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# Couples' Subjective Well-Being Around Live Birth and Pregnancy Loss

ALESSANDRO DI NALLO 

*This study examines the trajectories of subjective well-being (SWB) of women and their partners transitioning to parenthood or remaining childless after experiencing pregnancy loss in the United Kingdom.*

*Childbearing is generally associated with short-term improvements in women's and men's SWB. However, less is known about couples' well-being dynamics before and after pregnancies ending in losses, despite 10–20 percent of the pregnancies that occurred in high-income countries terminating spontaneously.*

*Using fixed-effects linear regressions, the study analyses first-time pregnancies of women recorded across the 13 waves of the UK Household Longitudinal Study (UKHLS), from 2009 to 2023 (N = 18,897 observations for women and N = 11,223 for men).*

*The results indicate that there are differences in SWB trajectories based on pregnancy outcomes, with mothers showing better SWB compared to women who experience pregnancy loss. The involuntary terminations negatively impact two indicators of women's SWB (mental health and life satisfaction) upon pregnancy loss, while women who had a live birth experience an increase in SWB around childbearing. Partners are less affected by pregnancy loss, though the effects on life satisfaction scores may be more persistent. These results suggest that the well-being consequences of pregnancy loss are primarily, but not exclusively, shouldered by women.*

## Introduction

The association between fertility and subjective well-being (SWB) is extensively documented. Previous research has shown that transitioning to parenthood can improve well-being, which is a crucial factor in the decision-making process regarding having children, particularly in

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This article is dedicated to V. and R., who enlightened me during the realization of this work.

high-income countries (Balbo and Arpino 2016; Mencarini et al. 2018; Myrskylä and Margolis 2014). Most studies indicate that SWB tends to remain relatively stable but may fluctuate during major life events (Luhmann et al. 2012). This pattern is evident during the transition to parenthood: well-being improves in the years surrounding the childbirth, but subsequently returns to prepregnancy levels or even drops below them (Clark and Georgellis 2013; Myrskylä and Margolis 2014; Tosi and Goisis 2021).

However, no study to date has examined the changes in couples' well-being before and after pregnancy, considering the pregnancy outcome. This gap is significant because pregnancy loss is associated with depression, grief, symptoms related to anxiety, and post-traumatic stress (e.g., Blackmore et al. 2011; Gold et al. 2016; Huss 2021; G. W. S. Kong et al. 2013). Advancements in medical care have generally stabilized overall pregnancy loss rates in high-income countries (Kniffka et al. 2025; Strumpf et al. 2021). However, the average age of conception has been rising, with higher maternal age being strongly associated with an increased risk of involuntary pregnancy loss (Dimitriadis et al. 2020). These trends not only influence the biological risk of pregnancy loss but also intersect with societal expectations around reproduction and parenthood, amplifying the emotional toll on individuals and couples. Understanding these dynamics is crucial, as the risk of adverse outcomes can shape decisions about future childbearing and impact partnership stability (G. Kong et al. 2010; McDonald, Dasch-Yee, and Grigg 2022). Despite their social relevance, involuntary pregnancy interruptions remain an underexplored public health issue (Bellhouse, Temple-Smith, and Bilardi 2018), with their emotional and psychological toll compounded by their economic impact. For instance, these losses impose significant costs on healthcare systems, with annual costs estimated at £471 million in the United Kingdom (Quenby et al. 2021). Addressing these gaps in knowledge is important for understanding their broader implications for individual well-being and public health.

Previous research has examined the fluctuations in individuals' well-being during the period preceding and following the parenthood transition (Clark and Georgellis 2013; Myrskylä and Margolis 2014). However, these studies have largely overlooked the experience of a pregnancy loss. This represents a gap in knowledge considering the prevalence of miscarriages and stillbirths, which affect approximately one in six pregnancies (Ammon Avalos, Galindo, and Li 2012). Past studies have predominantly focused on women, with comparatively little attention given to male partners and the dyadic dynamics of couples following pregnancy loss (e.g., Farren et al. 2016; He et al. 2019). Furthermore, most studies have used cross-sectional designs or short observation periods (e.g., Cumming et al. 2007; Farren et al. 2018). They primarily focused on postpregnancy changes in SWB, particularly in women and, to a lesser extent, men, following a loss, without examining the prepregnancy dynamics that may shape these

outcomes. Therefore, the role of gender in influencing emotional responses, as well as the differential trajectories of well-being before, during, and after pregnancy loss, remains underexplored.

Drawing data from the UK Household Longitudinal Study (UKHLS; “Understanding Society”), this study analyses the dynamics of the SWB of women and their partners before, during, and after women’s first-time pregnancy, whether it results in a live birth or a pregnancy loss. The analysis focuses on a sample of more than 2000 women and their partners, who can be followed for up to 13 waves. By employing fixed-effects linear regressions, the study explores how different pregnancy outcomes—live births and pregnancy losses (miscarriages and stillbirths)<sup>1</sup>—impact SWB trajectories, particularly in relation to mental health and life satisfaction.

This study makes three contributions. First, it uses longitudinal data to explore long-term shifts in SWB before and after pregnancy, covering both live births and pregnancy losses. Previous research, often limited by short observation periods and selective samples, typically established baselines for postpregnancy loss, capturing individuals amidst grief (see the reviews in Farren et al. 2018; Huffman, Schwartz, and Swanson 2015; Levy et al. 2022). While Huss (2021) also used panel data, it tracked well-being only 1 year before pregnancy, unlike the current study, which extends the observation period to over 2 years before the pregnancy ends. This approach provides a deeper, more comprehensive understanding of the childbearing dynamics before most pregnancies are planned (De La Rochebrochard and Joshi 2013). Additionally, the study differentiates between couples transitioning to parenthood and those experiencing a pregnancy loss, providing a comparative perspective rarely seen in previous research (Farren et al. 2016; Neugebauer et al. 1992). Importantly, it distinguishes the overall impact of pregnancy on SWB from the specific effects of pregnancy loss (Carter, Misri, and Tomfohr 2007).

