

WHEN THE CRADLE STAYS EMPTY: GRIEF IS DIFFERENT FOR EVERYONE

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ABSTRACT

OBJECTIVE

To explore women's experiences of perinatal grief, depression, anxiety, and stress across various personal and social factors.

STUDY DESIGN

Cross-sectional survey design.

PLACE & DURATION OF STUDY

The present study was conducted online over four months from November 2024 to February 2025.

METHOD

A total of 139 women (aged 18-55) who had recently experienced a miscarriage were included using purposive sampling technique. Data were collected through Perinatal Grief Scale and the Depression, Anxiety and Stress Scale. Data were analysed using the statistical software SPSS 27.

RESULTS

Women who reported satisfaction with their relationship had significantly lower scores on perinatal grief, depression, and anxiety. Similarly, women who reported satisfaction with their home environment scored lower on perinatal grief, depression, anxiety, and stress, and those who experienced emotional problems after miscarriage had significantly higher scores on all measures. One-way ANOVA analysis revealed significant differences in our study measures across three marital status groups: married, divorced, and widowed.

CONCLUSION

Women's experiences of perinatal grief, depression, anxiety, and stress varied significantly according to relationship satisfaction, family support, home environment, marital status, and emotional vulnerabilities.

KEYWORDS

Abortion, Spontaneous; Anxiety; Depression; Family Support; Female; Grief; Pregnancy; Social Factors; Spouses.

INTRODUCTION

Among South Asian countries, Pakistan has the highest miscarriage rate, with 30.6 per 1,000 total births.¹ Perinatal loss is a painful experience for both parents,² but mothers typically experience more intense grief than fathers.³ This grief often manifests in a variety of symptoms, including depression, anxiety, post-traumatic stress, guilt, somatisation, anger, loss of control, and hopelessness.^{4,5} Women tend to experience these negative emotions more intensely and, as a result, require more support from family, friends, and significant others to normalise and cope with their grief.⁶ However, in South Asian countries like Pakistan, women frequently face a lack of social and emotional support, often stigmatised for experiencing miscarriage, which further complicates their emotional recovery.¹

Despite the increasing incidence of miscarriage, the topic remains under-explored within the social and familial context in Pakistan. This lack of comprehensive understanding and literature is a growing concern that requires urgent attention. The present study addresses this gap by examining various personal and social factors that may explain the individual differences in how women experience this universal yet deeply personal event.⁷ The study seeks to provide valuable insights into the unique psychological and social dynamics surrounding miscarriage in the Pakistani context.

Perinatal loss brings with it a range of negative psychosocial outcomes. The present study focuses on identifying various psychosocial factors that influence perinatal grief, depression, anxiety, and stress among women following perinatal loss. We aim to explore why grief, despite being a universal experience, manifests so uniquely in each woman. While demographic variables such as women's age, history of previous miscarriage, relationship satisfaction, marital status, and social support have been associated with perinatal grief in Western contexts,^{8,9} this study seeks to understand how these factors, along with other factors specific to the South Asian context, shape the grieving process among women in Pakistan.

The objective of the study is to explore whether women's experiences of perinatal grief, depression, anxiety, and stress vary based on their satisfaction with their relationship with their husband and home environment, their marital status and family system, and emotional challenges following miscarriage.

METHOD

Participants

The study was based on a cross-sectional survey design, and a purposive sampling technique was used. A sample of 139 women (aged 18-55) who recently had a miscarriage were surveyed online through Google Forms. Women with a history of mental illness before miscarriage were excluded from the study. The sample size was calculated through an online software, Sample Size Calculator by Raosoft, Inc.,¹⁰ with a 5.3% margin of error, 95% confidence interval, and 18% response rate.

Instruments

Data were collected through an Urdu questionnaire which consisted of four parts: (i) an informed consent form, (ii) a demographic information sheet, (iii) a 33-item short version of the Perinatal Grief Scale (PGS-S),¹¹ and (iv) a 21-item version of the Depression, Anxiety, and Stress Scale (DASS-21).¹²

Each scale was translated and used after receiving permission from the scale's authors. The perinatal grief scale was developed by Potvin, Lasker, and Toedter. It measures parents' grief on a 5-point Likert scale, giving us a total PGS-S score and three subscale scores: (i) active grief, (ii) difficulty coping, and (iii) despair. The scale has a total Cronbach's alpha of .95.¹¹ The Depression, Anxiety, and Stress Scale was developed by Lovibond and Lovibond (1995). It uses a 4-point Likert scale, giving us a total DASS score with scores for three dimensions of psychopathology: (i) DASS-depression, (ii) DASS-anxiety, and (iii) DASS-stress. Cronbach's alpha of total DASS is .93.¹²

