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UNDERSTANDING GENDER DIFFERENCES IN BEREAVEMENT FOLLOWING THE DEATH OF AN INFANT: IMPLICATIONS FOR TREATMENT

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The death of an infant confronts parents with a multitude of difficult challenges. Bereaved parents often experience a grief that is unexpectedly pervasive, intense, and enduring. Support from family, friends, and medical professionals is often limited, and most parents rely predominantly on their partner or spouse for sustained support and understanding. Over time, partners often experience increased difficulties in supporting each other due to gender differences in grief and coping, strained communication, and characteristic patterns of misunderstandings. This article discusses research findings regarding gender similarities and differences in grief and coping following perinatal loss or loss from sudden infant death syndrome (SIDS), and regarding marital difficulties associated with incongruent grieving. Also discussed are the impact of social support on the experience of bereavement, typical patterns of misunderstandings underlying many grief-related marital difficulties, and treatment recommendations for psychotherapists working with individual clients or bereaved couples.

The death of an infant, either through miscarriage, stillbirth, newborn death, or sudden infant death syndrome (SIDS), has long been recognized as one of the most stressful events that adults may experience (DeFrain & Ernst, 1978; Dyregrov & Matthiesen, 1987a; Feeley & Gottlieb, 1988–1989; Fish, 1986). The death of a child of any age is a profoundly difficult and painful experience, according to empirical evidence from many studies (Bohannon, 1990–1991; Fish, 1986; Martinson, Davies, & McClowry, 1991; Sanders, 1979–1980; Zisook & Lyons, 1989–1990). For example, Sanders (1979–1980) compared grief reactions following three kinds of losses and found that adults experienced significantly higher intensities of grief following the death of a child than following the death of a spouse or a parent. The loss of a child can be extraordinarily stressful for mothers and fathers. Couples often encounter ongoing difficulties that place enormous burdens on their usual coping mechanisms and resources. Bereaved parents often experience a grief that is unexpectedly pervasive, intense, complex, and enduring. The death of an infant is also accompanied by a multitude of secondary losses, including the loss of hopes and dreams, the loss of the experience of raising a child, and the loss of one's sense of safety in the world. Members of the parents' social network may have difficulty recognizing the full extent of such losses, especially if the infant dies during pregnancy or shortly after birth, when the child's "reality" may be less evident to others than it is to the parents.

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Bereaved parents often report additional distress when people around them offer clichés or devaluing comments, when they avoid any discussion of the loss, or when they express impatience over the parent's "slow" rate of recovery.

Women and men report consistent differences in their experience of grief following the death of an infant, according to research conducted in Europe, North America, and Australia. Although much individual variability is evident, women generally appear to experience most grief reactions with greater intensity and for a longer duration than men (Benfield, Leib, & Vollman, 1978; Dyregrov & Matthiesen, 1987a, 1991; Fish, 1986; Forrest, Standish, & Baum, 1982; Lang & Gottlieb, 1993; Moriarty, Carroll, & Cotroneo, 1996; Smith & Borgers, 1988–1989; Vance, Boyle, Najman, & Thearle, 1995). Women and men also appear to differ in how they express their grief and how they cope with the loss (Cook, 1988; Dyregrov & Matthiesen, 1987a; Feeley & Gottlieb, 1988–1989; Schwab, 1992). These differences often lead to misunderstandings and conflicts between bereaved mothers and fathers and contribute to further pain and isolation (Clyman, Green, Rowe, Mikkelsen, & Ataide, 1980; Fish, 1986; Gilbert, 1989; Lang & Gottlieb, 1993; Lang, Gottlieb, & Amsel, 1996; Toedter, Lasker, & Alhadeff, 1988).

This article discusses the similarities and differences in mothers' and fathers' grief responses following the death of an infant, the challenges that these differences pose for bereaved parents, and recommendations for psychotherapists working with individual clients or bereaved couples.

Throughout this article, the term *grief* refers to the range of emotional and cognitive responses that are experienced following the death of an infant. *Bereavement* refers to the ongoing process of adjustment to the loss, which includes reactions and responses of an emotional, cognitive, biological, and behavioral nature. *Perinatal death* refers to the death of an infant due to miscarriage, prematurity, stillbirth, or complications within the first month of life. The specific cause of a particular miscarriage or stillbirth is often difficult to determine, and many parents are left with no reason for their loss. It has been estimated that between 15% and 30% of all pregnancies in the United States end in miscarriage, which corresponds to between 700,000 and 1,700,000 miscarriages per year (Hutti, 1984; Layne, 1992). During 1996, stillbirth accounted for 27,000 deaths in the United States, and neonatal death accounted for an additional 19,000 deaths (CDC, 1998). Perinatal death thus affects a substantial proportion of expectant mothers and fathers each year. SIDS refers to the sudden, unexpected death of an infant that remains unexplained after a thorough investigation. SIDS is the leading cause of death in the United States of infants between the ages of 1 month and 1 year, with the greatest number taking place between 2 and 4 months of age. In 1995, about 3,500 infants died of SIDS in the United States (Carroll & Siska, 1998).

