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Title: Adaptive and maladaptive grief responses following TOPFA: Actor and partner effects of coping strategies

Running head: Actor and partner effects of coping on grief

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1 **Adaptive and maladaptive grief responses following TOPFA: Actor and partner**
2 **effects of coping strategies**

3
4 **Abstract**

5 Objective: This study aimed to 1) compare women and men regarding absolute and
6 relative coping following a termination of pregnancy for fetal abnormality and 2) assess
7 the influence of relative coping on each partner's adaptive and maladaptive grief
8 responses.

9 Background: Although differences in coping have been cited to explain gender differences
10 on grief symptomatology after a spontaneous pregnancy loss, no study yet has compared
11 women and men regarding use of coping strategies after termination of pregnancy for
12 fetal abnormality. Furthermore, considering the relatively high prevalence of clinically
13 relevant grief symptomatology among women following this event, both one's and the
14 partner's coping responses should be explored as predictors.

15 Methods: 41 couples answered the Perinatal Grief Scale and the Brief COPE, one to six
16 months after termination of pregnancy for fetal abnormality.

17 Results: Women used Religion more frequently than men. Women's absolute and relative
18 scores on Emotional Support, Instrumental Support, and Venting were higher than men's.
19 Men presented higher scores on relative use of Acceptance, Humour, and Denial.
20 Acceptance positively predicted adaptive grief responses. Self-Blame, Denial, Active
21 Coping, and Instrumental Support were positive predictors of maladaptive grief
22 responses. Humour was negatively associated with both types of grief responses. Partner
23 effects were found for Self-Blame and Active Coping.

24 Conclusion: As gender differences regarding coping are normative, psychoeducation may
25 be used to foster intracouple acceptance. Due to their interdependence, both partners'
26 should be assessed. Coping strategies (i.e. self-blame) associated with maladaptive

27 responses should be prevented, while fostering the use of helpful strategies (i.e.
28 acceptance).

29 Keywords: Actor-Partner Interdependence Model; adaptive and maladaptive grief
30 responses; couple; relative coping; termination of pregnancy for fetal abnormality.

31

32

33 **Introduction**

34 A rise in pregnancies among women of advanced age (resulting in a higher
35 probability of fetal abnormalities; Hollier, Leveno, Kelly, McIntire, & Cunningham, 2000)
36 along with advances in prenatal technology (Wyldes & Tonks, 2007) have led to
37 termination of pregnancy for fetal abnormality (TOPFA) being increasingly common. Such
38 experience, along with spontaneous pregnancy loss and infertility, is considered an
39 adverse reproductive event (ARE; Jaffe & Diamond, 2011). As they simultaneously affect
40 the two partners, ARE represent direct dyadic stress (Bodenmann, 2005). Nevertheless,
41 there are significant intracouple differences on reactions to ARE. With regard to TOPFA,
42 women usually display more intense grief symptomatology than men (Korenromp, 2006;
43 Nazaré, Fonseca, & Canavarro, 2012). Although such gender differences have been linked
44 to women's physical experience of pregnancy and loss (Brier, 2008), coping strategies may
45 also play a role (Wing, Clance, Burge-Callaway, & Armistead, 2001), as coping style is a
46 "mediator of mourning" (Worden, 2008, p. 64). However, no study has, to our knowledge,
47 compared women's and men's use of coping strategies when dealing with TOPFA.

48 Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and
49 behavioural efforts to manage specific external and/or internal demands that are
50 appraised as taxing or exceeding the resources of the person" (p. 141) and classified
51 coping strategies as problem-focused (i.e. aimed at solving the problem) or emotion-
52 focused (i.e. focused on emotion regulation). However, according to Carver, Scheier, and
53 Weintraub (1989), coping strategies should be measured separately, considering that: 1)
54 different operationalizations of emotion- and problem-focused coping have been used,
55 making it difficult to compare results across studies (Tamres, Janicki, & Helgeson, 2002);
56 2) each category includes strategies that may not be equally adaptive (Carver et al., 1989;
57 Tamres et al., 2002), limiting conclusions regarding their role in adaptation; and 3) when
58 comparing genders, significant differences in the two categories may be illusory if limited

59 to one or two specific strategies; alternatively, such differences may not be found if only
60 the two categories are compared (Tamres et al., 2002).