Procedure

The present study was conducted between November 2024 and February 2025 after receiving ethical approval from the review board of Fountain House Institute for Mental Health, Lahore, Pakistan (ref: PPRC 2024 / Ethics 3; 2024; dated: 28th August 2024). The cross-sectional survey approached 139 women through Google Forms. Informed consent was taken from the participants before the study. Anonymity and confidentiality of the participants and all research data were ensured. Descriptive analysis of mean, standard deviation, Cronbach's alpha, frequencies, and percentages; and inferential statistics of Welch's and independent sample t-test and one-way ANOVA were computed using the statistical software SPSS 27.

RESULTS

During this four-month study, 139 women who recently experienced a miscarriage completed the survey. The participants ranged in age from 18 to 55 years ($M = 32.53$, $SD = 8.83$). Descriptive statistics, including frequencies and percentages, were computed for all the demographic variables (Table 1).

Table 1

Descriptive statistics of demographic variables (N=139).

Variable	n	%
Family system		
Nuclear	54	38.85
Joint	85	61.15
Marital status		
Married	126	90.65
Divorced	8	5.76
Widowed	5	3.60
Total number of children		
0	38	27.34
1	30	21.58
2	28	20.14
3	23	16.55
4 or more	20	14.39
Perceived relationship with husband		
Unsatisfactory	10	7.19
Satisfactory	129	92.81
Perceived home environment		
Unsatisfactory	14	10.07
Satisfactory	125	89.93
Total number of miscarriages		
1	104	74.82
2	25	17.98
3 or more (up to 7)	10	7.20
Emotional problems after miscarriages		
No	37	26.62
Yes	102	73.38

Mean, standard deviation, and Cronbach's alpha were computed for all study measures. The Perinatal Grief Scale (PGS) had a total mean score of 97.04 ($SD = 23.82$, $\alpha = .95$). Its subscales revealed the following mean scores: Active Grief ($M = 36.15$, $SD = 8.92$, $\alpha = .88$), Difficulty Coping ($M = 30.53$, $SD = 7.59$, $\alpha = .82$), and Despair ($M = 30.37$, $SD = 9.33$, $\alpha = .90$). For the Depression Anxiety Stress Scale (DASS), the total mean score was 22.69 ($SD = 12.33$, $\alpha = .94$). Subscale scores included Stress ($M = 8.53$, $SD = 4.38$, $\alpha = .84$), Anxiety ($M = 7.06$, $SD = 4.40$, $\alpha = .84$), and Depression ($M = 7.11$, $SD = 4.53$, $\alpha = .85$).

The study used independent samples t-tests to test the hypothesis that the relationship of participating women with their husband, family system, satisfaction with the home environment, and experience of emotional problems after miscarriage influence perinatal grief, depression, anxiety, and stress in women after recent miscarriages or not. The results of the independent samples t-test showed that women who reported satisfaction with their relationship with their husband had significantly lower scores on the PGS total and its active grief, difficulty coping, and despair subscales, as well as the DASS total and its anxiety and depression subscales. However, no significant differences were observed between the two groups on the DASS stress subscale. Similarly, women who reported satisfaction with their home environment had significantly lower scores on the PGS total and its three subscales and the DASS total and its three subscales (Table 2).

Table 2
Welch's t-test for Relationship with Husband and Home Environment (N=139).

Variable	Dissatisfied ^a		Satisfied ^a		t (137)	p-value	95% CI		Cohen ^c
	M	SD	M	SD			Lower	Upper	
Relationship with husband									
Perinatal grief total	115.20	18.95	95.64	23.64	2.55	.012*	4.40	34.73	.84
Active grief	41.90	8.41	35.71	8.84	2.14	.034*	0.48	11.91	.70
Difficulty coping ^b	35.90	4.86	30.11	7.61	3.45 ^d	.004**	2.16	9.42	.78
Despair	37.40	6.83	29.82	9.30	2.52	.013*	1.64	13.52	.83
DASS total	30.70	9.83	22.07	12.32	2.16	.032*	0.73	16.53	.71
Anxiety	9.90	3.93	6.84	4.37	2.15	.034*	0.24	5.88	.70
Depression	10.70	2.98	6.83	4.52	2.66	.009**	0.99	6.75	.87
Home environment									
Perinatal grief total	117.14	21.41	94.79	23.08	3.46	<.001***	9.57	35.13	.97
Active grief	43.21	7.57	35.36	8.74	3.23	.002**	3.04	12.67	.91
Difficulty coping	36.14	6.33	29.90	7.48	3.01	.003**	2.14	10.36	.85
Despair	37.79	8.74	29.54	9.05	3.24	.001**	3.22	13.28	.91
DASS total	34.93	8.72	21.32	11.94	4.14	<.001***	7.11	20.11	1.17
Stress	12.00	3.76	8.14	4.29	3.23	.002**	1.50	6.23	.91
Anxiety	10.71	3.20	6.65	4.34	3.40	<.001***	1.70	6.43	.96
Depression	12.21	2.75	6.54	4.33	4.79	<.001***	3.33	8.02	1.35