The second contribution is the analysis of well-being patterns in couples, both in the short and long term. While previous research indicates a modest post-childbirth increase in women’s SWB (Myrskylä and Margolis 2014), men’s post-parenthood psychological response is less clear. Further, the long-term effects of involuntary pregnancy interruptions on both partners are less understood. This research sheds light on the emotional experiences of both partners regarding parenthood transition and pregnancy loss, offering insights into how such events might influence partnership satisfaction (Gravensteen et al. 2018) and the stability of relationships (Gold, Sen, and Hayward 2010).

Third, from a methodological standpoint, the study addresses potential confounders in the link between pregnancy outcomes and couples’ mental conditions. Recognizing that couples who experience pregnancy loss might be prone to mental health issues due to factors like age, subfertility, genetic traits (Dimitriadis et al. 2020), or higher levels of baseline stress and

anxiety (Mulder et al. 2002; Nepomnaschy et al. 2006), the study employs a longitudinal design with fixed-effect multivariate analysis. This approach effectively controls for preconception SWB and sociodemographic characteristics, thereby mitigating bias from both unobserved time-invariant and time-varying confounding variables.

This study highlights the spectrum of emotional and psychological dimensions of reproduction, emphasizing their importance within medical sociology and public health. It argues that reproductive experiences are not only biological processes but are deeply shaped by social norms and expectations (Greil, Slauson-Blevins, and McQuillan 2010). Further, it addresses how deviations from these norms—such as experiencing an involuntary pregnancy interruption—can have lasting effects on well-being (Huijts, Kraaykamp, and Subramanian 2013). By analyzing two dimensions of SWB—mental health (emotional-affective) and life satisfaction (cognitive)—and examining the experiences of both partners, this study offers a comprehensive view of how pregnancy outcomes shape SWB. The findings have implications not only for academic research but also for informing policy and support systems aimed at mitigating the psychological impact of pregnancy loss on couples.

## Background

### Subjective well-being and pregnancy outcomes

The literature has shown that couples' well-being generally improves around the time of childbearing (Clark and Georgellis 2013; Myrskylä and Margolis 2014) before subsequently declining to prepregnancy levels (Clark et al. 2008; Myrskylä and Margolis 2014; Tosi and Goisis 2021), although postpartum depression is reported in variable proportions (A. F. Bell et al. 2016). This decline may occur when the economic and psychological costs associated with child-rearing potentially outweigh the feelings of pride, self-realization, and personal fulfillment (Hansen 2012, 31–33). Such findings align with the set-point theory (Kahneman, Diener, and Schwarz 1999), which posits that individuals possess baseline levels of well-being determined by personality and genetic traits, only temporarily influenced by certain life milestones, such as a childbirth (Luhmann et al. 2012).

Experiencing an involuntary pregnancy interruption can be traumatic, negatively impacting mental health and overall well-being (e.g., Janssen et al. 1996). Bereavement research consistently links pregnancy loss to symptoms of depression, anxiety, and prolonged grief (Blackmore et al. 2011; Janssen et al. 1996; Neugebauer et al. 1992; Obst et al. 2020). The emotional distress stemming from such a loss often leads couples to confront difficult decisions regarding future conception, including whether to attempt natural conception or pursue fertility treatments. The societal stigma

around infertility can amplify stress, altering family dynamics (Köksal and Goisis 2023) and challenging the stability of partnerships (Gold, Sen, and Hayward 2010; Pelikh et al. 2024). In societies where parenthood is highly valued, pregnancy losses may be perceived as personal or familial anomalies (Bellhouse, Temple-Smith, and Bilardi 2018), possibly discouraging couples from seeking support (Slade et al. 2007) and influencing their future child-bearing plans (Beringer and Milewski 2024).

### Variations in SWB before, during, and after pregnancy

Well-being fluctuations around pregnancy can be profound, with significant variations even before conception based on pregnancy outcomes. The transition to parenthood is usually associated with a peak in SWB around the delivery (Hansen 2012). Longitudinal analyses have documented a spike in happiness at least 1 year prior to childbirth (Clark and Georgellis 2013; Myrskylä and Margolis 2014). Couples often experience a boost in well-being around childbirth due to increased sexual activity and the novelty of planning for parenthood (Hansen 2012; Tosi and Goisis 2021). Upon childbirth, couples, and particularly the women, benefit from health-protective hormones, such as oxytocin, whose influence may last several months (Myrskylä and Margolis 2014; Ryan and Deci 2001). However, well-being typically decreases post-childbirth, returning to preconception levels (Myrskylä and Margolis 2014) or plummets below the preconception baseline after a few years or, in some cases, months (Nomaguchi and Milkie 2020; Pollmann-Schult 2014). Previous studies have suggested an intersection of economic, time, and relationship conflicts for this decrease. The postpregnancy period forces new parents to change their lifestyle by making room for child-rearing and reorganizing their work–family balance, which may eclipse the emotional uplift of parenthood (Luhmann et al. 2012; Matysiak, Mencarini, and Vignoli 2016).

