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The impact of perinatal loss or miscarriage on partnerships and quality of life in women

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ABSTRACT

Introduction: Modern obstetrics, owing to advancements in technology and medicine, offers women improved prenatal diagnosis, intrauterine treatment options, and more effective perinatal care. Despite these advancements, approximately 10% to 15% of pregnancies in Poland end in miscarriage. These statistics highlight the significant number of women who undergo the loss of a child, leading to changes in their quality of life and the potential risk of strained partner relationships. The study aims to investigate the impact of perinatal loss or miscarriage on partnerships and the quality of life in women.

Material and methods: The clinical material comprised 158 women aged 18 to 49 years, who willingly participated in the study. The research employed a diagnostic survey method with survey questionnaires in the Polish version, including The Quality of Relationships Inventory and The World Health Organisation Quality of Life (WHOQOL)-BREF. The collected data underwent statistical analysis using the IBM SPSS Statistics package (v. 28).

Results: A correlation was observed between the quality of life and the assessment of the quality of relationships. It has been found that perinatal loss or miscarriage affects women's quality of life and partnerships. It has been proven that the more experiences related to miscarriages, the worse the assessment of the somatic quality of life. Additionally, the difference between the number of children and the assessment of perceived support from the partner was presented.

Conclusions: Respondents attach more importance to issues related to the social environment and partner relationships than to health aspects. A positive relationship has been demonstrated between the quality of life in the social sphere and the depth of relationships, which contributes to increasing the level of relationship quality. Moreover, it has been found that the loss of pregnancy brings the couple closer together.

Key words: quality of life, partnerships, miscarriage, perinatal loss.

INTRODUCTION

Modern obstetrics, owing to advancements in technology and medicine, provides women with improved prenatal diagnosis, intrauterine treatment options, and more effective perinatal care. Despite this, in Poland, approximately 10% to 15% of all pregnancies end in miscarriage [1].

The normal duration of pregnancy is 37 to 41 completed weeks. By definition, a birth at less than 37 weeks of gestation is a premature birth, while a birth before the 22nd week of pregnancy is called a miscarriage [2].

The causes of obstetric failure can be divided into maternal and foetal causes [2]. Starting with genetic disorders, the most common are aneuploidies and autosomal trisomies (Edwards syndrome, Patau syndrome, Down syndrome) [3]. Another cause of miscarriages is trophoblast dysfunction [4]. Maternal causes include the following: age, and functional and endocrine disorders, which include polycystic ovary syndrome (PCOS), diabetes, and hypothyroidism. Immune problems can also contribute to pregnancy loss, including thrombophilia and antiphospholipid syndrome [3]. Some infections are a direct cause of miscarriages, especially when they occur in the first trimester of pregnancy [5]. The incidence of uterine anatomical defects in women experiencing recurrent miscarriages ranges from 15% to 42%. Defects in-

clude a septum in the uterus or an arcuate uterus [6]. Cervical insufficiency may contribute to the failure to maintain a pregnancy [7].

From statistical data prepared based on information obtained from the Centre for Health Information Systems, it can be concluded that in Europe, the stillbirth rate does not exceed 6 deaths per 1000 deliveries, while in Poland, it is slightly more than 3 stillbirths per 1000 deliveries. In 2019, in Poland, over 39,000 women experienced miscarriages, and approximately 1700 women giving birth had stillbirths [1].

The above statistics highlight how many women experience the loss of a child. This event may be challenging both physically and mentally [8]. Every woman copes with this situation in her own way. The role of the midwife, among other things, is to use sensitive language, show empathy and understanding, supporting the patient in this difficult moment. To initiate a healthy grieving process, it is important for the patient to create memories consistent with her wishes, such as holding the baby, taking a photo, or making a footprint on a piece of paper [9, 10].

Certain risk factors predispose a woman affected by pregnancy loss to mental illness. These include a history of mental illness, childlessness, a feeling of lack of support from the environment, difficulties adjusting in marriage, previous miscarriage, and an ambivalent attitude towards the foetus [11]. Additionally, there is a likelihood of co-occurring mental problems and marital dissatisfaction. Based on the analysis of the research conducted so far, it can be assumed that women after the loss of a child have a higher level of disappointment in their marriage, negatively affecting interpersonal relationships and the sense of sexual fulfilment. Research indicates increased difficulties in relationships and marital breakdown after stillbirth [12-15].

