimate experiences, it is necessary for them to perceive from their partners a sense of  
85 validation and acceptance, which are components of intimate relationships (Schaefer &  
86 Olson, 1981). Sharing intimate experiences fosters couple interdependency, that is, one  
87 member's behavior significantly influences the partner, in multiple ways and for a long  
88 period (Brehm, Miller, Perlman, & Campbell, 2002). Considering this, couples with higher  
89 marital intimacy are expected to be more prone to display congruent reactions to a  
90 perinatal loss. However, the role of marital intimacy in fostering couple congruence in the  
91 context of perinatal loss, to our knowledge, has not been previously studied.

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

109         Our study aimed to: 1) compare congruent and incongruent couples in the first six  
110 months following TOPFA regarding: a) women's and men's intensity of grief responses;

111 and b) women's and men's prevalence of clinically relevant grief responses; and to 2)  
112 assess the role of marital intimacy in couple congruence on grief responses. Considering  
113 the lack of previous studies on these topics, no hypotheses were advanced.

114

## 115 **Methods**

### 116 *Procedure*

117 This study is part of an ongoing longitudinal investigation entitled "Reproductive  
118 decisions and transition to parenthood following a pre- or postnatal diagnosis of fetal  
119 abnormality", which was approved by the Ethics Committee of Hospitais da Universidade  
120 de Coimbra, Portugal. Inclusion criteria included having terminated a pregnancy due to  
121 fetal abnormality one to six months earlier, being 18 years or older, and having a level of  
122 literacy that allowed the comprehension of the assessment protocol. From September  
123 2009, to December 2011, all women who filled the inclusion criteria were contacted by  
124 telephone by the researchers (consecutive sampling), and the study goals were presented.  
125 Women who accepted to participate were mailed an informed consent for signing and two  
126 versions of the questionnaires (their own and the one for their partners), and were told  
127 that both spouses should complete the questionnaires separately and return it in a pre-  
128 stamped envelope provided by the researchers. Regardless of participation in the study,  
129 psychological counseling was available to all couples.

130 A total of 62 couples were contacted, from which seven (11.29%) refused to  
131 participate, and 18 (29.03%) did not return the questionnaires. Of the remaining 37  
132 (59.68%), only those in which both members of the couple answered the questionnaires  
133 were considered. The final sample comprised 31 couples, that is, the participation rate for  
134 this study was 50.00%. For four of these couples, marital intimacy was assessed during  
135 pregnancy and before the diagnosis, due to their participation in another research project  
136 the authors were carrying out at the time.

### 137 *Participants*

138 (Table 1 about here)

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

#### 143 *Measures*

144 Perinatal Grief Scale (PGS; Potvin, Lasker, & Toedter, 1989; Portuguese version:  
145 Rocha, 2004): This 33-item measure assesses thoughts and feelings associated with a  
146 perinatal loss. Answers are based on a 5-point Likert scale ranging from 1 (*Strongly agree*)  
147 to 5 (*Strongly disagree*), with higher scores indicating more intense grief reactions (factor  
148 scores falling between 11 and 55). It is comprised of three factors: Active Grief (normative  
149 grief manifestations such as crying, sadness, and missing the baby), Difficulty Coping  
150 (difficulty performing usual activities and relating to others), and Despair (feelings of  
151 hopelessness and worthlessness). In this sample, Cronbach alphas varied from .90  
152 (Difficulty Coping, Despair) to .92 (Active Grief) for women, and from .81 (Difficulty  
153 Coping) to .88 (Active Grief) for men. To identify clinically relevant grief responses, a cut-  
154 off score of 90 was considered (Davies, Gledhill, McFayden, Whitlow, & Economides,  
155 2005).