The dynamics of well-being surrounding pregnancy loss, especially during the preconception period, remain understudied. Pregnancy losses, which often occur unexpectedly, are more common among older couples (Dimitriadis et al. 2020). While some evidence shows a rise in SWB during the months leading up to conception—similar to couples transitioning to parenthood—those who experience pregnancy loss may follow a different trajectory. This pattern can be attributed to factors such as subfertility issues (Hakim and Gray 1995; Koot et al. 2011; Macklon 2002), previous miscarriages or stillbirths (Dimitriadis et al. 2020), or involvement in medically assisted reproduction (MAR) procedures (Farr, Schieve, and Jamieson 2007; Schirmer et al. 2020). Couples undergoing MAR often face stress related to hormonal treatments (Verhaak et al. 2007) and the challenge of balancing medical appointments with work (Courbiere et al. 2020), which can strain relationship dynamics. This suggests that couples who experience

a pregnancy loss may not experience the rise in well-being observed among those transitioning to parenthood.

The aftermath of pregnancy loss often brings about grief and bereavement (Obst et al. 2020). Both women and men may endure a prolonged period of heightened stress as they navigate renewed conception efforts. Research highlights the presence of depressive and anxiety symptoms in postpregnancy loss (e.g., Blackmore et al. 2011; Janssen et al. 1996; Neugebauer et al. 1992) lasting anywhere from weeks (Hughes, Turton, and Evans 1999; Thapar and Thapar 1992) up to several years (Nordal Broen et al. 2005). Some studies suggest that women who are unable to complete a pregnancy may struggle to return to their prepregnancy baseline levels of well-being, especially in studies with limited follow-up durations (Delgado et al. 2023). Therefore, this study hypothesizes that *women (and their partners) who experience a pregnancy loss will not exhibit the same short-term increase in SWB typically observed within individuals transitioning to parenthood (Hypothesis 1a)*, and that *their well-being may consistently remain below preconception benchmarks after pregnancy end in the long term (Hypothesis 1b)*.

### Variation by gender

Pregnancy and fertility experiences are highly gendered, with women often shouldering greater societal and biological expectations (Almeling 2015). The gendered dynamics become evident during the transition to parenthood. Research shows that women typically experience a surge in happiness around childbirth, though this increase tends to diminish over time (Myrskylä and Margolis 2014; Tosi and Goisis 2021). This pattern aligns with broader sociological findings that highlight the social isolation women often face post-childbirth. This isolation is largely driven by societal norms that expect women to take on the main caregiver role and, in some cases, to leave the workforce temporarily (Della Giusta, Jewell, and Kambhampati 2011). Also, elevated expectations of parenthood pre-birth might further contribute to a decline in women's satisfaction (Myrskylä and Margolis 2014).

In contrast, the influence of fatherhood on men's SWB is more ambiguous. Some studies show negligible changes in men's well-being before and after pregnancy (Clark and Georgellis 2013; Myrskylä and Margolis 2014), while others suggest brief positive effects (Balbo and Arpino 2016; Matysiak et al. 2016; Tosi and Goisis 2021). Fathers' lower or nonsignificant response may be attributed to biological factors, given their lack of direct physical experience during pregnancy and the absence of protective hormones that women produce (Myrskylä and Margolis 2014; Ryan and Deci 2001). Additionally, fathers may face similar challenges to mothers, such as sleep disturbances, which could offset any well-being gains from fatherhood (Matysiak et al. 2016). Therefore, this study hypothesizes that

*men may not experience the same significant increase in SWB during childbearing as women (Hypothesis 2a).*

Regarding pregnancy losses, societal norms often exacerbate the burden on women, as motherhood is frequently seen as central to female identity (A. V. Bell 2019). Empirical research consistently demonstrates the negative consequences on women's well-being (Kulathilaka, Hanwella, and De Silva 2016; Nordal Broen et al. 2006; Huss 2021). However, findings on male partners remain limited and based on small sample sizes (Davoudian, Gibbins, and Cirino 2021; G. Kong et al. 2010). Men's grief responses tend to be more varied (Delgado et al. 2023; Volgsten et al. 2018) and typically less pronounced than those of women (Farren et al. 2018; Obst et al. 2020). Several factors may explain these differences: men often feel less connected to the unborn child due to the lack of physical experience of pregnancy (Beutel et al. 1996), and societal stigma surrounding subfertility tends to affect women more (Slade et al. 2007), increasing their distress. Men may also downplay their own loss, viewing their primary role as supporters in the aftermath of pregnancy loss (Delgado et al. 2023). This perception may arise from the unequal physical burden of pregnancy (Delgado et al. 2023), uneven parental leave policies, and different views on the division of childcare responsibilities (Koster et al. 2022). Lastly, men may cope by increasing their involvement in work, leisure activities, or compensatory behaviors, such as higher alcohol consumption, to regain a sense of normalcy (Davoudian, Gibbins, and Cirino 2021; Due, Chiarolli, and Riggs 2017; Obst and Due 2021). Based on these observations, this study hypothesizes that *women who experience pregnancy losses display a decline in SWB indicators, while their male partners may remain relatively unaffected compared to their baseline (Hypothesis 2b)*. Figure 1 depicts the expected well-being patterns for women and men around their first pregnancies depending on the outcome.