61 Regarding gender comparisons, seeking emotional support is the only strategy
62 consistently found to be more frequently used by women than men across stressors
63 (Tamres et al., 2002), including the death of a baby during pregnancy or soon after birth
64 (Carroll & Shaefer, 1994; Feeley & Gottlieb, 1988; Wing et al., 2001). With regard to other
65 strategies, results are inconsistent. For instance, women were shown to use self-blame and
66 religion more frequently than men in one study (McGreal, Evans, & Burrows, 1997) but
67 not in another (Feeley & Gottlieb, 1988). Nevertheless, when significant differences are
68 found, women's absolute coping is consistently shown to be higher than men's. That
69 pattern of gender differences changes, however, when comparing relative coping, as the
70 frequency of use of a specific strategy is considered while simultaneously acknowledging
71 the frequency of use of all strategies assessed (Peterson, Newton, Rosen, & Skaggs, 2006).
72 As several coping strategies are used when dealing with TOPFA (Desrochers, 2011), the
73 influence of relative coping on adaptation is particularly informative and should be
74 explored.

75 With regard to adaptation following the death of a baby during pregnancy or soon
76 after birth, only absolute coping was considered in the studies we found. Furthermore,
77 broad categories of coping were used in most studies. Specifically, positive associations
78 were found between problem-focused coping and women's, but not men's, adjustment (a
79 composite measure of personal disturbance, and physical and grief symptomatology;
80 Murray & Terry, 1999), emotion-focused coping and women's grief symptomatology
81 (Engler, 1998), and passive coping and women's depressive symptomatology (Swanson,
82 2000). The only study assessing coping strategies separately showed that, after a
83 miscarriage, women's use of social withdrawal and wishful thinking was associated with
84 worse adjustment (a composite measure of stress, anxious and depressive

85 symptomatology, and emotional reactions), while cognitive restructuring was found to be
86 beneficial (James & Kristiansen, 1995).

87 The low controllability of ARE may explain why some strategies seem to be more
88 adaptive than others (Murray & Terry, 1999; Terry & Hynes, 1998). However, it remains
89 unexplored whether this applies to TOPFA, which presents a challenging specificity:
90 although a prenatal diagnosis of fetal abnormality may be a low-control situation, couples
91 have an active role in determining the end of the pregnancy. Nevertheless, as the
92 pregnancy is usually wanted (Korenromp, Iedema-Kuiper, van Spijker, Christiaens, &
93 Bergsma, 1992; White-Van Mourik, Connor, & Ferguson-Smith, 1992) and termination
94 may conflict with personal and/or societal values (Korenromp et al., 1992; McCoyd, 2007;
95 White-Van Mourik et al., 1992), intense feelings of guilt in both partners (particularly
96 among women) are common (Desrochers, 2011; Korenromp et al., 1992; McCoyd, 2007;
97 Nazaré, Fonseca, & Canavarro, in press; White-Van et al., 1992). Women blaming their
98 character for the occurrence of a miscarriage were found to be more likely to use self-
99 criticism as a coping strategy (James & Kristiansen, 1995). This may explain why chronic
100 guilt proneness (Barr, 2004) and trait self-criticism (Franche, 2001) are positive
101 predictors of women's and men's grief symptomatology after the death of a baby during
102 pregnancy or soon after birth.

103 Although grief responses such as sadness, disappointment, guilt, and anger are
104 common following the death of a baby (Kavanaugh & Wheeler, 2003), 10-47% of women
105 present clinically relevant grief symptomatology (i.e. scores above the cut-off point or
106 symptoms of Complicated Grief, indicating the possible existence of pathological grief
107 reactions) in the first six months after TOPFA (Davies, Gledhill, McFayden, Whitlow, &
108 Economides, 2005; Kersting et al., 2007; Korenromp, 2006; Nazaré et al., 2012).
109 Considering this, when studying the influence of coping on grief symptomatology we
110 should differentiate between adaptive (e.g. sadness, crying, missing the baby) and
111 maladaptive responses (e.g. difficulty performing usual activities, feelings of

112 worthlessness and hopelessness; Toedter, Lasker, & Janssen, 2001). As self-criticism was
113 found to influence both types of grief responses (Franche, 2001), the influence of self-
114 blame on grief symptomatology may be particularly pervasive.

115 Parental grief should be regarded as both an intrapersonal and an interpersonal
116 process (Wijngaards-de Meij et al., 2008). Similarly, coping is a relational and
117 interdependent process, as the coping response of one partner may not only influence the
118 other's coping response and the outcome (Bodenmann, Meuwly, & Kayser, 2011), but also
119 become a stressor for the partner (Bodenmann, 2005). This is consistent with the Actor-
120 Partner Interdependence Model (Cook & Kenny, 2005), which considers both actor (the
121 influence of one's characteristics on one's outcomes) and partner effects (the influence of
122 the partner's characteristics on one's outcomes). In the context of ARE, to our knowledge,
123 only studies on infertility have explored partner effects of coping on adjustment (e.g.
124 Berghuis & Stanton, 2002; Peterson, Pirritano, Christensen, & Schmidt, 2008). As the
125 decision to terminate the pregnancy is usually shared by the couple (Korenromp et al.,
126 2007), partners may be particularly prone to influence each other. Therefore, both actor
127 and partner effects should be considered when studying adaptation to TOPFA.