^aFor relationship with husband, n=10, and for home environment, n=14;

^bFor relationship with husband, n=129, and for home environment, n=125;

^cThe Welch test is reported because Levene's test indicated that the homogeneity of variance assumption was not met for this variable; df=12.71. *p < .05, **p < .01, ***p < .001

An independent samples t-test was conducted to assess the impact of family structure on study variables, comparing women from nuclear and joint family systems. The results revealed no statistically significant differences, indicating that family structure did not significantly influence perinatal grief or related psychological outcomes. Additionally, a separate t-test showed that women who experienced emotional problems after miscarriage had significantly higher scores on perinatal grief and its subscales, and depression, anxiety, and stress (Table 3).

Table 3
Independent Sample t-Test Results for Emotional Problems after Miscarriage (N=139).

Variable	No ^a		Yes ^b		t (137)	p-value	95% CI		Cohen ^c
	M	SD	M	SD			Lower	Upper	
Perinatal grief total	83.70	23.35	101.88	22.18	-4.21	<.001***	-26.72	-9.64	-.81
Active grief	29.57	8.91	38.54	7.67	-5.83	<.001***	-12.01	-5.93	-1.12
Difficulty coping	27.43	7.18	31.65	7.45	-2.98	.003**	-7.02	-1.41	-.57
Despair	26.70	9.03	31.70	9.12	-2.86	.005**	-8.45	-1.54	-.55
DASS total	17.65	12.31	24.52	11.88	-2.99	.003**	-11.42	-2.32	-.57
Stress	6.27	4.05	9.34	4.23	-3.83	<.001***	-4.66	-1.49	-.74
Anxiety	5.73	4.61	7.54	4.24	-2.17	.032*	-3.46	-0.16	-.42
Depression	5.65	4.42	7.64	4.47	-2.32	.022*	-3.68	-0.30	-.45

The present study used a one-way ANOVA analysis to examine differences in our study measures across three marital status groups: married, divorced, and widowed. The analysis revealed significant group differences in PGS total [$F(2, 136) = 3.62, p = .029$], difficulty coping [$F(2, 136) = 4.09, p = .019$], and despair [$F(2, 136) = 3.71, p = .027$]. No significant differences were observed in active grief, DASS total, DASS-stress, DASS-anxiety, and DASS-depression.

DISCUSSION

This study advances the literature on the psychological impact of miscarriage by demonstrating that women's experiences of perinatal grief, depression, anxiety, and stress are significantly

influenced by their satisfaction with their husbands and home environment, their marital status and family system, and whether they experienced emotional problems after the miscarriage. Our findings reinforce the conceptualisation of grief as not an individual emotional state but an experience embedded within social and relational frameworks.¹³

Women who reported greater satisfaction with their relationships with their husbands exhibited significantly lower levels of perinatal grief, depression, anxiety, and stress. These findings align with the stress-buffering hypothesis proposed by Cohen and Wills, which suggests that strong social support can protect individuals from the adverse effects of stressful events by acting as a psychological buffer.¹⁴ Our findings are also consistent with studies conducted in other Asian countries, such as India,¹⁵ where cultural expectations and social pressures can intensify the emotional impact of pregnancy loss. In a country like Pakistan, where women who miscarry often face stigmatisation, being labelled as 'child-killers' or 'cursed' or seen as being punished by God,¹ the presence of social support, especially from spouses, becomes even more crucial for psychological recovery.