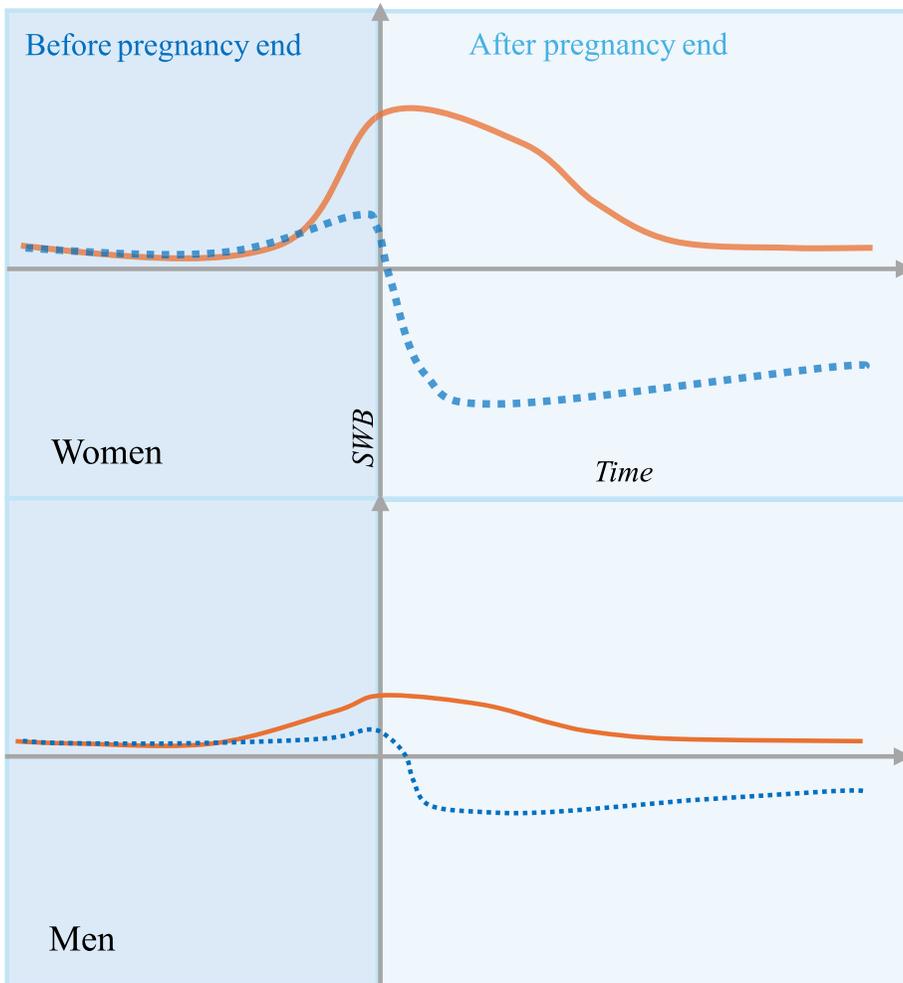
## Data and method

### Sample

This study uses data from the UKHLS (Understanding Society, University of Essex 2023, <https://www.understandingsociety.ac.uk>), a population-representative survey encompassing 40,000 households in the United Kingdom, spanning from 2009 to 2023. The dataset collects annual information on fertility, health, and family dynamics. The survey interviews all household members aged 16 or older and includes details on reported pregnancies, such as the date of conception (month and year), gestational length (in months), reasons for interruptions, and delivery outcomes reported by women.

The analysis focuses on a subgroup of women aged 15–45 who experienced their first pregnancy, either transitioning to parenthood or remaining

**FIGURE 1** Hypothesized trajectories of SWB for women (upper panel) and men (lower panel) around their first pregnancy, by live birth (continuous line) or pregnancy loss (dotted line)



childless after a pregnancy loss. This inclusion criterion is essential to ensure a reliable baseline value for examining the dynamics of well-being indicators around pregnancy and facilitating comparisons of these responses before and after pregnancy between women entering motherhood and those experiencing pregnancy loss. Supplementary analyses have also been conducted to account for maternal status, analyzing live births and involuntary terminations for mothers and previously childless women, as well as for women who experienced multiple instances of pregnancy losses.

Consequently, the analysis excludes the respondents who had previously given birth before their participation in the survey or those who did

not report any pregnancies prior to the conclusion of the follow-up period. Additionally, pregnant women who dropped out of the sample before reporting any pregnancy outcomes are not included in the analysis. To ensure consistency, five homosexual couples and 25 heterosexual couples reporting both live births and pregnancy losses between two consecutive waves are excluded.

The analyses involve two distinct samples: (a) women experiencing pregnancies and (b) their partners, whenever these partners are identified, as each woman's data are linked to her married or cohabiting partner if reported. This approach acknowledges that some pregnancies occur when women are single or with an undisclosed partner. Additionally, supplementary analyses are conducted, pooling data from women and their partners, to determine if there are systematic gender differences in SWB patterns around live births and pregnancy losses.

The final analytical sample includes 18,897 observations, which pertain to 2,146 women reporting live births and 257 women reporting pregnancy losses. Abortion cases are excluded from the analyses, as the focus of this study is on involuntary interruptions. Pregnancy losses, accounting for about 10.7 percent of all reported conceptions in the sample, align with estimates reported in the literature (Ammon Avalos, Galindo, and Li 2012; Buss et al. 2006). Official UK statistics lack comprehensive data on miscarriage prevalence, while stillbirths constitute 0.45 percent of pregnancies, consistent with available data (ONS 2023). In the analytical sample, stillbirths represented 0.47 percent of all conceptions, which precluded a separate specific analysis of stillbirths distinct from miscarriages due to their low incidence. The attrition rates are observed at 4.7 percent ranging from 24.1 percent between Waves 1 and 2 to 1.1 percent between Waves 12 and 13. Each woman's data are linked to her married or cohabiting partner if reported. The final analytical sample of partners consists of 1741 individuals and 11,223 observations. The attrition rates in this partner sample are slightly higher compared to those in women's sample (25.3 percent between Waves 1 and 2; 3.2 percent between Waves 12 and 13), predominantly due to union dissolution.