128 Trying to overcome several limitations previously addressed, our study aimed to
129 1) compare women and men in the first six months following TOPFA regarding absolute
130 and relative coping; and 2) assess the influence of relative coping on each partner's
131 adaptive and maladaptive grief responses. Given the scarcity of studies on these topics,
132 only two hypotheses are advanced: 1) emotional support will be more frequently used by
133 women than men; and 2) self-blame will positively predict both adaptive and maladaptive
134 grief responses.

135

136 **Methods**

137 *Procedure*

138 This study is part of the longitudinal investigation “Reproductive decisions and
139 transition to parenthood following a pre- or postnatal diagnosis of fetal abnormality”,
140 approved by the Ethics Committee of Hospitais da Universidade de Coimbra, Portugal.
141 Inclusion criteria included having experienced TOPFA one to six months earlier, being 18
142 years or older, and having a level of literacy that allowed comprehension of the
143 questionnaires. From September 2009 to May 2012, researchers telephoned all women
144 filling the criteria (consecutive sampling) and presented the study goals. Women willing to
145 participate were mailed a letter with all the information they were previously told by
146 telephone (so that their partners would be able to make an informed decision regarding
147 participation in the study), an informed consent and two versions of the questionnaires
148 (theirs’ and their partners’). Couples were told that both partners should complete the
149 questionnaires separately and return it in a pre-stamped envelope provided by the
150 researchers. Regardless of participation, psychological counseling was available to all
151 couples.

152 Seventy-three couples were contacted, from which seven (9.56%) refused to
153 participate, and 17 (23.29%) did not return the questionnaires. Of the remaining 49
154 (67.12%), only those in which both partners answered the questionnaires were
155 considered ($n = 41$; participation rate: 56.16%).

156 *Participants*

157 (Insert_Table1)

158 Sociodemographic and clinical data for the 41 cohabitating couples are presented
159 in Table 1. Significant gender differences were only found regarding age (with men being
160 older) and educational level (with women having studied for longer).

161 *Measures*

162 Brief COPE (Carver, 1997; Portuguese version: Pais Ribeiro & Rodrigues, 2004):
163 This 28-item measure assesses the use of 14 different strategies (Active Coping, Planning,
164 Positive Reframing, Acceptance, Humour, Religion, Using Emotional Support, Using

165 Instrumental Support, Self-Distraction, Denial, Venting, Substance Use, Behavioral
166 Disengagement, and Self-Blame) when coping with a specific event (TOPFA, in this study).
167 Answers are based on a 4-point Likert scale ranging from 0 (*I haven't been doing this at all*)
168 to 3 (*I've been doing this a lot*), with higher scores indicating more use. Planning, Self-
169 Distraction, Substance Use, and Behavioral Disengagement were not used in this study, as
170 their internal consistencies were $< .50$ for one or both genders. In the remaining subscales,
171 Cronbach alphas varied between .55 (Acceptance) and .91 (Humour) for women, and .59
172 (Self-Blame) and .76 (Positive Reframing) for men.

173 Perinatal Grief Scale (PGS; Toedter et al., 2001; Portuguese version: Rocha, 2004):
174 This 33-item measure assesses thoughts and feelings associated with a perinatal loss.
175 Answers are based on a 5-point Likert scale ranging from 1 (*Strongly agree*) to 5 (*Strongly*
176 *disagree*), with higher scores indicating more intense grief symptomatology. It includes
177 three factors: Active Grief (normative grief manifestations such as crying, sadness, and
178 missing the baby), Difficulty Coping (difficulty performing usual activities and relating to
179 others), and Despair (feelings of hopelessness and worthlessness). The last two subscales
180 concern maladaptive grief responses. In this sample, Cronbach alphas varied from .90
181 (Despair) to .91 (Active Grief, Difficulty Coping) for women, and from .82 (Difficulty
182 Coping) to .90 (Active Grief) for men.

183 *Statistics*

184 Data analysis was carried out on the Statistical Package for the Social Sciences
185 (version 17.0). Each couple was the subject of the analysis, with each partner score being a
186 different variable. Missing data were handled by case mean substitution (Fox-Wasylyshyn
187 & El-Masri, 2005) as they were random and low level ($< 5\%$). Demographic and clinical
188 data were not substituted.