156 Personal Assessment of Intimacy in Relationships (Schaefer & Olson, 1981;  
157 Portuguese version: Moreira, Amaral, & Canavarro, 2009): This 35-item measure assesses  
158 the perception of the intimacy level of a dyadic relationship. Answers are based on a 5-  
159 point Likert scale ranging from 0 (*Strongly disagree*) to 4 (*Strongly agree*), with higher  
160 scores indicating higher intimacy. The Portuguese version is comprised of three factors:  
161 Engagement (couple's sense of validation and acceptance by each other, regarding feelings  
162 and opinions, and emotional closeness), Communication (couple's ability to express  
163 opinions, feelings, and desires to each other), and Shared Friendships (couple's



164 relationships with others). Only the total score ( $\alpha = .90$  for women and  $\alpha = .87$  for men)  
165 was used in the present study.

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

#### 170 *Statistics*

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

177 Three indexes of couple congruence on grief scores were computed. The  
178 discrepancy between women's and men's scores on each variable was computed  
179 considering the absolute values for the difference. The discrepancy value was subtracted  
180 from 44 (the maximum possible difference), with higher values reflecting higher couple  
181 congruence. Based on the three congruence indexes, a K-means cluster analysis was run in  
182 order to classify couples as congruent or incongruent (two-cluster solution). Women's and  
183 men's grief scores were compared with Wilcoxon and Mann-Whitney U tests. Women's  
184 and men's prevalence of clinically relevant grief responses were compared with Fisher's  
185 exact test. Pearson correlations between marital intimacy and the couple congruence  
186 indexes were calculated. The association between marital intimacy and the couple  
187 congruence indexes was explored with multiple linear regressions. The method Enter was  
188 used; for control purposes gestational age at TOPFA, time since TOPFA, and parity were  
189 entered in the first step, and the remaining variables were entered in the second step. Post  
190 hoc power calculations made for this analysis performed with a significance level of .05

191 and power  $\geq .80$  indicated that only large effects could be detected (Faul, Erdfelder, Lang,  
192 & Buchner, 2007).

### 193 **Results**

194 (Table 2 about here)

195 In our sample, 23 (74.19%) couples were classified as congruent, while eight  
196 (25.81%) were classified as incongruent. In the incongruent group, all women presented  
197 higher scores than their partners (data not shown). Gender differences were significant in  
198 the three grief dimensions (see Table 2). In the congruent group, significant gender  
199 differences were found for Active Grief and Difficulty Coping (see Table 2). Women in  
200 incongruent couples displayed significantly more intense grief responses than women in  
201 congruent couples (see Table 2), regarding Active Grief (Mann-Whitney  $U = 35.00$ ,  $p =$   
202  $.010$ ), Difficulty Coping (Mann-Whitney  $U = 14.50$ ,  $p < .001$ ), and Despair (Mann-Whitney  
203  $U = 20.00$ ,  $p = .001$ ). No group differences were found for men (see Table 2).

204 While in the congruent group no gender differences were found regarding the  
205 prevalence of clinically relevant grief responses, this prevalence was significantly higher  
206 for women than men in the incongruent group (see Table 2). A significantly (Fisher exact  $p$   
207  $= .006$ ) higher proportion of women with clinically relevant grief responses was found in  
208 the incongruent group compared to the congruent group (see Table 2). No such difference  
209 was found for men (see Table 2).

210 (Table 3 about here)

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

214 (Table 4 about here)

215 All regression models were found to be significant (see Table 4). Women's  
216 perception of marital intimacy positively predicted couple congruence on grief responses,

217 while men's perception was found not to be a significant predictor. Regarding Active Grief  
218 and Difficulty Coping, less time since loss predicted more couple congruence.

## 219 **Discussion**

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

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

232 Nevertheless, both in congruent and in incongruent couples, women had more  
233 intense grief responses than men, which is consistent with the literature on TOPFA  
234 (Korenromp et al., 1992, 2005, 2007; White-Van Mourik et al., 1992). Such gender  
235 differences have been linked to women's physical experience of pregnancy, which  
236 promotes a stronger bond to the child and, hence, a stronger sense of loss (Beutel et al.,  
237 1996; Brier, 2008; Dyregrov & Matthiesen, 1987; Lang et al., 1996). Supporting this  
238 hypothesis is the fact that more intense grief responses were found in men who have seen  
239 the baby in an ultrasound, compared to those who did not (Puddifoot & Johnson, 1999).