### Dependent variables

The first outcome is the Mental Component Summary (MCS) score, a measure of mental health—one of the indicators of SWB—derived from the SF-12 health questionnaire. The MCS score has been extensively validated and is used to identify mental health issues, including anxiety and depression (Ware, Kosinski, and Keller 1996). It comprises six questions related to mental well-being: “During the last four weeks, how much of the time (1) have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?” (2) “Did

you work or perform other regular daily activities with less care than usual due to emotional problems, such as feeling depressed or anxious?" (3) "Have you felt calm and peaceful?" (4) "Did you have a lot of energy?" (5) "Have you felt downhearted and depressed?" and (6) "Have your physical or emotional health issues interfered with your social activities, such as visiting friends or relatives?" The response options range from 1 ("all of the time") to 5 ("none of the time"). The MCS score is provided as a summated scale from lower to higher mental health levels (0–100). This scale is then standardized across the entire UKHLS sample, with a mean of 0 and a standard deviation of 1 (also see Tosi and Goisis 2021). The upper panel of Table 1 presents the MCS scores for both the "pregnancy loss" (left) and "live birth" (right) groups, stratified by female (upper panel) and male (lower panel) respondents over time.

The main analysis incorporates an additional indicator: life satisfaction. In the survey, this variable is measured by the question, "All in all, how satisfied are you with your life currently?" with responses ranging from 1 (not satisfied at all) to 7 (completely satisfied) and is standardized across all survey respondents, with higher values denoting greater life satisfaction (bottom panel of Table 1). Unlike the MCS scale, which belongs to the emotional-affective dimension of SWB, focusing on short-term, fluctuating emotional responses to life events, the life satisfaction measure involves a reflective and rational judgment about life circumstances, capturing a more stable, long-term perspective and providing a cognitive overview (Diener, Inglehart, and Tay 2013). By including both mental health and life satisfaction, the current analysis covers both the emotional-affective and cognitive domains of SWB, offering a comprehensive evaluation of individuals' conditions across pregnancies.

### Explanatory variables

The main independent variable identifies the outcome of a pregnancy between two consecutive waves. It is derived from a combination of questions that examine: (a) whether the woman reported a conception and (b) whether the pregnancy resulted in a live birth, or in a miscarriage or stillbirth. To investigate changes in well-being scores across pregnancy outcomes, the duration between the dates of conception and interview is computed. The dates of conception and involuntary interruption are usually recorded. If the dates of conception were not reported; the pregnancies are assumed to have ended between the wave in which the outcomes were reported and the preceding wave. The date of the interview is random and by no means associated with the timing of conception and pregnancy end. Therefore, the start and the end of gestation may occur anytime between two consecutive interviews.

**TABLE 1** Descriptive statistics of mental health and life satisfaction

	Mental health							
	Pregnancy loss				Live birth			
	<i>N</i>	Mean	<i>SD</i>	<i>z</i> -Score	<i>N</i>	Mean	<i>SD</i>	<i>z</i> -Score
Periods in months: <i>Women</i>								
25+ before	562	46.9	10.1	-0.1	3637	47.7	10.06	-0.03
13-24 before	172	45.74	10.95	-0.21	1280	46.76	10.38	-0.11
1-12 before	199	46.05	10.49	-0.18	1598	48.35	9.84	0.03
0-12 after	233	43.02	11.62	-0.47	1939	47.82	9.71	-0.01
13-24 after	179	46.83	10.74	-0.11	1594	46.77	10.33	-0.11
25-36 after	158	46.56	10.7	-0.13	1426	46.42	10.13	-0.15
37+ after	520	45.59	10.16	-0.22	5400	45.45	10.54	-0.24
Year-observations	2,023				16,874			
Individuals	257				2,146			
Periods in months: <i>Men</i>								
25+ before	202	50.16	8.21	-0.08	1713	50.96	8.23	0.01
13-24 before	91	48.94	9.63	-0.21	776	50.73	8.34	-0.02
1-12 before	113	48.89	9.33	-0.22	1067	50.43	8.23	-0.05
0-12 after	135	48.86	8.88	-0.22	1149	49.59	8.6	-0.14
13-24 after	119	48.31	9.05	-0.28	1037	48.81	9.16	-0.23
25-36 after	101	49.47	9.31	-0.16	945	48.38	9.22	-0.28
37+ after	324	48.86	8.73	-0.22	3451	48.04	9.43	-0.31
Year-observations	1,083				10,138			
Individuals	178				1,563			
Life satisfaction								
	Pregnancy loss				Live birth			
	<i>N</i>	Mean	<i>SD</i>	<i>z</i> -Score	<i>N</i>	Mean	<i>SD</i>	<i>z</i> -Score
Periods in months: <i>Women</i>								
25+ before	551	5.19	1.36	0.01	3637	5.36	1.33	0.14
13-24 before	171	5.29	1.33	0.08	1280	5.34	1.32	0.12
1-12 before	198	5.17	1.34	0	1598	5.51	1.26	0.24
0-12 after	233	5	1.5	-0.11	1939	5.6	1.27	0.3
13-24 after	178	5.25	1.45	0.06	1594	5.39	1.3	0.15
25-36 after	158	5.22	1.39	0.04	1426	5.36	1.31	0.13
37+ after	520	5.3	1.25	0.09	5400	5.22	1.32	0.04
Year-observations	2,023				16,874			
Individuals	257				2,146			
Periods in months: <i>Men</i>								
25+ before	202	5.47	1.07	0.15	1713	5.46	1.2	0.14
13-24 before	91	5.3	1.28	0.02	776	5.43	1.23	0.12
1-12 before	113	5.38	1.19	0.08	1067	5.43	1.26	0.12
0-12 after	135	5.38	1.21	0.08	1149	5.44	1.25	0.13
13-24 after	119	5.11	1.41	-0.12	1037	5.34	1.24	0.05
25-36 after	101	5.19	1.33	-0.06	945	5.29	1.24	0.02
37+ after	324	5.41	1.12	0.1	3451	5.23	1.24	-0.03
Year-observations	1,083				10,138			
Individuals	178				1,563			