189 Relative coping is expressed as a proportion of use of a specific strategy
190 considering all coping strategies used (Peterson et al., 2006). Gender comparisons in
191 absolute and relative coping were explored with repeated-measures MANOVAs (effect

192 sizes are presented - small: $\eta^2 \geq .01$, medium: $\eta^2 \geq .06$, large: $\eta^2 \geq .14$; Volker, 2006). Post
193 hoc power calculations with $p \leq .05$ and power $\geq .80$ indicated that only medium to large
194 effects could be detected (Faul, Erdfelder, Lang, & Buchner, 2007).

195 Pearson correlations between clinical variables (parity, gestational age at TOPFA,
196 and time since TOPFA), relative coping and grief responses were calculated in order to
197 select the variables to enter in the regression models (effect sizes are presented - small: $r \geq$
198 $.10$, medium: $r \geq .30$, large: $r \geq .50$; Cohen, 1992). Regarding multiple linear regressions, the
199 method Enter was used; for control purposes, clinical variables were entered in the first
200 step; actor variables were entered in the second step and partner variables in the third
201 step (effect sizes are presented - small: $f^2 \geq .02$, medium: $f^2 \geq .15$, large: $f^2 \geq .35$; Cohen,
202 1992). Post hoc power calculations with $p \leq .05$ and power $\geq .80$ indicated that only large
203 effects could be detected (Faul et al., 2007).

204 Although significance was defined as $p < .05$, marginally significant results ($p < .10$)
205 are also reported.

206

207 **Results**

208 (Insert_Table2)

209 A significant multivariate effect of gender was found for absolute coping (Pillai's
210 Trace = .48, $F_{10,31} = 2.85$, $p = .012$, $\eta^2 = .48$). Three coping strategies (Using Emotional
211 Support, Using Instrumental Support, and Venting) were significantly more used by
212 women than men; the same pattern was found for Religion, with gender differences being
213 marginally significant (see Table 2). Gender also had a multivariate effect (Pillai's Trace =
214 $.52$, $F_{10,31} = 3.41$, $p = .004$, $\eta^2 = .52$) on relative coping. Relative use of Instrumental Support
215 and Venting was higher among women, while relative use of Denial was higher among
216 men. Marginally significant differences were found regarding Acceptance and Humour
217 (proportionately more used by men), and Emotional Support (proportionately more used
218 by women; see Table 2).

219 (Insert_Table3)

220 Table 3 shows the correlates entered in the regression models. All regression
221 models were significant (see Tables 4 and 5). For women, Active Grief increased when
222 they proportionately used more Acceptance and both they and their partners
223 proportionately used more Self-Blame. For both genders, relative use of Humour
224 negatively predicted Active Grief. Women's relative use of Humour and Self-Blame
225 positively predicted Difficulty Coping. For men, Difficulty Coping was positively predicted
226 by their relative use of Instrumental Support and their partners' relative use of Active
227 Coping. Three positive predictors were found for women's levels of Despair: their relative
228 use of Denial and Self-Blame and their partners' relative use of Active Coping. Men's levels
229 of Despair increased the more their partners proportionately used Self-Blame.

230 (Insert_Table4)

231 (Insert_Table5)

232

233 **Discussion**

234 Our study provides an important contribution to our understanding in this area. To
235 our knowledge, this is the first quantitative approach to coping with TOPFA. Such
236 specificity is important as type of stressor seems to influence both use (Tamres et al.,
237 2002) and effectiveness (Murray & Terry, 1999; Terry & Hynes, 1998) of coping strategies.
238 Furthermore, as TOPFA represents direct dyadic stress (Bodenmann, 2005), both partners
239 were considered and actor and partner effects of coping were explored. Regarding coping
240 assessment, strategies were measured separately (Carver et al., 1989) and relative coping,
241 which is more informative, was considered. Moreover, in order to identify which coping
242 strategies are associated with better outcomes, we considered the influence of relative
243 coping on both adaptive and maladaptive grief responses. Finally, there was homogeneity
244 regarding time since TOPFA, as use of strategies changes over time (Feeley & Gottlieb,
245 1988).

246 Men and women were compared regarding coping. As previously shown (Peterson
247 et al., 2006), different patterns emerged for absolute (all significant differences included
248 strategies being more frequently used by women than men) and relative coping (some
249 strategies were proportionately more used by women, while others were proportionately
250 more used by men). Also consistently with previous research (Carroll & Shaefer, 1994;
251 Feeley & Gottlieb, 1988; Tamres et al., 2002) and confirming our hypotheses, women used
252 emotional support more frequently than men, which is concordant with results regarding
253 venting. Three factors may explain such differences: 1) men are usually less willing and
254 feel less need to talk about the death of the baby, as they find it less useful than women
255 (Abboud & Liamputtong, 2003; Beutel, Willner, Deckardt, von Rad, & Weiner, 1996;
256 Gilbert, 1989; Korenromp et al., 1992); 2) many men do not have a chance to express their
257 grief (McCreight, 2004), because few people are available to support them (Murphy,
258 1998); and 3) some men hide or repress their feelings regarding the loss (Desrochers,
259 2011; Korenromp et al., 1992; McCreight, 2004; Murphy, 1998; White-Van Mourik et al.,
260 1992). As using instrumental support (i.e. asking help and advice from others) requires
261 men to share their difficulty coping with TOPFA (which they do not want or have
262 opportunity to do), gender differences regarding that coping strategy are understandable.