240 Differences regarding emotional expression have also been mentioned as  
241 accounting for incongruent grief. It has been suggested that most men are not given a  
242 chance to express their grief (McCreight, 2004) or, alternatively, choose to hide, repress,  
243 or internalize their feelings regarding the loss (Desrochers, 2011; Dyregrov & Matthiesen,

244 1987; Korenromp et al., 1992; McCreight, 2004; White-Van Mourik et al., 1992), as they  
245 find it necessary to provide support to their wives (Abboud & Liamputtong, 2003;  
246 Desrochers, 2011; Dyregrov & Matthiesen, 1987; Korenromp et al., 1992; McCreight,  
247 2004), not to add to their spouses' distress (Dyregrov & Matthiesen, 1987; Schwab, 1992),  
248 and/or not to display their emotions due to societal norms (Gilbert, 1989; White-Van  
249 Mourik et al., 1992).

250         On the other hand, while women have more need to talk about the loss (Beutel et  
251 al., 1996; Gilbert, 1989; Korenromp et al., 1992), men were found to have less positive  
252 attitudes about communicating their grief experience (Kamm & Vandenberg, 2001).  
253 Talking about the loss is seen as considerably less useful by men than women (Beutel et  
254 al., 1996), leading to men being less willing to discuss this topic (Abboud & Liamputtong,  
255 2003). Consistently with these findings, women were found to seek social support (i.e.,  
256 share their feelings) to deal with the loss more frequently than men (Feeley & Gottlieb,  
257 1988; McGreal, Evans, & Burrows, 1997).

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

270 as we have discussed, the opportunity for emotional expression seems to be less valued by  
271 men, which may also contribute to these findings.

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

277         Second, as our study confirmed that men tend to display less intense grief  
278 reactions than women following TOPFA, clinicians should stress the normativity of such  
279 differences. It should be underscored that although both partners lose a child there can be  
280 disparities in the meaning of the loss for each parent (Gilbert & Smart, 1992). It is  
281 important for clinicians to assess and discuss the reasons behind men's lack of overt  
282 manifestations, as women may interpret it incorrectly (e.g., that men do not care about the  
283 loss of the baby; Schwab, 1992). Couples who acknowledge and accept these differences  
284 have been shown to be more able to share their feelings with each other (Beutel et al.,  
285 1996; Schwab, 1992).

286         For couples to be able to share their feelings regarding the loss, they need to be  
287 capable of expressing their opinions as well as of listening to the other's. Expressing  
288 feelings regarding the loss may be particularly difficult for men (Dyregrov & Matthiesen,  
289 1987; Korenromp et al., 1992), who may not find it as useful as women (Beutel et al.,  
290 1996). As such, developing communication skills may be particularly important in this  
291 context. Couple communication was identified as an important resource when dealing  
292 with a stressor such as perinatal loss (White-Van Mourik et al., 1992), while low levels of  
293 communication may lead to partners feeling withdrawn from each other (Dyregrov &  
294 Matthiesen, 1987), in a time when many couples feel socially isolated (Gilbert, 1989).

295         Given that intimacy is a continuous process (Schaefer & Olson, 1981), it is likely  
296 that not only a more intimate relationship leads couples to share loss-related feelings and