Bereavement Following the Death of an Infant

Bereavement is widely recognized as a complex and dynamic process characterized by a variety of responses. For example, Lindemann (1944) found that symptoms of acute grief in conjugally bereaved adults could be grouped into five categories: (a) somatic distress and intense subjective distress, (b) preoccupation with thoughts of the deceased, (c) feelings of guilt and preoccupation with one's negligence or minor omissions, (d) feelings of hostility toward others, and (e) a disruption of normal functioning. There is widespread agreement among researchers that bereaved individuals vary enormously in the intensity, duration, and expression of grief after the death of an infant. Many researchers agree that bereavement after a perinatal or SIDS death is not a linear or stage-like process. This is because parents generally describe their grief responses as happening in a concurrent or fluctuating manner rather than in a phasic or sequential pattern (Fish, 1986; Hughes & Page-Lieberman, 1989; Kagan, 1998). The nonlinear nature of the grieving process means that bereaved individuals are likely to revisit any or all of their grief responses many times throughout their bereavement journey (Lang et al., 1996; Walwork & Ellison, 1985). Although grief is often compared to a wound, which may be expected to heal in a steady fashion over time, the death of a child is more like a loss of a limb or a permanent loss of functioning. No amount of healing can restore what has been lost. Instead, what occurs is a gradual acceptance of and adaptation to a painful, irretrievable loss (Furman, 1978).

Bereaved parents often complain that their experience of bereavement conflicts with their own and others' expectations of what a "normal" course of bereavement should be. For many years, the death of a young infant was widely

believed to be less meaningful and consequential than other types of death. Influential but poorly grounded theories portrayed perinatal deaths as "non-deaths" of "non-persons" (Deutsch, 1945). Consequently, bereaved parents were often told, "it was probably for the best," "you can always have another," or "it was only a baby you didn't know" (Helmrath & Steinitz, 1978). For many years, it was also widely believed that grief would lead to lasting psychological problems if mourners failed to sever all attachments with the deceased or took too long to reach a final state of adaptation (Bowlby, 1980; Raphael, 1983). Consequently, bereaved parents were often discouraged from seeing or touching their dead infant and often judged to be "pathologically stuck" in their grieving if they continued to experience intense symptoms more than 6 months after the death of their baby. Findings from an expanding body of empirical research have led to a serious reevaluation of these assumptions (Lasker & Toedter, 1991; Wortman & Silver, 1989). For now, on the basis of current empirical evidence, bereavement after perinatal loss is best described as an ongoing process of adaptation to recurring episodes of intense emotional pain, accompanied by chronic disruptions in social functioning.

Gender Similarities and Differences in Bereavement Following Perinatal Loss

In presenting the following grief responses, nearly all of the studies referred to below represent quantitative approaches to research and are alike in terms of (a) assessing substantial numbers of fathers and mothers, (b) focusing primarily on current emotions and functioning, (c) using standardized self-report measures plus interviews or questionnaires, and (d) employing cross-sectional or prospective longitudinal designs. The cited studies tend to minimize a host of methodological problems, such as those associated with (a) small samples (involving increased variability of results, poor generalization beyond the study sample, and poor statistical power to detect real differences between subgroups of parents), (b) inaccuracies in recalling retrospective information, and (c) the use of subjective or poorly defined measures of bereavement. Studies embodying the above-mentioned problems were omitted. Although the following studies succeed in avoiding many methodological errors, other problems have been more difficult to control. These include (a) typically high rates of attrition affecting longitudinal studies in bereavement research, (b) difficulties in convincing fathers to participate in research involving perinatal loss (especially ethnic-minority fathers), and (c) substantial difficulties in convincing parents who live in non-Western industrialized countries to participate in perinatal loss research. In fact, only a few preliminary studies have attempted to examine grief following perinatal loss in the context of non-Anglo-European cultures (i.e., Cowles, 1996; Hébert, 1998; Wikan, 1988). The following grief responses should therefore be understood as primarily representing the experience of majority-culture fathers and mothers living in Australia, Great Britain, the Netherlands, Canada, and the United States.

Shock, numbness, and disbelief. Mothers' and fathers' most immediate response following the death of their baby is usually a shock state, consisting of numbness, confusion, disbelief, and feelings of unreality (Benfield et al., 1978; Clyman et al., 1980; Kavanaugh, 1997; Stinson, Lasker, Lohmann, & Toedter, 1992; Tudehope, Iredell, Rodgers, & Gunn, 1986). During the first month following a perinatal death, parents' rates of numbness and disbelief have been found to range from 55% to 69% for mothers, and 43% to 64% for fathers (Benfield et al., 1978; Giles, 1970; Hughes & Page-Lieberman, 1989). Parkes noted that the initial reaction of shock appears to serve an adaptive function by insulating parents from the full impact of their child's death (Parkes, 1972). Recent evidence indicates that feelings of shock, numbness, and disbelief are experienced by bereaved parents long after the death of their infant. Lang and her colleagues found that bereaved parents reported significantly greater feelings of depersonalization (involving numbness, confusion, and feelings of unreality) than nonbereaved parents up to 3 years after the death of their infant (Lang et al., 1996). Mothers have been found to experience depersonalized feelings to a significantly greater extent than fathers when assessed 12 months (on average) postloss (Lang & Gottlieb, 1993), 20 to 26 months postloss (Bohannon, 1990–1991; Smith & Borgers, 1988–1989), and 2 to 4 years postloss (Fish, 1986).

Denial. Denying the emotional impact of an infant's death appears to be much more common among bereaved fathers than among bereaved mothers during the first 2 years following the loss, but not thereafter (Bohannon, 1990–1991; Fish, 1986; Smith & Borgers, 1988–1989). In a study

assessing 67 couples, 2 months after the death of their newborn baby, Tudehope and his colleagues found that 10% of the fathers exhibited "almost complete denial of the death" of their newborn (Tudehope et al., 1986). Fathers were also found to exhibit significantly more denial than mothers 20 months postloss (Smith & Borgers, 1988–1989), as well as 26 months postloss (Bohannon, 1990–1991). However, as time goes on, fathers' decreasing use of denial reaches the point where fathers and mothers do not differ in their use of denial when measured 2 to 4 years after their loss (Fish, 1986).