The aim of the study was to assess the impact of the experience of miscarriage or perinatal loss on partner relationships and quality of life in women by analysing factors such as gender, age, place of residence, voivodeship, level of education, professional activity, number of children, and previous experiences related to stillbirth/miscarriage.

Table 1. Reliability of WHOQOL-BREF and assessment of the quality of the relationship (IJZ) domain scores

WHOQOL-BREF/IJZ	Cronbach's α
Somatic domain	0.848
Psychological domain	0.832
Social domain	0.707
Environmental domain	0.740
Perceived support	0.779
Interpersonal conflict	0.834
Depth of relationship	0.607

Few scientific studies on this topic have been undertaken in the Polish population. Few of them assess both the quality of life of women after miscarriage/perinatal loss and the relationships between partners. The topic is important and draws attention to the need for psychological help for women affected by this event.

MATERIAL AND METHODS

The material included a group of 158 women suffering from perinatal loss or miscarriage. Consent was obtained from the Independent Bioethics Committee for Scientific Research at the Medical University of Gdańsk, under number KB/300/2023. All participants were informed about the aims of the study and agreed to answer the questions in the questionnaire. The authors collected data in accordance with the Computer-Assisted Web Interview (CAWI) research methodology – an interview conducted *via* an internet channel. The questions were posted on social media accounts and among groups of women who had experienced pregnancy loss. Each participant in the target population had an equal chance of being included in the study. In the case of research conducted *via* the internet (CAWI), accessibility is wide, which favours the diversity of participants. Giving a negative answer to any of the exclusion criteria resulted in termination of participation in the study. The inclusion criteria for the study were female gender, age from 18 to 49 years, and confirmation of pregnancy loss. Data quality was controlled using various precautions, such as avoiding multiple responses from the same person through unique identifiers or mechanisms to check the uniqueness of participation. All these steps ensured the reliability and quality of the collected data. Participation in the study was completely voluntary and anonymous. The respondents' data was protected in accordance with the Personal Data Protection Act of 11 May 2023 [16].

The study was conducted by utilising a diagnostic survey method using a questionnaire. The questionnaire contained 60 questions (open and categorised). The first part included inquiries about demographic data, such as gender, age, place of residence, voivodeship, education, and professional activity. The following examinations concerned the obstetric past.

Lastly, the questions concerned the quality of life and relationships between partners. Two standardised questionnaires were used to collect data:

- The World Health Organisation Quality of Life (WHOQOL)-BREF standardised questionnaire, which is a shortened version in the Polish adaptation (Baran-Furga H, Habrat B, Steinbarth-Chmielewska K), enabling obtaining a quality of life profile in 4 areas: physical, psychological, social relations, and in the environmental field [17];

Table 2. Characteristics of the study group

Variable	*n*	%
Age (years)		
18-26	25	16
27-35	75	47
36-49	58	37
Domicile		
Village	53	33.5
City up to 50,000 inhabitants	35	22.1
City up to 50,000 to 200,000 inhabitants	35	22.2
City with over 200,000 inhabitants	35	22.2
Voivodeship of residence		
Lower-Silesian	11	7.0
Kuyav-Pomeranian	5	3.2
Lubelan	10	6.3
Lubush	5	3.2
Lodz	9	5.7
Lower-Polish	6	3.8
Mazovshan	21	13.3
Opolan	5	3.2
Subcarpathian	9	5.7
Subforrest	7	4.4
Pomeranian	31	19.6
Silesian	12	7.6
Holly-Cross	2	1.3
Varmy-Mazurian	6	3.8
Upper-Polish	12	7.6
West-Pomeranian	7	4.4
Education		
Basic	1	0.6
Middle school	1	0.6
Professional	3	1.9
Medium	35	22.2
Higher	116	73.4
Other	2	1.3
Professional activity		
Working person	131	82.9
A person working and studying	7	4.4
Student	3	1.9
Unemployed	17	10.8
Number of miscarriages		
1	101	63.9
2	34	21.5
3	17	10.8
4	3	1.9
5	1	0.6
6	2	1.3
Time since last miscarriage/stillbirth		
Less than 1 year	66	41.8
1-5 years	62	39.2
Over 5 years	30	19.0
Number of children		
Lack	84	53.2
1	30	19.0
2	29	18.4
3	11	7.0
4	3	1.9
5	1	0.6
Number of children		
Yes	135	85.4
No	23	14.6

- The Quality of Relationships Inventory standardised questionnaire – Polish adaptation (Suwalska-Barancewicz DK, Liberska H, Izdebski PK) allowing the assessment of relationships between partners [18, 19].