263 Two main reasons may explain men's internalization of feelings regarding the loss:
264 societal norms (Gilbert, 1989; White-Van Mourik et al., 1992) and their supporting role
265 (Abboud & Liamputtong, 2003; Desrochers, 2011; Korenromp et al., 1992; McCreight,
266 2004; Murphy, 1998). In trying not to add to their partners' distress (Schwab, 1992), many
267 men opt to stay positive, which may explain why they use proportionately more humour
268 (Murphy, 1998). Avoidance strategies (which may lead to gender differences on denial)
269 are also used, with many men trying to ignore or forget the loss and look forward
270 (McGreal et al., 1997; Murphy, 1998). Men also used proportionately more acceptance, and
271 it was suggested that they accept a miscarriage sooner than their wives (Abboud &
272 Liamputtong, 2003). Despite being paradoxical, such strategies may be prompted by the

273 same reasons: men's earlier return to daily routines (Korenromp et al., 1992; Murphy,
274 1998), resulting in fewer opportunities to think about the loss or leading men to try to
275 overcome it in order to be able to focus on their activities; and the low controllability of
276 the event (Tamres et al., 2002) - as men are unable to change it, they may try not to think
277 about it. Women are more prone to think about the loss and its meaning (Feeley &
278 Gottlieb, 1988), thus using religion more frequently, in order to find comfort. However,
279 inconsistent results regarding religion have been found (Feeley & Gottlieb, 1998; McGreal
280 et al., 1997), which may be due to different assessment instruments, timings, and
281 statistical analyses (paired or independent samples).

282 No gender differences were found regarding active coping and positive reframing,
283 consistent with previous studies assessing similar strategies (Feeley & Gottlieb, 1988;
284 McGreal et al., 1997). The same pattern was found for self-blame. Although the death of
285 the baby results from a decision shared by the couple and feelings of guilt following
286 TOPFA are expressed by both partners, women are usually more prone to display this
287 emotion (Desrochers, 2011; Korenromp et al., 1992; McCoyd, 2007; Nazaré et al., in press).
288 This may be due to the fact that the parental role tends to be more central to women's
289 than men's identity (Jaffe & Diamond, 2011). However, guilt does not necessarily lead to
290 self-blame (Worden, 2008), which may explain our results.

291 Regarding grief symptomatology, the three PGS subscales represent "increasingly
292 problematic responses to the loss" (Toedter et al., 2001, p. 217). Therefore, it is
293 understandable that different predictors emerged for each subscale. This allowed us to
294 identify four coping strategies which proved unhelpful. First, for women, self-blame was
295 found to be a positive predictor of grief responses (given the limited power of our study,
296 men's actor effects may not be large enough for us to detect it). Self-blame has a negative
297 impact on adaptation to the death of a baby during pregnancy or soon after birth (Barr,
298 2004; Franche, 2001; Swanson, 2000), as it may impede several processes necessary to
299 mourning (e.g. experiencing and accepting the pain of loss, revising the assumptive world,

300 and reinvesting in other relationships and activities; Gray & Lassance, 2003; Rando, 1993).
301 Furthermore, self-blame also had negative interpersonal effects. The coping response of
302 one partner may become a stressor for the other (Bodenmann, 2005), which, in this case,
303 may occur in three ways: 1) grief symptomatology resulting from self-blame may not only
304 trigger similar reactions in the partner, but also generate distress due to being unable to
305 prevent the partners' suffering (Beutel et al., 1996; Schwab, 1992); 2) as the decision to
306 terminate the pregnancy is usually shared (Korenromp et al., 2007), individuals blaming
307 themselves may be likely to also blame their partners, which increases the partner's grief
308 symptomatology; and 3) noticing the partner's use of self-blame may lead individuals to
309 question their decision to terminate the pregnancy, fostering ambivalence and guilt, and
310 increasing grief symptomatology. More studies are needed to explore such mechanisms.