While previous studies have shown that miscarriage can affect interpersonal relationships, reduce relationship satisfaction, and increase family conflicts,¹⁶ our findings reveal that 89.93% of women who recently had a miscarriage perceived their home environment as satisfactory. These women also reported lower levels of perinatal grief, depression, anxiety, and stress, aligning with Taylor and Brown's proposition that positive perceptions, even if not fully reflective of reality, can foster psychological well-being.¹⁷

Another key finding of our study is that women who experienced emotional problems soon after miscarriage reported significantly higher levels of grief and psychopathology later on. This suggests that pre-existing or concurrent psychological vulnerabilities can intensify the emotional impact of miscarriage, making recovery more challenging. These results align with previous research indicating that difficulties in emotion regulation are central to the persistence and severity of complicated grief, with more maladaptive emotional responses being linked to higher levels of distress.¹⁸

Interestingly, no significant differences were observed between nuclear and joint family structures in terms of perinatal grief and associated psychological outcomes. This suggests that the functional quality of support, including perceived empathy, understanding, and effective communication, may be more critical than the mere number of family members present. These findings align with existing literature, which emphasises that emotional support is the most desired and impactful form of support following traumatic loss.¹⁹

Lastly, consistent with the findings of Zhang et al, the present study also observed differences in perinatal grief and psychological outcomes based on marital status (married, widowed, divorced), highlighting the significant role of relationship status in emotional recovery after miscarriage.²⁰

Given the findings of this research, several recommendations for both clinical practice and future research emerge. Healthcare providers should prioritise emotional support, with a strong focus on relationships with partners and family, as these factors significantly influence recovery. In culturally sensitive contexts where miscarriage remains stigmatised, such as in Pakistan, targeted interventions should be developed to address both emotional and psychological needs. Marital counselling and support programs should be integrated into reproductive health services, and mental health professionals should screen not only for symptoms of grief and psychological distress but also for relationship satisfaction and environmental stressors. Brief, structured interventions that improve partner communication or address home environment dynamics may be valuable additions to post-miscarriage care protocols.

Additionally, future research should include longitudinal studies to capture the long-term psychological impact of miscarriage and the evolving role of social support. The experiences of men, which are often overlooked, should also be explored, particularly regarding emotional regulation and psychological vulnerabilities.

Strengths and Limitations

This study has several strengths, including its focus on a culturally sensitive topic in a region where miscarriage is highly stigmatised, providing valuable insights into the unique psychological challenges faced by women. It uses an effective sample size and standardised assessment tools, enhancing the reliability and generalisability of the findings. Additionally, it highlights the importance of perceived support, moving beyond structural family dynamics to explore the quality of emotional connections. However, the study is limited by its cross-sectional design, which prevents causal inferences, and its reliance on self-reported data, which may introduce social desirability and recall biases. Also, it focuses primarily on women, ignoring the important yet less frequently studied experiences of men after perinatal loss. Moreover, the single cultural context may limit the generalisability of the findings, and the absence of longitudinal follow-up restricts insights into the long-term psychological impact of miscarriage.

CONCLUSION

In conclusion, this study demonstrates that women differ in their experiences of perinatal grief, depression, anxiety, and stress based on their satisfaction with relationships with their husbands, perceived family support, home environment, marital status, and emotional vulnerabilities. Positive perceptions of the home environment are associated with lower levels of perinatal grief, depression, anxiety, and stress, while emotional vulnerabilities exacerbate grief and psychological distress. These findings highlight the importance

of culturally sensitive, relationship-focused interventions to support emotional recovery after miscarriage, particularly in contexts where stigma remains a significant barrier to seeking help.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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DISCLOSURE

None

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REFERENCES

1. Asim M, Karim S, Khwaja H, Hameed W, Saleem S. The unspoken grief of multiple stillbirths in rural Pakistan: an interpretative phenomenological study. *BMC Womens Health*. 2022;22(1):45. doi:10.1186/s12905-022-01622-3
2. Mota C, Sánchez C, Carreño J, Gómez ME. Paternal Experiences of Perinatal Loss-A Scoping Review. *Int J Environ Res Public Health*. 2023;20(6):4886. doi:10.3390/ijerph20064886
3. Youngblut JM, Broton D, Glaze J, Promise T, Yoo C. Parent Grief 1-13 Months After Death in Neonatal and Pediatric Intensive Care Units. *J Loss Trauma*. 2017;22(1):77-96. doi:10.1080/15325024.2016.1187049
4. Herbert D, Young K, Pietrusińska M, MacBeth A. The mental health impact of perinatal loss: A systematic review and meta-analysis. *J Affect Disord*. 2022;297:118-129. doi:10.1016/j.jad.2021.10.026
5. Leon IG. Psychodynamics of perinatal loss. *Psychiatry*. 1986;49(4):312-324. doi:10.1080/00332747.1986.11024331
6. Gillani SA, Zafar F, Javaid R. The Journey of Grief: Exploring Gender Differences and Social Support, Following the Death of Significant Others. *The Critical Review of Social Sciences Studies*. 2025;3(1): 917-931. doi: <https://doi.org/10.59075/ayzvag81>
7. Silverman GS, Baroiller A, Hemer SR. Culture and grief: Ethnographic perspectives on ritual, relationships and remembering. *Death Stud*. 2021;45(1):1-8. doi:10.1080/07481187.2020.1851885
8. Janssen HJ, Cuisinier MC, de Graauw KP, Hoogduin KA. A prospective study of risk factors predicting grief intensity following pregnancy loss. *Arch Gen Psychiatry*. 1997;54(1):56-61. doi:10.1001/archpsyc.1997.01830130062013