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

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

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

323

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Table 1

*Sociodemographic and Clinical Data*

	Women	Men		
	<i>M (SD)</i>	<i>M (SD)</i>	<i>t</i>	<i>p</i>
Age (years)	31.10 (4.59)	34.16 (5.83)	-5.03	< .001
Educational level (years)	13.23 (4.33)	11.32 (4.05)	3.12	.004
	<i>n (%)</i>	<i>n (%)</i>	$\chi^2$	<i>p</i>
Currently employed	28 (90.30)	29 (93.50)	1.02	.601
No living children	18 (58.10)	16 (51.60)	0.26	.610
Couple-shared variables				
	<i>M (SD)</i>			
Relationship length (years)	7.10 (4.23)			
Gestational age at TOPFA (weeks)	20.93 (5.07)			
Time since TOPFA at assessment (months)	2.35 (0.88)			
	<i>n (%)</i>			
Fetal diagnosis of chromosomopathy	12 (37.50)			
Decision to terminate shared by the couple	31 (100.00)			

1 Table 2

2 *Grief Scores: Gender Comparisons and Couple Congruence*

	Congruent couples		<i>Z</i>	<i>p</i>	Incongruent couples		<i>Z</i>	<i>p</i>	Couple congruence <i>M (SD)</i>
	<i>(n = 23)</i>				<i>(n = 8)</i>				
	Women	Men			Women	Men			
	<i>M (SD)</i>	<i>M (SD)</i>			<i>M (SD)</i>	<i>M (SD)</i>			
Active Grief	31.22 (8.16)	27.96 (8.99)	-2.30	.022	43.13 (8.98)	25.62 (8.11)	-2.52	.012	35.45 (6.80)
Difficulty Coping	21.17 (5.31)	19.48 (5.25)	-1.95	.052	34.75 (7.31)	19.75 (5.18)	-2.52	.012	37.39 (6.35)
Despair	18.96 (5.92)	18.61 (5.47)	-0.61	.541	31.75 (7.96)	18.13 (6.06)	-2.52	.012	38.16 (6.08)
Total PGS > 90	4 (17.40%)	1 (4.30%)	-	.173	6 (75.00%)	0 (0.00%)	-	.003	-

3

1 Table 3

2 *Correlations Between Marital Intimacy and Couple Congruence*

Marital intimacy		Couple congruence			
Women	Men	Active Grief	Difficulty Coping	Despair	
1	1	.65***	.57**	.59**	.48**
2		1	.28	.34	.22
3			1	.77***	.83***
4				1	.84***
5					1

3 \*\*  $p < .01$ . \*\*\*  $p < .001$ .

1 Table 4

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

3 *(Final Models)*

	<i>B (SE)</i>	$\beta$	<i>t</i>	<i>p</i>	<i>F</i>	<i>p</i>	<i>R</i> <sup>2</sup>
<i>Active Grief (PGS)</i>							
Gestational age at TOPFA	-0.04 (0.23)	-.03	-0.19	.848			
Time since TOPFA	-3.44 (1.48)	-.37	-2.33	.029			
Parity <sup>a</sup>	3.18 (2.14)	.23	1.49	.151			
PAIR - Total (Women)	8.68 (3.32)	.53	2.61	.015			
PAIR - Total (Men)	0.36 (3.60)	.02	0.10	.921	4.36	.006	.48
<i>Difficulty Coping (PGS)</i>							
Gestational age at TOPFA	0.01 (0.22)	.01	0.07	.949			
Time since TOPFA	-2.44 (1.42)	-.29	-1.71	.099			
Parity <sup>a</sup>	-0.04 (2.06)	-.00	-0.02	.984			
PAIR - Total (Women)	8.09 (3.20)	.54	2.53	.019			
PAIR - Total (Men)	0.33 (3.47)	.02	0.10	.924	3.57	.015	.43
<i>Despair (PGS)</i>							
Gestational age at TOPFA	0.28 (0.23)	.23	1.27	.217			
Time since TOPFA	-2.34 (1.45)	-.28	-1.61	.120			
Parity <sup>a</sup>	1.08 (2.10)	.09	0.51	.613			
PAIR - Total (Women)	6.02 (3.26)	.41	1.85	.077			
PAIR - Total (Men)	1.33 (3.53)	.09	0.38	.711	2.83	.038	.37

4 <sup>a</sup> 0 = no living children, 1 = living children; based on women's data, as two men had  
5 children from previous relationships.

6