Depression and intense sadness. Intense distress, depression, and sadness are among the most common reactions reported by bereaved parents. For example, Benfield and his colleagues found that 100% of mothers and 95% of fathers reported intense feelings of sadness when assessed 40 days after the death of their newborn baby (Benfield et al., 1978). Bereaved mothers and fathers often experience symptoms of depression long after the perinatal death of their child. For example, Murray and Callan (1988) used a standardized measure of global depression to assess parents several years after the perinatal death of their baby. These authors found that even as long as 2¼ years after the loss, bereaved parents were significantly more depressed than the nonpatient normative group, while also being significantly less depressed than depressed patients. These findings indicate that long-term bereavement after perinatal loss not only exists, but it appears to be both normal and distinguishable from major depression.

Gender differences in depression are most clearly evident during the first few years following a perinatal or SIDS death. For example, Dyregrov and Matthiesen (1991) examined the prevalence of mild to severe depression in bereaved mothers and fathers during the first 13 months following a perinatal or SIDS loss. These authors found that mothers' rates of depression varied between 52% and 63%, whereas fathers' rates were found to be significantly lower, varying between 24% and 35%. The pattern of mothers being more depressed than fathers after a perinatal or SIDS death has been found up to 4 years postloss, although the consistency of findings is greatest soon after the loss. More specifically, all three studies that assessed depression or despair within 6 months of a perinatal loss found mothers to be significantly more depressed than fathers (Dyregrov & Matthiesen, 1991; Goldbach, Dunn, Toedter, & Lasker, 1991; Stinson et al., 1992). However, only four of the six studies that assessed depression 12 to 15 months postloss found the same pattern of gender differences (Dyregrov & Matthiesen, 1991; Lang & Gottlieb, 1993; Moriarty et al., 1996; Wilson, Fenton, Stevens, & Soule, 1982), while two others did not (Goldbach et al., 1991; Stinson et al., 1992). Finally, only four of the seven studies that assessed depression or despair 20 months to 4 years postloss found mothers to be more depressed than fathers (Bohannon, 1990–1991; Dyregrov & Matthiesen, 1987a; Fish, 1986; Smith & Borgers, 1988–1989), while three others did not (Goldbach et al., 1991; Stinson et al., 1992; Wilson, Witzke, Fenton, & Soule, 1985). It appears from these data that mothers' and fathers' levels of depression tend to converge with the passage of time.

Preoccupation. Intense preoccupation with thoughts and images of the dead baby is very common among bereaved parents after a perinatal or SIDS loss (Benfield et al., 1978; Cornwell, Nurcombe, & Stevens, 1977; DeFrain, Martens, Stork, & Stork, 1990–1991; Kennell, Slyter, & Klaus, 1970; Sanders, 1979–1980; Tudehope et al., 1986). According to several studies, between 65% and 95% of mothers and 51% and 85% of fathers report problems with preoccupation or irrational thoughts about their dead baby (Benfield et al., 1978; DeFrain et al., 1990–1991). It is not unusual for bereaved parents to experience illusions and hallucinations that their child is still alive. Many parents report that they believe that they have heard their dead baby cry, or felt a sense of their baby's presence. Some mothers may feel fetal movements long after delivery. Many authors emphasize that these kinds of experiences fall within the normal range of grief experiences (Averill, 1968; Menke & McClead, 1990; Stierman, 1987). Mothers report consistently higher levels of preoccupation, yearning, and intrusive thinking than fathers, throughout the first 4 years following a perinatal or SIDS death (Bohannon, 1990–1991; Dyregrov & Matthiesen, 1987a, 1991; Lang & Gottlieb, 1993; Moriarty et al., 1996; Smith & Borgers, 1988–1989; Stinson et al., 1992).

Somatic symptoms. According to research by Benfield et al. (1978), 95% of mothers and 80% of fathers experience one or more distressing somatic symptoms following the perinatal death of their infant. Typical somatic symptoms include sleep disturbances, appetite problems, fatigue,

gastrointestinal problems, headaches, dizziness, and chest pain (Dyregrov & Matthiesen, 1987a; Giles, 1970; Smith & Borgers, 1988–1989). Following a perinatal or SIDS death, mothers experience significantly higher rates of somatic symptoms than fathers, both immediately after the loss, and up to 32 months postloss (Bohannon, 1990–1991; Dyregrov & Matthiesen, 1987a, 1991; Lang & Gottlieb, 1993; Moriarty et al., 1996; Smith & Borgers, 1988–1989). Bereaved fathers report significantly more somatic symptoms than nonbereaved adults up to 6 months postloss, but not at 13 months postloss (Dyregrov & Matthiesen, 1991).

Anxiety. Parents report experiencing strong anxiety up to 4 years following the death of an infant (Dyregrov & Matthiesen, 1987a, 1987b, 1991; Lang & Gottlieb, 1993; Lang et al., 1996; Moriarty et al., 1996; Phipps, 1985–1986; Stinson et al., 1992). Like other traumatic events, the death of an infant can shatter parents' fundamental beliefs in their own future safety and in the future safety of their family and children (Dyregrov & Matthiesen, 1987b; Perloff, 1983). Consequently, bereaved parents may feel extremely vulnerable and anxious for extended periods of time. Gender differences in anxiety remain evident for several years following perinatal loss. Mothers report experiencing significantly stronger anxiety than fathers, from 2 months to 2¼ years after a perinatal or SIDS loss (Bohannon, 1990–1991; Dyregrov & Matthiesen, 1987a, 1987b, 1991; Lang & Gottlieb, 1993; Lang et al., 1996; Moriarty et al., 1996; Smith & Borgers, 1988–1989). Although mothers and fathers continue to experience high levels of anxiety 2 to 4 years after a perinatal or SIDS loss, they appear to do so with equal intensity (Lang et al., 1996).