9. Lasker JN, Toedter LJ. Predicting outcomes after pregnancy loss: results from studies using the perinatal grief scale. *Illn Crisis Loss*. 2000;8(4):350–372. doi:10.1177/105413730000800402
10. Sample size calculator [Internet]. Raosoft, Inc.; [cited 01 May 2025]. Available from : <http://www.raosoft.com/samplesize.html>
11. Potvin L, Lasker J, Toedter L. Measuring grief: A short version of the perinatal grief scale. *J Psychopathol Behav Assess*. 1989; 11(1): 29–45. doi: <https://doi.org/10.1007/BF00962697>
12. Henry JD, Crawford JR. The short-form version of the Depression Anxiety Stress Scales (DASS-21): construct validity and normative data in a large non-clinical sample. *Br J Clin Psychol*. 2005;44(2): 227–239. doi:10.1348/014466505X29657
13. Smid GE. A framework of meaning attribution following loss. *Eur J Psychotraumatol*. 2020;11(1):1776563. doi:10.1080/20008198.2020.1776563
14. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. *Psychol Bull*. 1985;98(2):310–357.
15. Roberts LR, Renati SJ, Solomon S, Montgomery S. Perinatal Grief Among Poor Rural and Urban Women in Central India. *Int J Womens Health*. 2021;13:305–315. doi:10.2147/IJWH.S297292
16. Wendołowska A, Kiełtek-Rataj E, Kalus A, Czyżowska D. Perceived Partner's Self-Control and Social Support Effects on Relationship Satisfaction in Couples Experiencing Infertility or Miscarriage: Dyadic Analyses. *Int J Environ Res Public Health*. 2022;19(4):1970. doi:10.3390/ijerph19041970
17. Taylor SE, Brown JD. Illusion and well-being: a social psychological perspective on mental health. *Psychol Bull*. 1988;103(2):193–210.
18. Eisma MC, Stroebe MS. Emotion Regulatory Strategies in Complicated Grief: A Systematic Review. *Behav Ther*. 2021;52(1):234–249. doi:10.1016/j.beth.2020.04.004
19. Cacciatore J, Thielemann K, Fretts R, Jackson LB. What is good grief support? Exploring the actors and actions in social support after traumatic grief. *PLoS One*. 2021; 16(5): e0252324. doi:10.1371/journal.pone.0252324
20. Zhang X, Chen Y, Zhao M, Yuan M, Zeng T, Wu M. Complicated grief following the perinatal loss: a systematic review. *BMC Pregnancy Childbirth*. 2024;24(1):772. doi:10.1186/s12884-024-06986-y

AUTHOR(S) CONTRIBUTION / UNDERTAKING FORM

Sr. #	Author(s) Name	Author(s) Affiliation	Contribution
1.	Fahmida Naheed	Department of Gynaecology (Unit 4), Bolan Medical College/Bolan Medical Complex Hospital, Quetta, Pakistan.	Provided initial research questions and hypotheses; designed the overall study framework; outlined the theoretical framework, and discussion sections; drafted and revised the initial manuscript.
2.	Mirrat Gul Butt	Department of Psychiatry & Behavioural Sciences, Mayo Hospital, Lahore, Pakistan.	Supervised the research process. Drafted the introduction and methodology and reviewed the final manuscript.
3.	Laiba Qayyum	Department of Psychiatry & Behavioural Sciences, Mayo Hospital, Lahore, Pakistan.	Led data collection, data analysis, and drafting and reviewing the results section.

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