311 Second, denial influenced women's maladaptive grief responses. Although this may
312 be a useful strategy immediately after the loss, acting as a buffer against difficult
313 circumstances, it soon becomes ineffective, as it prevents an adaptive mourning process
314 (Worden, 2008). Third, men's relative use of instrumental support was found to be a
315 positive predictor of difficulty coping with the loss. This was an unexpected result,
316 considering that such strategy is seen as effective in these circumstances (Worden, 2008).
317 As this is a cross-sectional study, it is possible that men facing great difficulty coping with
318 TOPFA feel the need to use proportionately more instrumental support. More studies are
319 needed in order to clarify this. Finally, partner effects of active coping were found for
320 maladaptive grief responses. The items composing this subscale are rather vague (i.e. "I've
321 been concentrating my efforts on doing something about the situation I'm in"; "I've been
322 taking action to try to make the situation better"), particularly as the death of the baby is
323 an irreversible situation. Nevertheless, among our sample, active coping was one of the
324 most used strategies. In order to understand its influence in grief responses, future studies
325 should explore the actions and efforts implemented by couples in order to cope with
326 TOPFA.

327 Two strategies emerged as helpful following TOPFA. First, women's relative use of
328 acceptance was associated with adaptive grief responses. Accepting the loss and
329 expressing its associated pain are the first two tasks of the mourning process (Worden,
330 2008). Thus, people who are able to accept the loss may be more prone to display
331 normative grief responses. Second, for both genders, humour was found to be a negative
332 predictor of grief symptomatology (although not of all subscales, perhaps due to the
333 limited power of our study). Worden (2008) described such strategy as effective in the
334 short-term, as it requires some distancing from the event. Using humour may be a way for
335 individuals to feel good and not face the pain of loss, resulting in less intense grief
336 symptomatology. It is also possible that those displaying less intense grief
337 symptomatology are more able to resort to humour. Such hypotheses should be further
338 explored in future studies.

339 Several clinical implications derive from our results. First, gender differences
340 regarding coping seem to be normative. As difficulties may arise when couples cope
341 differently with the death of the baby (e.g. men feel guilty for wanting to move on while
342 their partners are dwelling on the loss; Desrochers, 2011; Gilbert, 1989), psychoeducation
343 is an important clinical tool for fostering intracouple understanding. Second, as coping is
344 associated with grief symptomatology, both partners' strategies should be assessed. On
345 the one hand, the use of coping strategies associated with maladaptive grief responses
346 should be prevented. With regard to self-blame, guilt can be considered legitimate, given
347 the couple's active role in the decision-making leading to the baby's death (Rando, 1993).
348 Thus, clinical interventions should foster acceptance and forgiveness (Gray & Lassance,
349 2003). The use of denial may be particularly likely following TOPFA, as the loss may not be
350 socially recognized and the family has few tangible memories of the baby. Therefore, the
351 loss should be validated, by creating memories and encouraging couples to talk about this
352 experience (Gray & Lassance, 2003). Attention should also be given to the use of
353 instrumental support and active coping. On the other hand, two strategies may be

354 particularly helpful following TOPFA. Fostering acceptance should be the main aim, as this
355 is the initial task of the mourning process (Worden, 2008). Accepting the loss may be
356 specially challenging following TOPFA, given the inconsistencies between the event and
357 the parents' assumptive world (e.g. children are not expected to die before their parents;
358 Gray & Lassance, 2003). Finally, humour may also be effective in the short-term (Worden,
359 2008). However, it is important to assess whether using humour represents an attempt to
360 avoid the pain of loss. We should also note that this was the least used strategy among our
361 sample. As TOPFA entails multiple losses (e.g. the baby, the parental identity; Jaffe &
362 Diamond, 2011), some of which irreversible, using humour may be seen as inadequate by
363 some couples.

364 Some limitations of our study should be acknowledged. Given our small sample,
365 only medium to large effects could be detected. Furthermore, we cannot draw a causal
366 relationship between the study variables. Although several studies focusing ARE showed
367 coping to influence adjustment (e.g. Murray & Terry, 1999; Terry & Hynes, 1998), it has
368 also been suggested that gender differences on coping may be due to women's greater
369 distress (Peterson et al., 2006). Consistently, distress was found to predict use of
370 avoidance strategies in both genders (Murray & Terry, 1999). **Considering this, future**
371 **studies should replicate our findings in larger samples, preferably using a longitudinal**
372 **design.** Finally, four Brief COPE subscales were excluded from the study due to low
373 reliability.

374 In sum, our work underlines the importance of considering coping strategies and
375 exploring actor and partner effects when studying adaptation to direct dyadic stress.