The authors of the questionnaires agreed to use Polish adaptations for the study. For the above-mentioned questionnaires, Cronbach's α is presented in Table 1.

The respondents expressed their opinions by marking the correct option on a verbal scale that was closest to the emotions they felt. Appropriate points were assigned to each answer in accordance with the above questionnaires. The collected research material was subjected to statistical analysis using the IBM SPSS Statistics package (v. 28). Quantitative variables were described using mean, standard deviation, median, quartiles, and minimum and maximum values. For qualitative variables, the number and percentage of categories were provided. First, the normality of data distribution was checked using the Shapiro-Wilk test, and the homogeneity of variances was checked using Levene's F test. Both groups were compared using the Mann-Whitney *U* test. The Kruskal-Wallis signed-ranked ANOVA test was used to compare more than 2 independent groups. Pearson's linear correlation coefficient was used to determine the correlation between quantitative variables. The obtained analysis results were considered statistically significant at $p < 0.05$.

RESULTS

The characteristics of the respondents are presented in Table 2.

WHOQOL-BREF was used to assess quality of life. The respondents rated their quality of life the highest in the environmental area. The somatic area was rated the lowest. Moreover, the respondents rated

their overall quality of life slightly higher than their satisfaction with their health (Table 3).

Women who experienced 3 or more pregnancy losses were characterised by the lowest somatic quality of life ($p < 0.05$) (Table 4).

The assessment of the quality of the relationship showed that the respondents obtained the highest score on the "Perceived support" scale. The lowest result was recorded in the "Interpersonal conflict" scale (Table 5).

Statistical analysis showed that the higher the satisfaction with health and the overall assessment of the quality of life, the greater the perceived support from the partner and the greater their participation and involvement in the relationship. Higher satisfaction with health and the overall assessment

Table 3. Assessment of quality of life after miscarriage/stillbirth (WHOQOL-BREF)

	M	Me	SD	Min	Max	Q1	Q3
Overall assessment of quality of life	3.78	4.00	0.83	1.00	5.00	3.00	4.00
Satisfaction with health condition	3.58	4.00	0.88	1.00	5.00	3.00	4.00
Somatic domain	12.99	13.60	2.96	5.60	19.20	11.20	15.20
Psychological domain	13.66	14.00	2.83	6.67	19.33	11.83	16.00
Social domain	14.11	14.67	3.22	4.00	20.00	12.00	16.00
Environmental domain	14.36	14.50	2.10	8.00	19.00	13.00	15.50

M – mean, Me – median, SD – standard deviation, Q1 – lower quartile, Q3 – upper quartile

Table 4. Number of pregnancy losses experienced and the assessment of the quality of life after miscarriage/stillbirth (WHOQOL-BREF) and the assessment of the quality of the relationship (IJZ)

WHOQOL-BREF/IJZ	Number of pregnancy									Statistics	
	1			2			3 and more				
	Q1	Me	Q3	Q1	Me	Q3	Q1	Me	Q3	H	*p*
Overall assessment of quality of life	3.00	4.00	4.00	3.00	4.00	4.00	3.00	4.00	4.00	3.062	0.216
Satisfaction with health condition	3.00	4.00	4.00	3.00	4.00	4.00	3.00	3.00	4.00	5.614	0.060
Somatic domain	11.20	13.60	15.20	11.20	14.00	15.20	8.80	11.20	13.60	7.100	0.029
Psychological domain	12.00	14.00	16.00	11.83	14.00	16.00	10.00	12.00	14.67	5.359	0.069
Social domain	13.33	14.67	16.67	12.00	14.67	16.00	12.00	12.00	16.00	5.060	0.080
Environmental domain	13.00	15.00	16.00	13.38	14.50	15.50	12.50	13.50	15.00	4.360	0.113
Perceived support	3.00	3.29	3.57	2.82	3.14	3.32	2.71	3.29	3.57	3.126	0.210
Interpersonal conflict	1.90	2.10	2.45	2.00	2.15	2.73	2.10	2.40	3.00	3.629	0.163
Depth of relationship	2.67	3.00	3.17	2.79	3.00	3.33	2.83	3.17	3.17	0.789	0.674