The main explanatory variable is categorized into groups (see Tosi and Goisis 2021): (1) 25 or more months before the event, (2) 24 to 13 months before, (3) 12 to 1 month before, (4) 0 to 12 months after, (5) 13 to 24 months after, and (6) 25 to 36 months after, (7) 37 or more months after. The category “25 or more months before” is chosen as the baseline reflecting the understanding that most pregnancies are planned within a 2-year time-frame (Tosi and Goisis 2021), with about 40 percent in the United Kingdom being unplanned (De La Rochebrochard and Joshi 2013). However, some pregnancies may be preceded by fertility treatments, resulting in longer planning periods. For example, women may undergo natural conception attempts before resorting to MAR. Consequently, fertility treatments could be associated with past infertility or increased risk of pregnancy loss, and women who experienced a miscarriage or a stillbirth may have already encountered episodes of infertility during the baseline period, potentially reporting lower-than-normal levels of well-being (Tosi and Goisis 2021).

### Confounding variables

The models control for a set of confounding variables: respondent's and partner's age groups, year of conception, partnership status, job class, own and partner's highest education, and proxies of labor market conditions, such as the years of work experience, the annual number of job interruptions, and the logarithm of total net monthly personal income. The taxonomy of selected control variables (Table A.1) and the descriptive statistics by pregnancy outcomes and gender (Table A.2) are displayed in the Supporting Information (SI).

### Analytical strategy

The analysis employs longitudinal fixed-effect linear regressions to examine the changes in mental health and life satisfaction prior to and following pregnancy. The models incorporate mutually exclusive dichotomous indicators that capture the time (in months) leading to or since a live birth or a pregnancy loss. The estimated coefficients provide insights into how the scores change within individuals before, during, and after the conclusion of a pregnancy.

By incorporating individual fixed effects, this model accounts for and mitigates the bias stemming from time-invariant characteristics that may influence the relationship between pregnancy outcomes and SWB scores. This is particularly crucial when considering individuals who report a pregnancy loss. For instance, previous research has identified genetic predisposition, assumed time-invariant, as associated with a higher risk of miscarriage (Dimitriadis et al. 2020). The research design effectively addresses time-invariant drivers of selection, whether positive or negative.

The estimated coefficients reflect the specific circumstances experienced by partners both prior to and following pregnancy outcomes. The reference period (at least 25 months before pregnancy end) is identical for both groups and is not estimated because it coincides with the individual-specific constant. The design draws upon previous studies that have examined pre- and post-events in the life course (Myrskylä and Margolis 2014; Tosi and Goisis 2021) and is modeled as follows:

$$Y_{it} = \alpha_i + \beta LB_{it}^k + \gamma PL_{it}^k + \delta X_{it} + \varepsilon_{it},$$

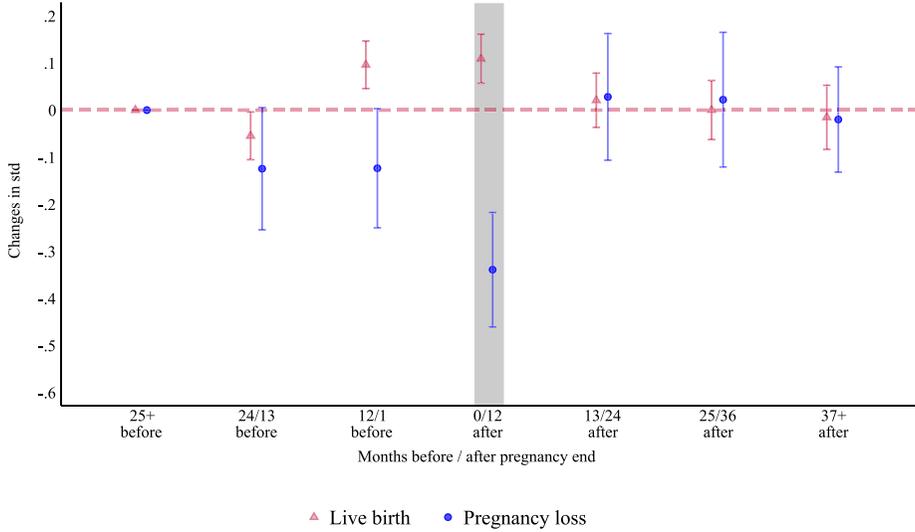
In this equation,  $Y$  represents the SWB outcomes of individual  $i$  at time  $t$ .  $LB$  denotes the set of time dummy variables capturing the time to or since a live birth, and  $PL$  represents the set of time dummy variables capturing the time to or since a pregnancy loss. The superscript  $k$  specifies the dummy variables for the two groups (live births and pregnancy losses), while  $\beta$  and  $\gamma$  are vectors of coefficients associated with the time intervals in the pre- and postpregnancy periods.  $\delta$  is the vector of coefficients of covariates  $X$ , while  $\alpha$  captures the individual fixed effects, accounting for baseline differences between  $LB$  and  $PL$ .