376

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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)	31.88 (4.59)	34.83 (5.69)	-5.49	< .001
Educational level (years)	13.34 (4.15)	11.71 (3.86)	2.90	.006
	<i>n (%)</i>	<i>n (%)</i>	χ^2	<i>p</i>
Currently employed	37 (90.24)	39 (95.12)	1.25	.535
No living children	23 (56.10)	20 (48.78)	0.44	.507
Religiosity ^a				
Non-religious	4 (10.00)	5 (12.19)	0.16	.924
Non-practicing Christian	23 (57.50)	22 (53.66)		
Practicing Christian	13 (32.50)	14 (34.15)		
Couple-shared variables				
	<i>Md (Interquartile Range)</i>			
Relationship length (years)	6 (7)			
Gestational age at TOPFA (weeks)	21 (6)			
Time since TOPFA at assessment (months)	2 (0)			
	<i>n (%)</i>			
Fetal diagnosis of chromosomopathy	18 (43.90)			
Decision to terminate shared by the couple	41 (100.00)			

^a There was a missing value regarding this value among women.

Table 2

Gender Comparisons regarding Absolute and Relative Coping

	Absolute coping					Relative coping				
	Women	Men	<i>F</i>	<i>p</i>	η^2	Women	Men	<i>F</i>	<i>p</i>	η^2
	<i>M (SD)</i>	<i>M (SD)</i>				<i>M (SD)</i>	<i>M (SD)</i>			
Active Coping	3.10 (1.50)	2.93 (1.71)	0.40	.531	.01	13.85 (7.29)	15.55 (10.61)	1.40	.244	.03
Positive Reframing	3.27 (1.69)	2.90 (1.91)	1.41	.242	.03	14.65 (8.07)	14.57 (8.37)	0.00	.953	.00
Acceptance	4.32 (1.29)	4.07 (1.57)	0.84	.364	.02	20.29 (7.34)	25.95 (18.61)	3.10	.086	.07
Humour	0.59 (1.26)	0.85 (1.39)	1.55	.220	.04	2.68 (5.77)	4.95 (8.86)	3.60	.065	.08
Religion	1.80 (1.75)	1.27 (1.61)	3.93	.054	.09	7.76 (7.23)	6.28 (7.08)	1.44	.237	.04
Using Emotional Support	3.07 (1.56)	2.02 (1.62)	9.60	.004	.19	15.90 (14.83)	10.56 (9.52)	3.31	.076	.08
Using Instrumental Support	1.59 (1.57)	0.95 (1.26)	6.63	.014	.14	6.05 (5.53)	3.92 (4.78)	6.24	.017	.14
Denial	1.05 (1.26)	1.46 (1.73)	1.91	.175	.05	4.78 (6.26)	7.37 (9.17)	4.73	.036	.11
Venting	2.37 (1.50)	1.49 (1.49)	6.31	.016	.14	10.25 (5.89)	6.98 (6.46)	5.56	.023	.12
Self-Blame	1.00 (1.52)	0.93 (1.39)	0.08	.778	.02	3.78 (5.66)	3.86 (4.97)	0.01	.935	.00

Table 3

Correlations Between Relative Coping, Clinical Variables, and Grief Responses

	Active Grief		Difficulty Coping		Despair	
	Women	Men	Women	Men	Women	Men
<i>M (SD)</i>	34.49 (9.48)	27.59 (8.43)	25.12 (9.17)	19.66 (5.23)	23.00 (8.72)	19.12 (5.67)
Active Coping W	.03	.16	-.02	.35*	-.01	.18
Active Coping M	.20	.20	.26	.19	.27+	.18
Positive Reframing W	-.23	.02	-.14	-.08	-.18	-.03
Positive Reframing M	.05	.03	.05	-.13	.05	.00
Acceptance W	-.12	.01	-.28*	-.14	-.27*	-.19
Acceptance M	-.31*	-.44**	-.20	-.20	-.22	-.33*
Humour W	-.43**	-.27+	-.36*	-.26+	-.28+	-.14
Humour M	-.19	-.42**	-.16	-.21	-.14	-.27+
Religion W	-.06	.10	-.19	-.04	-.09	.04
Religion M	-.09	.04	-.07	.01	-.09	.03
Using Emotional Support W	-.25	-.22	-.03	-.11	-.12	-.19
Using Emotional Support M	-.07	.10	-.09	-.00	-.06	.08
Using Instrumental Support W	.32*	.21	.24	.17	.19	.22
Using Instrumental Support M	.27+	.36*	.20	.32*	.18	.34*
Denial W	.39*	.12	.32*	.08	.43**	.06
Denial M	.20	.34*	.15	.11	.16	.09
Venting W	.15	-.13	-.02	-.13	.00	-.03
Venting M	.07	.23	-.11	.12	-.14	.19
Self-Blame W	.71***	.28+	.71***	.34*	.70***	.42**
Self-Blame M	.52***	.39*	.36*	.27+	.35*	.41*
Parity ^a	.11	.26	.17	.12	.11	.10
Gestational age at TOPFA	.28+	.31+	.12	.10	-.03	.12

Time since TOPFA	.09	-.14	.14	-.06	.17	-.14
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Note. W = Women, M = Men.