H – Kruskal-Wallis test

Table 5. Assessment of relationship quality (IJZ)

	M	Me	SD	Min	Max	Q1	Q3
Perceived support	3.18	3.29	0.52	1.14	4.00	3.00	3.57
Interpersonal conflict	2.26	2.15	0.48	1.30	3.40	2.00	2.60
Depth of relationship	2.99	3.00	0.37	1.67	3.83	2.79	3.17

M – mean, Me – median, SD – standard deviation, Q1 – lower quartile, Q3 – upper quartile

Table 6. Correlation between general quality of life and satisfaction with health (WHOQOL-BREF) and the assessment of relationship quality (IJZ)

	Overall assessment of quality of life		Satisfaction with health condition	
	r	*p*	*r*	*p*
Perceived support	0.303	0.000	0.293	< 0.001
Interpersonal conflict	–0.290	0.000	–0.331	< 0.001
Depth of relationship	0.166	0.038	0.161	0.044

r – Pearson's r coefficient, p – significance

Table 7. Correlation between 4 domains of quality of life (WHOQOL-BREF) and the assessment of relationship quality (IJZ)

	Somatic domain		Psychological domain		Social domain		Environmental domain	
	r	*p*	*r*	*p*	*r*	*p*	*r*	*p*
Perceived support	0.199	0.012	0.269	0.001	0.497	< 0.001	0.351	< 0.001
Interpersonal conflict	–0.235	0.003	–0.328	< 0.001	–0.518	< 0.001	–0.275	< 0.001
Depth of relationship	0.054	0.497	0.063	0.434	0.199	0.012	0.135	0.091

r – Pearson's r coefficient, p – significance

Table 8. Number of pregnancy losses experienced and the assessment of the quality of life after miscarriage/stillbirth (WHOQOL-BREF) and the assessment of the quality of the relationship (IJZ)

WHOQOL-BREF/IJZ	Number of pregnancy									Statistics	
	Lack			1			2 and more				
	Q1	Me	Q3	Q1	Me	Q3	Q1	Me	Q3	H	*p*
Overall assessment of quality of life	3.00	4.00	4.00	3.00	4.00	4.00	4.00	4.00	4.75	9.456	0.009
Satisfaction with health condition	3.00	4.00	4.00	3.00	4.00	4.00	3.25	4.00	4.00	9.634	0.008
Somatic domain	10.40	12.80	15.20	11.00	13.60	16.00	11.20	14.40	16.00	3.447	0.178
Psychological domain	11.33	13.33	15.33	11.83	14.00	16.17	12.67	14.67	16.00	4.311	0.116
Social domain	12.33	14.67	16.00	10.67	13.33	17.33	12.00	14.67	16.00	1.714	0.424
Environmental domain	13.50	14.50	15.50	12.38	14.50	16.00	13.00	14.50	16.00	0.503	0.778
Perceived support	3.04	3.29	3.57	2.43	3.21	3.71	2.71	3.14	3.43	6.869	0.032
Interpersonal conflict	2.00	2.10	2.30	2.00	2.25	3.00	2.00	2.35	2.80	6.067	0.048
Depth of relationship	2.83	3.00	3.29	2.67	3.00	3.33	2.67	3.00	3.17	1.631	0.442

H – Kruskal-Wallis test

of the quality of life can reduce the level of anger and ambivalent feelings towards one's partner (Table 6).

The higher the quality of life in the somatic, psychological, social, and environmental areas, the higher the partner's support rating. In turn, a higher level of quality in the areas indicated above determined a lower level of anger and ambivalent feelings towards one's partner. Moreover, it has been shown that the higher the quality of life in the social area, the higher the level of relationship quality in terms of relationship depth (Table 7).

Women who had 2 or more children rated their quality of life the highest and were the most satisfied with their health. Interestingly, respondents who did not have children rated the perceived support from their partner the highest, and the experience of interpersonal conflicts the lowest ($p < 0.05$) (Table 8).

The relationship between place of residence, education, and professional activity was examined, but no differences were found.

DISCUSSION

The aim of the study was to assess the impact of the experience of perinatal loss or miscarriage on partner relationships and the quality of life in women.