The main specification accounts for all the confounding variables but the transition to another child, while four models with controls added step-wise are presented in Tables A.3 and A.4 of SI. These estimations are performed separately for women and their partners to assess whether there are distinct effects of live births and pregnancy loss on SWB based on gender. To facilitate the interpretation of the findings, the Results section displays the predicted changes in women's and men's outcomes for both pregnancy outcomes. Figures 2 and 3 depict the results for mental health, while Figures 4 and 5 display the findings for life satisfaction z-scores, with separate figures for women and men.

## Results

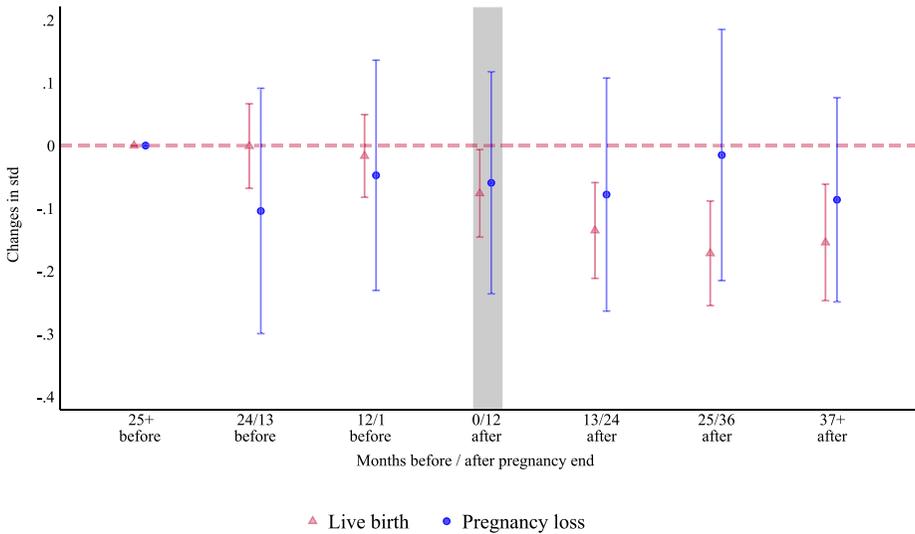
Table 2 presents the changes in mental health scores and life satisfaction based on fixed-effect linear regressions for women and men separately. Figure 2 shows the predicted changes in women's z-scores of mental health. Two distinct patterns in mental health trajectories between the two groups of women emerge: women reporting a pregnancy loss exhibit a U-shaped pattern, whereas women transitioning to motherhood display an inverse U-shaped trajectory. Mental health scores increased during the 12 months preceding and following a live birth by 0.10 and 0.11 standard deviations ( $p$ -value < 0.001), respectively. From the period "13–24 months" after live birth, mental health returns to baseline levels. Conversely, women who experience an involuntary pregnancy interruption report a sharp decrease (0.34  $SD$ ,  $p$ -value < 0.001) within the first 12 months from pregnancy end. A marginally significant decline ( $p$ -value < 0.10) is also observed in the 24

**FIGURE 2** Predicted changes in women's mental health (z-score) around pregnancy

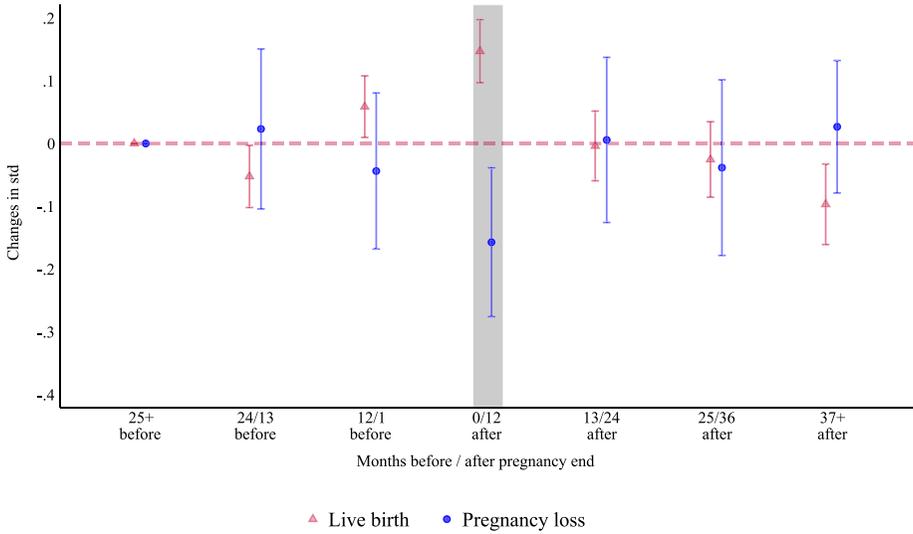


NOTE: Figure 2 plots coefficient estimates from Table 2.  
SOURCE: Understanding Society, United Kingdom (2009–2023).