Anger. Anger and irritability have been identified as common bereavement responses following perinatal loss. For example, Smith and Borgers (1988–1989) found that 59% of mothers and 46% of fathers reported experiencing anger and hostility when assessed from 6 months to 7 years postloss. Mothers generally report significantly stronger feelings of anger than fathers during the first year and a half following the loss (Fish, 1986; Lang & Gottlieb, 1993; Smith & Borgers, 1988–1989). While mothers and fathers continue to experience high levels of anger past the first year and a half, there is less evidence for gender differences in anger as time goes on. Although Fish (1986) found that mothers were more angry than fathers 2 to 4 years postloss, the majority of long-term studies indicate that mothers and fathers experience equivalent intensities of anger when assessed more than a year and a half postloss (Bohannon, 1990–1991; Moriarty et al., 1996; Stinson et al., 1992).

Several common sources of anger have been identified (Bowlby, 1980; Cerney & Buskirk, 1991). Bereaved parents often express anger out of an enormous sense of unfairness and injustice: "Parents are not supposed to bury their children." "Why is it that we lost a child that we loved when abusive parents have children who live?," and "Why me?" It is common for parents to have jealous or resentful feelings toward other parents and their living babies. Anger can also arise out of a frustrated search for meaning: "Why did God allow this to happen?," and "Could this have been prevented if someone had done something differently?" Blame may be directed inward, resulting in guilt or self-reproach, or it may be directed outward. Wolff, Nelson, and Schiller (1970) investigated ways in which blame was directed by 50 mothers shortly after the perinatal death of their baby. They found that 34% blamed themselves, 18% blamed their husband or their physician, and 20% blamed God or fate. Findings from several studies of bereaved parents indicate that 13% to 30% of fathers and 10% of mothers blamed each other for the death of their child (Dunn, Goldbach, Lasker, & Toedter, 1991; Fish, 1986).

Guilt, self-blame, and blaming the mother. Feelings of guilt and shame are very common among bereaved parents after perinatal loss, especially among women (Benfield et al., 1978; Clyman et al., 1980; Fish, 1986; Giles, 1970; Lang & Gottlieb, 1993; Lang et al., 1996; Smith & Borgers, 1988–1989). According to several studies that assessed parents 1 to 12 months after their loss, 89% of mothers and 49% to 57% of fathers felt guilty or thought that they had personally done something to cause their baby's death (Benfield et al., 1978; Clyman et al., 1980; Hughes & Page-Lieberman, 1989). Perinatally bereaved mothers appear to experience guilt and shame to a significantly greater extent than fathers at 1 to 2 months postloss (Benfield et al., 1978; Dyregrov & Matthiesen, 1987a; Stinson et al., 1992), as well as up to 3 years postloss (Fish, 1986; Lang & Gottlieb, 1993; Lang et al., 1996; Smith & Borgers, 1988–1989). The tendency of fathers to blame mothers (13% to 30% of fathers, according to Dunn et

al., 1991, and Fish, 1986) and of mothers to blame themselves (26% to 34% of mothers, according to Dunn et al., 1991, and Wolff et al., 1970) is likely to contribute to this disparity. Guilt appears to be especially prevalent when the cause of the death is unknown (DeFrain & Ernst, 1978; Mandell, McAnulty, & Reece, 1980).

Bereaved mothers may feel guilty over realistic contributions involving medical conditions and failure to adhere to prescribed regimens as well as unrealistic causes involving eating habits, exercise, intercourse, arguments, or their thoughts and feelings about the pregnancy (Fish, 1986; Leppert & Pahlka, 1984; Wolff et al., 1970). Guilt is often described by parents as related to a general sense of failure. For a man, the sense of failure often involves his identity and role as a family protector. For a woman, the sense of failure may involve multiple aspects of her identity, including her role as a mother, wife, and woman, and her sense of biological competence when the death was due to genetic abnormalities (Giles, 1970; Kennell et al., 1970; Lovell, 1983).

Withdrawal and social isolation. Withdrawing from social contacts and feeling isolated are common reactions following a perinatal or SIDS death (Benfield et al., 1978; Fish, 1986; Lang & Gottlieb, 1993; Smith & Borgers, 1988–1989). During the first year following the loss, mothers' rates of social withdrawal range from 18% to 41%, and fathers' rates range from 6% to 46% (Benfield et al., 1978; Tudehope et al., 1986). Although mothers and fathers do not differ in terms of isolation or withdrawal during the first year following their infant's death (Benfield et al., 1978; Fish, 1986; Tudehope et al., 1986), mothers report significantly stronger feelings of isolation, interpersonal sensitivity, and withdrawal behaviors than fathers 1 to 4 years after the loss (Fish, 1986; Lang & Gottlieb, 1993; Moriarty et al., 1996; Smith & Borgers, 1988–1989).

Bereaved parents withdraw from social contacts for many reasons. The prolonged strain of living with so many exhausting emotions tends to leave them with less energy to devote to others. In addition, some of the emotions experienced by bereaved parents are less socially acceptable than others—namely, tearful crying by men and intense preoccupation and expressions of anger by both men and women. Bereaved parents often develop heightened sensitivity to being misunderstood and may withdraw to avoid being hurt. Many parents report that they feel abandoned or misunderstood by family and friends after a perinatal or SIDS death (Benfield et al., 1978; Clyman et al., 1980; Forrest et al., 1982; Peppers & Knapp, 1980; Wilson et al., 1982). The death of a developing infant may not be acknowledged by others as the death of an existing child, and may not be seen as a reason for extensive mourning. Some family and friends may feel uncomfortable when encountering prolonged grief, and may contribute to the parents' sense of isolation by becoming less available. Bereaved parents may also feel hurt and isolated when people around them offer well-intended but devaluing remarks or advice, or when people avoid the subject altogether and consequently fail to acknowledge that the infant ever existed (Benfield et al., 1978; Clyman et al., 1980; Forrest et al., 1982; Helmrath & Steinitz, 1978; Peppers & Knapp, 1980; Wilson et al., 1982).