The impact of experiencing a perinatal loss or miscarriage is not indifferent to the quality of life in women because the more miscarriages experienced, the worse the somatic domain of quality of life (Table 4). It seems that there are other factors related to the deterioration of the quality of life of women in Poland that may have a significant impact on the results of this study, e.g. the unexplored impact of hormones on somatic sensations, depression, and interpersonal contacts.

There is a correlation between the quality of life and the assessment of the quality of the relationship. It has been shown that the higher the quality of life, the higher the assessment of the partner's support and the lower the level of anger and ambivalent feelings towards one's partner. Moreover, it has been shown that the higher the quality of life in the social area, the higher the level of relationship quality in terms of relationship depth (Table 7). A factor that has not been examined but which could have an impact on the study result is the financial status of the respondents and access to psychological support.

Our research shows that respondents who have experienced a miscarriage or perinatal loss may refer to a loved one to receive help in various situations. The lowest result was recorded on the "Interpersonal conflict" scale. The result of this scale determines the degree to which respondents experience anger and ambivalent feelings towards their partner.

Our result is contrary to the results of other researchers. From the analysis of another study, research-

ers showed that women (after losing a child in the prenatal or perinatal period) are characterised by a higher level of marital disappointment, compared to the control group [12].

The last but most significant result of this research is the ratio of the number of children to the assessment of perceived support from the partner. The respondents who did not have children rated the perceived support from their partner the highest and the experience of interpersonal conflicts the lowest (Table 8). This contradicts the results obtained by other researchers involving couples struggling with infertility and a control group [19]. In this study, we conclude that the inability to take on a parental role increases marital problems and reduces satisfaction with sexual contact. Emotions associated with the inability to get pregnant have a negative impact on communication [19]. It can be assumed that pregnancy loss and unsuccessful conception are situations that have different impacts on partner relationships.

The aspect of connecting partnership relationships with quality of life is shown in other studies, but in different contexts. An example is a study that analysed the health-related quality of life (HrQoL) and relationships with male partners in postpartum women. Researchers proved that higher relationship satisfaction is associated with increased HrQoL [20].

The next study aimed to determine whether cognitive behavioural therapy (CBT) improves the quality of life of participants with anxiety disorders and whether the marital adjustment of couples with anxiety disorders could be improved using behavioural marital therapy (BMT). Researchers have shown that cognitive behavioural therapy for a partner with anxiety disorders and BMT for couples with anxiety disorders and marital discord, as well as the involvement of the spouse in therapy, will be a useful adjunct to the therapy of a couple in which one partner has an anxiety disorder [21].

LIMITATIONS OF THE STUDY

There is little scientific research on the abovementioned topics. This is due to a controversial topic regarding the intimate sphere of life, which many women affected by loss do not want to talk about. The study is difficult, and there are few people willing to participate in the study due to its type. The lack of direct contact with women resulted in a small number of respondents, which can limit the accuracy of the study.

CONCLUSIONS

The more experiences related to miscarriages, the worse the assessment of the somatic domain of women's quality of life. This highlights the cumulative impact of experiences of miscarriage trauma on aspects of women's physical health and well-being.

There are other, unexplored factors that may have a significant impact on the quality of life of women in Poland, such as the need to receive psychological help. This suggests the need for further research to more fully understand these relationships.

Women after pregnancy loss rated their quality of life the highest in the environmental area, while the somatic area was rated the lowest (Table 3). It can be concluded that women after a miscarriage give greater importance to issues related to the social environment, closeness, and interpersonal relationships than to health aspects.

There is a clear correlation between overall quality of life and the assessment of relationship quality. A positive relationship has been demonstrated between the quality of life in the social sphere and the depth of relationships, which contributes to increasing the level of relationship quality.

The findings show that improving the overall quality of life and social life can have a positive impact on the dynamics and depth of relationships, and taking care of the well-being and support of a partner may be crucial to supporting healthier and more satisfying relationships. The impact of the respondents' financial situation and access to psychological support should be examined to explore the topic further.

Respondents who did not have children rated the perceived support from their partner the highest and the experience of interpersonal conflicts the lowest. It can be concluded that the loss of a pregnancy brings the couple closer together. You could even go as far as to say that the loss of a child deepens relationships.

Disclosure

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