^a0 = no living children, 1 = living children.

+ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 4

Multiple Linear Regressions with Relative Coping Predicting Adaptive Grief Reactions (Final Models)

	<i>B (SE)</i>	β	<i>t</i>	<i>p</i>	<i>Semipartial correlation</i>	<i>F</i>	<i>p</i>	<i>R</i> ²	<i>f</i> ²
<i>Active Grief (Women)</i>									
Gestational age at TOPFA	0.16 (0.21)	.08	0.78	.442	.00				
Acceptance W	0.37 (0.15)	.29	2.42	.022	.04				
Humour W	-0.42 (0.17)	-.26	-2.45	.020	.04				
Using Instrumental Support W	-0.11 (0.22)	-.07	-0.51	.615	.00				
Denial W	0.13 (0.16)	.08	0.77	.445	.00				
Self-Blame W	1.11 (0.18)	.66	6.05	< .001	.26				
Acceptance M	-0.04 (0.05)	-.07	-0.67	.507	.00				
Using Instrumental Support M	0.08 (0.21)	.04	0.36	.723	.00				
Self-Blame M	0.61 (0.20)	.32	3.00	.005	.06	11.98	< .001	.77	3.35
<i>Active Grief (Men)</i>						3.98	.002	.49	0.96

Gestational age at TOPFA	0.24 (0.24)	.14	0.99	.330	.02
Acceptance M	-0.08 (0.07)	-.17	-1.13	.268	.02
Humour M	-0.30 (0.15)	-.31	-2.02	.052	.06
Using Instrumental Support M	0.28 (0.25)	.16	1.09	.284	.02
Denial M	0.17 (0.13)	.19	1.32	.197	.03
Self-Blame M	0.42 (0.25)	.25	1.69	.101	.04
Humour W	0.01 (0.25)	.01	0.05	.961	.00
Self-Blame W	0.18 (0.21)	.12	0.84	.409	.01

Note. W = Women, M = Men.

Table 5

Multiple Linear Regressions with Relative Coping Predicting Maladaptive Grief Reactions (Final Models)

	<i>B (SE)</i>	β	<i>t</i>	<i>p</i>	<i>Semipartial correlation</i>	<i>F</i>	<i>p</i>	<i>R</i> ²	<i>f</i> ²
<i>Difficulty Coping (Women)</i>									
Acceptance W	0.15 (0.16)	.12	0.97	.341	.01				
Humour W	-0.34 (0.19)	-.21	-1.78	.083	.04				
Denial W	0.01 (0.18)	.01	0.08	.940	.00				
Self-Blame W	1.11 (0.22)	.69	4.96	< .001	.30				
Self-Blame M	0.22 (0.22)	.12	0.99	.327	.01	9.40	< .001	.57	1.33
<i>Difficulty Coping (Men)</i>									
Active Coping M	-0.06 (0.08)	-.13	-0.76	.456	.01				
Humour M	-0.12 (0.10)	-.20	-1.16	.253	.02				
Using Instrumental Support M	0.28 (0.16)	.26	1.77	.087	.05				
Self-Blame M	0.26 (0.16)	.25	1.66	.107	.05				
Active Coping W	0.39 (0.12)	.55	3.32	.002	.18				
Humour W	-0.05 (0.15)	-.05	-0.30	.763	.00				

Self-Blame W	0.22 (0.14)	.23	1.60	.119	.04	3.84	.004	.45	0.82
<i>Despair (Women)</i>									
Active Coping W	-0.07 (0.16)	-.06	-0.41	.685	.00				
Acceptance W	0.10 (0.16)	.08	0.61	.547	.00				
Humour W	-0.06 (0.19)	-.04	-0.29	.773	.00				
Denial W	0.32 (0.18)	.23	1.78	.084	.04				
Self-Blame W	0.85 (0.22)	.55	3.86	.001	.18				
Active Coping M	0.20 (0.11)	.24	1.75	.089	.04				
Self-Blame M	0.31 (0.22)	.18	1.42	.164	.02	7.04	< .001	.60	1.50
<i>Despair (Men)</i>									
Acceptance M	-0.04 (0.04)	-.15	-1.00	.326	.02				
Humour M	-0.14 (0.09)	-.22	-1.63	.111	.05				
Using Instrumental Support M	0.17 (0.17)	.14	0.97	.340	.02				
Self-Blame M	0.27 (0.17)	.24	1.59	.121	.05				
Self-Blame W	0.27 (0.15)	.27	1.83	.076	.06	3.98	.006	.36	0.56

Note. W = Women, M = Men.