Search for explanations and attributing responsibility. Almost all bereaved parents search for explanations following a perinatal or SIDS death. According to research that examined parents' search for causes, Dunn and her colleagues (1991) found that 97% of parents believed that it was highly important for them to understand the cause of their baby's perinatal death. However, this search for meaning was stymied for 38% of the parents because no scientific reason could be determined for the death. Parents who lose a child to SIDS are left with similar unanswered questions, since all SIDS deaths are, by definition, of unknown etiology (Rubin, 1982). Dunn and her colleagues (1991) found that parents' explanations generally matched those provided by their physician, with the exception that parents more often attributed responsibility for the death to the mother (20%), whereas physicians rarely blamed the mother (1%). Although mothers and fathers did not differ significantly in the explanations they gave for the loss, 26% of the mothers and 13% of the fathers attributed responsibility for the infant's death to the mother. In other words, despite being given other explanations by their physician, many mothers and fathers continued to believe that the mother was somehow responsible for the death. This unwarranted tendency to blame the mother is likely to cause unnecessary pain and difficulties, both in the marital relationship and in each partner's adjustment to the child's death.

In summary, bereavement after a perinatal or SIDS death is a complex process of adaptation characterized by a wide range of responses. Be-

reaved mothers and fathers report consistent differences in their experience of grief, with mothers usually experiencing most grief reactions with greater intensity and for a longer duration than fathers. The only apparent exceptions to this pattern involve (a) the experience of denial, where fathers generally exhibit more denial than mothers, and (b) the search for meaning, where mothers and fathers do not differ in the explanations they give for their loss. It is clear from these data that long-term bereavement is both common and normal following the death of an infant. It is also clear that the gender of the parent is an influential factor affecting the experience of bereavement following a perinatal or SIDS death.

The Influence of Social Factors on Bereavement After Perinatal or SIDS Death

Before expanding the discussion to address the problems that gender differences in bereavement can create for grieving parents, it is helpful to first discuss how social factors influence the grieving process.

Social support from family, friends, and healthcare professionals. Support from family, friends, and healthcare professionals is strongly associated with reduced distress and adaptation problems following a perinatal or SIDS loss. This association is supported by findings from qualitative studies (Clyman et al., 1980; DeFrain et al., 1990–1991; Helmrath & Steinitz, 1978; Malacrida, 1997), as well as findings from quantitative studies (Dyregrov & Matthiesen, 1987b, 1987c; Forrest et al., 1982; Graham, Thompson, Estrada, & Yonekura, 1987; LaRoche et al., 1984; Nicol, Tomkins, Campbell, & Syme, 1986; Price, Carter, Shelton, & Bendell, 1985; Tudehope et al., 1986; Wilson et al., 1985). Adequate and appropriate social support has also been recognized as an important resource for limiting adaptation problems after the death of a spouse or other close family member (Maddison & Walker, 1967; Raphael, 1977; Stylianos & Vachon, 1993). Findings from studies of intervention programs provide further evidence that social support promotes better bereavement outcomes following a perinatal or SIDS death (Forrest et al., 1982; Lowman, 1979; Schreiner, Gresham, & Green, 1979).

Emotional support from one's partner. Bereaved parents rely quite heavily on their partner for comfort, understanding, and support following the death of their infant (Gilbert, 1989; Wilson et al., 1985). For example, Tudehope and his colleagues (1986) found that the bereaved parents in their study relied most heavily on the partner to provide them with support and understanding (63% of parents). Far fewer parents received support from other sources, such as their own parents (33%), friends (16%), and neighbors (15%). One of the greatest challenges facing bereaved parents is the task of providing support for their partner while coping with their own grief and turmoil. Different parents are likely to vary in their ability to provide such support for each other, and circumstances involving misunderstandings, coping differences, gender-role socialization, and sheer exhaustion may prevent such support from materializing to varying degrees. Resulting feelings of disappointment, isolation, anger, and insecurity may intensify or prolong the mourning process. In fact, research findings have demonstrated that poor social support from one's partner is strongly associated with greater incidence, intensity, and duration of grief symptoms among women and men after a perinatal or SIDS death (Bohannon, 1990–1991; Dyregrov & Matthiesen, 1987b, 1987c; Forrest et al., 1982; Graham et al., 1987; Lang & Gottlieb, 1993; Lang et al., 1996; LaRoche et al., 1984; Nicol et al., 1986; Toedter et al., 1988; Wilson et al., 1985).

Effects on the Couple's Relationship

Sexual difficulties. The death of a child often has a profound effect on the sexual relationship of bereaved parents. For example, several investigators have found that 60% to 67% of bereaved couples experience serious sexual distress involving a period of reduced or absent sexual activity following the death of an infant or child (Fish, 1986; Hagemeister & Rosenblatt, 1997). Couples in Hagemeister and Rosenblatt's study (1997) attributed their break or decline in sexual activity to grief-related factors such as fatigue, depression, numbness, preoccupation, and psychological discomfort with sexual intimacy. Couples' reasons for wanting to abstain from sex included (a) viewing sex as a reminder of how the dead child was conceived, which felt emotionally overwhelming; (b) fear of pregnancy and the possibility of losing another child; and (c) viewing sexual pleasure as incompatible with one's beliefs and feelings about mourning (with such beliefs, sexual pleasure is often accompanied by strong feelings of guilt). Gender differences appear to play a strong role in these difficulties. For example, Fish (1986)

noted that 60% of the bereaved women in his study reported experiencing a loss of interest in sex and an inability to find pleasure in sexual activity. On the other hand, Fish and other authors have reported that bereaved men tend to view sexual activity as comforting, and experience little or no loss of interest (Fish, 1986; Hagemeister & Rosenblatt, 1997; Johnson, 1984–1985; Schwab, 1992). Sexual conflicts are often played out through (a) perceptions of one's partner as being insensitive, uncaring, or unsupportive; (b) behaviors such as blaming or inducing guilt in each other; and (c) feelings of increased isolation. On the brighter side, about a third of the couples in Hagemeister and Rosenblatt's study (1997) reported feeling supported and comforted throughout their period of sexual difficulties by increasing their level of nonsexual touching.

Separation and divorce. Many bereaved couples experience serious marital distress after the death of an infant, with rates among couples ranging between 28% and 81% (Clyman et al., 1980; Cornwell et al., 1977; Gilbert, 1989; Hagemeister & Rosenblatt, 1997; Lang & Gottlieb, 1991). Despite the prevalence of such difficulties, relatively few marriages appear to end in separation or divorce. Although much attention was given to early estimates claiming divorce rates in the 70% to 90% range (Kubler-Ross, 1969; Schiff, 1986), the bulk of empirical evidence indicates that only 2% to 13% of bereaved parents end their marriages within 7 years of a perinatal or SIDS loss (DeFrain et al., 1990–1991; Dorner & Atwell, 1985; Forrest et al., 1982; Mandell et al., 1980; Mitchell, Scragg, & Clements, 1996). These data suggest that most parents eventually overcome the marital difficulties that are so common following the death of an infant. The relatively few relationships that end in divorce appear to be characterized by extensive pre-loss difficulties (Klass, 1986–1987).

Marital Distress Due to Incongruent Grieving, Discordant Coping, and Poor Communication

Incongruent grieving. A fairly large proportion of couples who lose an infant appear to experience serious marital distress stemming from gender differences in grieving, with rates among couples ranging between 46% and 81% (Clyman et al., 1980; Fish, 1986; Gilbert, 1989). For example, Fish (1986) found that 70% of parents reported serious marital distress related to incongruent grieving, with the greatest differences in grief occurring 2 to 4 years after the loss of an infant (as opposed to an older child), among couples where the father was less than 30 years old (Fish, 1986). These findings raise serious concerns, especially in light of the previously discussed association between inadequate emotional support from one's partner and increased intensity and duration of grief symptoms following a perinatal or SIDS loss. Taken together, this evidence indicates that young parents who lose an infant (especially women) have a greater risk than other bereaved parents of experiencing serious marital difficulties and substantial psychological distress 2 to 4 years after the perinatal or SIDS death of the infant.

The source of much of the distress that accompanies incongruent grieving is the popular belief that people are united by intense common experiences. Bereaved couples often apply this belief to themselves and assume that because they both experienced the same loss, they should expect to experience the same grief (Fish, 1986; Gilbert, 1989; Peppers & Knapp, 1980). However, as we have seen, bereaved mothers generally experience most grief reactions with greater intensity and for a longer duration than bereaved fathers after a perinatal or SIDS death.

Discordant coping. Discordant coping strategies also contribute to incongruent grieving and marital distress among mothers and fathers. Common findings indicate that women tend to use more expressive and process-oriented forms of coping, while men exert greater control over the expression of painful emotions and cope with such emotions in a more solitary fashion. In terms of social interactions, women tend to talk about their feelings more with others and immerse themselves in their grief, while men tend to assume the role of manager and breadwinner and preoccupy themselves with supporting their wives and engaging in outside activities (Cook, 1988; Feeley & Gottlieb, 1988–1989; Forrest et al., 1982; Helmrath & Steinitz, 1978; Mandell et al., 1980; McGreal, Evans, & Burrows, 1997; Williams & Nikolaisen, 1982). Discordant coping has been found to be strongly associated with increased marital distress and communication difficulties among bereaved parents following a perinatal or SIDS death (Feeley & Gottlieb, 1988–1989; Fish, 1986; Kennell et al., 1970).

Typical misunderstandings. A distinctive pattern of misunderstandings occurs when unrealistic expectations combine with incongruent grieving

in the absence of adequate communication (Clyman et al., 1980; Cook, 1983, 1988; DeFrain et al., 1990–1991; Dyregrov & Matthiesen, 1987a; Fish, 1986; Gilbert, 1989; Helmrath & Steinitz, 1978; Hughes & Page-Lieberman, 1989; Mandell et al., 1980; Schwab, 1992). Wives often find it hard to understand why their husbands are not grieving as intensely as they are. Husbands are equally baffled about the greater intensity and duration of the wife's grief reactions. Typical patterns of male inexpressiveness and coping behavior often lead to a particular misunderstanding among wives. Husbands often find it difficult to grieve openly (Cook, 1983, 1988; Dyregrov & Matthiesen, 1987a; Helmrath & Steinitz, 1978; Schwab, 1992), and many husbands report that they have experienced negative consequences when they've openly expressed their grief (Cook, 1988; Mandell et al., 1980). Many husbands report that they fear expressing their grief because their wife often responds by crying, and it appears to create additional pain for their wife. In addition, husbands often internalized the gender-role message that their job is to "be strong" for their wives and to not break down and cry (Cook, 1983, 1988; Dyregrov & Matthiesen, 1987a; Helmrath & Steinitz, 1978; Schwab, 1992). Consequently, a wife often misinterprets her husband's lower levels of grief and his reluctance to talk about the loss as evidence that he does not care about her or about their dead infant. The considerable distress, anger, and disappointment that accompanies this misinterpretation appears to compound the effects of the loss and to place additional strain on the marital relationship. A husband, on the other hand, often misinterprets the greater intensity and duration of his wife's grief reactions as evidence that his spouse is "going crazy." Husbands also misinterpret open communication with the partner about the loss as creating more pain for each other, instead of viewing it as a potentially helpful opportunity to experience mutual support and understanding. The partner's loss of interest in sex may also be misinterpreted as a sign of indifference toward an activity that was once an important source of closeness and support. Husbands often respond to their own misinterpretations by feeling hurt, isolated, and increasingly helpless about their apparent inability to ease the partner's grief. Husbands may also respond by becoming even less communicative and expressive, which leads to further marital distress. Psychotherapists can help to correct such misunderstandings by educating parents about gender differences in grief and coping, by facilitating communication between wives and husbands, and by helping bereaved parents to view each other's behavior from an informed perspective.

Possible Theoretical Explanations for Gender Differences in Bereavement

It is unclear why gender differences in bereavement exist, according to current available evidence. From a theoretical perspective and from the studies reviewed, there are several possible explanations that may contribute to gender differences in grieving: (a) The differences may be due to differences between mothers and fathers in the bond or attachment they form with the developing infant (Fish, 1986; Hughes & Page-Lieberman, 1989; Klaus & Kennell, 1982a, 1982b); (b) the differences may have their source in gender differences in reaction to stress (Kessler & McRae, 1981; Stroebe & Stroebe, 1983; Weissman & Klerman, 1977); (c) the differences may be due to differences in gender-role socialization involving emotional expressiveness and willingness to acknowledge and report emotions (Cook, 1988; Lang & Gottlieb, 1993; Mandell et al., 1980; Notarius & Johnson, 1982; Schwab, 1992); (d) the differences may be influenced by different methods of coping among women and men (Cook, 1988; Feeley & Gottlieb, 1988–1989; Fish, 1986); and (e) the differences may have their source in the different identity configurations and different social environments that women and men experience following the loss (Dyregrov & Matthiesen, 1991; Giles, 1970; Kessler & McRae, 1982; Lovell, 1983). Current available evidence does not clearly favor any of the above explanations, and it is likely and plausible that gender differences in bereavement have their source in a combination of causes. It is important that future research be conducted to determine how the above explanations may separately, or in combination, account for gender differences in bereavement following a perinatal or SIDS loss.

Psychological Services for Bereaved Parents

Treatment Services at the Time of Death

Parents who experience the perinatal or SIDS death of their infant require a range of treatment services immediately following the loss. These services are important because they are collec-

tively associated with reduced risk for adverse bereavement outcomes (Forrest et al., 1982; Lowman, 1979; Schreiner et al., 1979). Such treatments are generally provided in medical settings by physicians, nurses, and other members of interdisciplinary teams including chaplains, social workers, and psychologists. Although a thorough discussion of such services is beyond the scope of this article (for a description of various treatment programs see Forrest et al., 1982; Lowman, 1979; Schreiner et al., 1979), it is important for psychotherapists to be aware of early intervention services because bereaved parents so clearly benefit from them. Such services include (a) assisting parents to recognize the reality of their loss by gently encouraging them to see, hold, and name their dead baby and to participate in a memorial or funeral service; (b) assisting parents in the gathering of important mementos, such as photographs and locks of hair; (c) calmly accepting the full range of parents' grief reactions without becoming anxious, defensive, judgmental, or inaccessible; (d) providing ongoing opportunities for discussions with medical professionals about the cause of death and the parents' feelings and concerns about the death; (e) providing written information about the variability of normal grief responses (including gender differences), about the problems that parents can expect to encounter, and about opportunities to meet with other bereaved parents through professionally facilitated support groups; and (f) providing multiple follow-up contacts that make some form of bereavement counseling available to grieving family members (Forrest et al., 1982; Lowman, 1979; Schreiner et al., 1979). Although little information has been published on the availability of such services, it is believed that access varies widely across the United States and Canada. According to the only published study to date assessing the availability of such services, Segal, Fletcher, and Meekison (1986) interviewed bereaved parents living in and around Vancouver, British Columbia, and found that 80% of parents reported that they had not received adequate information or counseling after the death of their child. Over half of the parents reported that such services were either not available or not offered to them. This lack of services was perceived by parents as a serious deficiency (Segal et al., 1986). Although these findings only reflect the availability of services in a limited geographical area, it is probably safe to conclude that a sizable proportion of bereaved parents in the United States and Canada have minimal access to adequate counseling services immediately following the perinatal or SIDS death of their infant. Psychologists need to take a leadership role in educating medical and hospital personnel about the psychological needs of newly bereaved parents, in advocating for more widespread funding of early intervention services, and in advocating for more research on the helpfulness of such services.

Clinical Treatment Recommendations

Clinically, it is important to recognize the presence of gender differences in bereavement so that such knowledge may be used to promote understanding and support among grieving mothers and fathers and thereby minimize marital conflict and individual distress and isolation. Psychotherapists generally encounter bereaved parents in three contexts: (a) several months or years after the loss when a bereaved parent seeks help for the treatment of depression or other psychiatric symptoms with grief-related roots; (b) when a bereaved parent seeks help in coping with blame, guilt, or anger; and (c) when bereaved parents seek help for marital difficulties.

Requests for psychotherapy or symptom relief. Although most bereaved parents cope with their grief without professional assistance, many parents seek help for dealing with grief or accompanying marital difficulties through group, individual, or couples psychotherapy (Gilbert & Smart, 1992; Hughes, 1995). Some bereaved parents may seek medical treatment for sleeplessness and depression (Giles, 1970; Menke & McClead, 1990). Experts generally recommend that medication be prescribed sparingly for bereaved parents so as not to interfere with the grieving process. For example, if a parent is exhausted from prolonged grief-related sleeplessness, Menke and McClead (1990) recommend that mild medication be used only at bedtime, for 4 nights out of 7, and for no more than 2 weeks at a time.

For psychotherapists, it is not unusual for unresolved bereavement issues to emerge during psychotherapy for the treatment of depression or anxiety (Zisook & Lyons, 1989–1990). As we have seen, many bereaved parents experience strong anxiety and intense sadness for many years following the death of an infant. Also, most bereaved parents appear to receive inadequate information and support from medical professionals following a perinatal or SIDS loss (Segal et al.,

1986), which is likely to lead to a more intense and prolonged experience of bereavement than might otherwise occur (Forrest et al., 1982; Schreiner et al., 1979). Misguided beliefs about perinatal death, SIDS death, and mourning may compound a bereaved parent's suffering when family and friends make unhelpful statements and behave in ways that are unsupportive. No matter how much time has passed since the loss, it is never too late to offer a bereaved parent acceptance, support, information, and compassionate understanding. Many of the services that have been associated with beneficial outcomes can be provided in modified form even years after a loss. These include (a) acknowledging the child's death and the accompanying loss of specific hopes and dreams; (b) assisting the parent in processing the full range of grief reactions, including guilt, anger, and loss of self-esteem; (c) assisting the parent in creating a place for that child within one's current life, by naming the child, by memorializing the child through artistic or charitable activities, by writing letters or imaginatively conversing with the child, and by sharing one's memories and experiences with friends, surviving siblings, and other bereaved parents; (d) encouraging the parent to meet with the physician to obtain accurate information about the cause of death; and (e) providing information about the full range of normal grief responses (including gender differences and individual variations) and about the kinds of difficulties that bereaved parents often encounter following a perinatal or SIDS loss.

Blame, guilt, and anger. Bereaved parents frequently use unrealistic and inaccurate explanations when blaming themselves or their partner for the perinatal or SIDS death of their infant. As was mentioned earlier, Dunn and her colleagues (1991) found striking evidence for this when they examined how explanations given to parents by physicians compared with the explanations that parents gave for the perinatal death of their infant. Although physicians only held 2 of 138 mothers accountable for contributing to the deaths of their babies, 26% of the mothers and 13% of the fathers attributed responsibility for the death to the mother, despite being given other explanations by their physicians (Dunn et al., 1991). In this instance, it appears that most of the parents who entertained the belief that the mother was responsible for the death engaged in unrealistic and inaccurate thinking. Although Dunn and her colleagues (1991) did not examine related behaviors, such as blaming the mother and inducing guilt, it is likely that parents who engage in such behaviors do so on the basis of similar misattributions of responsibility. It is therefore vital for parents who believe that they may have contributed to their baby's death to meet with their physician, to have the possible reasons for the loss explained to them, and to discuss their concerns about how they may have contributed to their baby's death. Such discussions provide parents and therapists with a basis for identifying blame-related misattributions and unrealistic thinking. Psychotherapists can then assist bereaved parents to identify and challenge unrealistic beliefs, to reduce blaming and guilt-inducing behaviors, and to develop effective anger-management skills.

Marital difficulties and couples therapy. As we have seen, incongruent grieving, discordant coping, and poor communication often lead to conflicts and misunderstandings between partners following a perinatal or SIDS death. Couples who are successful at minimizing such difficulties have been found to exhibit strengths in several key areas relative to couples who report high levels of conflict and misunderstandings. Such strengths include (a) being willing to engage in open and honest communication (involving listening, expressing emotions, and exchanging information) and to spend time together as a couple; (b) being willing to accept differences in their experience of grief, in their beliefs about bereavement and mourning, and in their ways of coping with grief; (c) being willing to view their partner's behavior from an informed perspective; and (d) being sensitive and flexible in adapting to each other's needs (Gilbert, 1989). It is critical that psychotherapists working with bereaved couples help facilitate improvements in these areas.

Summary and Conclusions

Bereavement following perinatal or SIDS death can stress the marital relationship in many ways. Each parent's response to the loss can lead to a spiraling course of escalating pain and increased marital difficulties. Clinicians who are aware of these risks can assist bereaved parents to rejoin and support each other in their time of need through (a) encouraging each parent, both individually and together, to talk about their bereavement experiences and the impact of the loss on their relationship; (b) providing the couple with information about gender differences in bereavement and coping and about the difficulties that

many parents encounter after a perinatal or SIDS loss; (c) encouraging each parent to explore the difficulties that they may have in adapting to each other's needs; (d) assisting parents to view each other's behavior from a more informed perspective and to correct misinterpretations and faulty attributions about each other's behavior; (e) educating parents about the destructive power of blaming, as well as helping them to challenge the unrealistic and inaccurate thinking that often accompanies blaming; and (f) assisting parents not to lose sight of shared goals, values, and all that they continue to appreciate about their life together. Psychotherapists who provide empathy, a strong therapeutic alliance, and a sense of safety create ideal conditions for parents to look at these issues and to begin to work toward rejoining each other while continuing to process their own unique experience of loss.

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