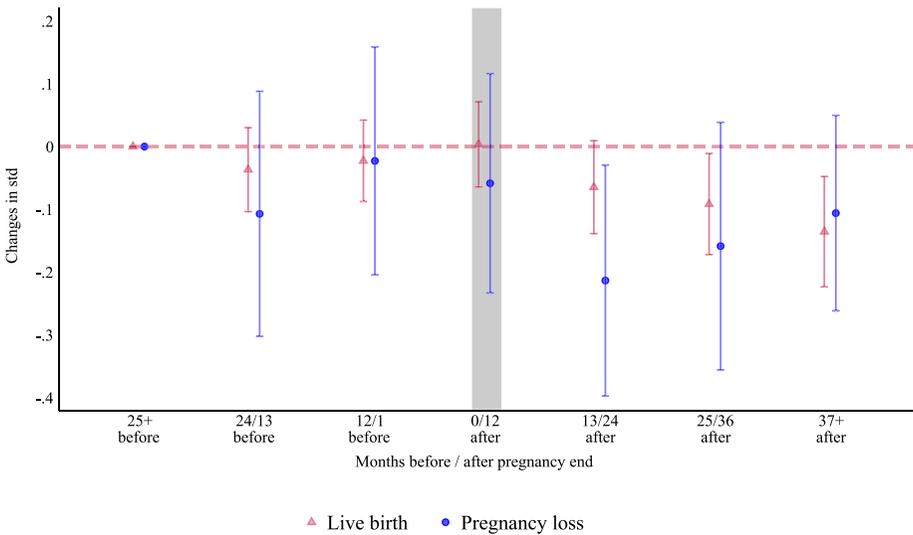
**FIGURE 3** Predicted changes in men's mental health (z-score) around pregnancy



NOTE: Figure 3 plots coefficient estimates from Table 2.  
SOURCE: Understanding Society, United Kingdom (2009–2023).

**FIGURE 4** Predicted changes in women's life satisfaction (z-score) around pregnancy

NOTE: Figure 4 plots coefficient estimates from Table 2.  
SOURCE: Understanding Society, United Kingdom (2009–2023).

**FIGURE 5** Predicted changes in men's life satisfaction (z-score) around pregnancy

NOTE: Figure 5 plots coefficient estimates from Table 2.  
SOURCE: Understanding Society, United Kingdom (2009–2023).

**TABLE 2** Fixed-effects linear regression models predicting changes in women's and men's outcomes around pregnancy (z-score). Main explanatory variables only

	Mental health		Life satisfaction	
	Women	Men	Women	Men
Months to/from live birth ( <i>Ref:</i> 25+ before)				
24–13 before	–0.05 <sup>*</sup> (0.026)	–0.00 (0.034)	–0.05 <sup>*</sup> (0.025)	–0.04 (0.034)
12–1 before	0.10 <sup>***</sup> (0.026)	–0.02 (0.034)	0.06 <sup>*</sup> (0.025)	–0.02 (0.033)
0–12 after	0.11 <sup>***</sup> (0.027)	–0.08 <sup>*</sup> (0.036)	0.15 <sup>***</sup> (0.026)	0.00 (0.035)
13–24 after	0.02 (0.029)	–0.14 <sup>***</sup> (0.039)	–0.00 (0.028)	–0.06 <sup>+</sup> (0.038)
25–36 after	0.00 (0.032)	–0.17 <sup>***</sup> (0.043)	–0.03 (0.031)	–0.09 <sup>*</sup> (0.041)
37+ after	–0.02 (0.035)	–0.15 <sup>**</sup> (0.047)	–0.10 <sup>**</sup> (0.033)	–0.14 <sup>**</sup> (0.045)
Months to/from pregnancy loss ( <i>Ref:</i> 25+ before)				
24–13 before	–0.12 <sup>+</sup> (0.066)	–0.10 (0.100)	0.02 (0.065)	–0.11 (0.100)
12–1 before	–0.12 <sup>+</sup> (0.065)	–0.05 (0.094)	–0.04 (0.063)	–0.02 (0.093)
0–12 after	–0.34 <sup>***</sup> (0.062)	–0.06 (0.090)	–0.16 <sup>**</sup> (0.060)	–0.06 (0.089)
13–24 after	0.03 (0.069)	–0.08 (0.095)	0.01 (0.067)	–0.21 <sup>*</sup> (0.094)
25–36 after	0.02 (0.073)	–0.02 (0.102)	–0.04 (0.071)	–0.16 (0.101)
37+ after	–0.02 (0.057)	–0.09 (0.083)	0.03 (0.054)	–0.11 (0.079)
Observations	18,897	11,223	18,897	11,223
Individuals	2,403	1,741	2,403	1,741

NOTE: Standard errors are in parentheses. Covariates of this specification (Model 3 in Supporting Information): age (categorical), year fixed effects, woman's educational attainment and NS-SEC5 job class, partnership status, partners' NS-SEC5 job class, and total net monthly personal income (in logarithm), years of work experience, the annual number of job interruptions. The full set of models (Models 1–4) and relative controls are displayed in Tables S.3 and S.4 of the Supporting Information. <sup>+</sup> $p < 0.1$ , <sup>\*</sup> $p < 0.05$ , <sup>\*\*</sup> $p < 0.01$ , <sup>\*\*\*</sup> $p < 0.001$ .

months leading to this event. This “anticipation effect” implies that a pregnancy loss may be preceded by a period of personal discomfort. Following the drop after the pregnancy termination, mental health recovers and returns to baseline levels.

Figure 3 presents the mental health trajectories of women's partners. The findings reveal the absence of anticipation effects and a significant and sustained decrease in mental health following the birth of a child compared to the baseline, in line with previous research. No clear decline is observed before or after a pregnancy loss, in contrast to the decrease experienced by women.

Figures 4 and 5 illustrate the estimated changes in women's and men's life satisfaction, respectively. Consistent with the findings on mental health, women's life satisfaction exhibits a significant increase 1 year before and in the same year as the live birth, by 0.06 ( $p < 0.05$ ) and 0.15 ( $p < 0.001$ ) standard deviations, respectively. Conversely, a statistically significant decline is observed for women in the year of experiencing a pregnancy loss. Similar to the analyses of mental health, this negative effect is concentrated solely during that period. In contrast to those analyses, no clear "anticipation effect" emerges throughout the 24 months preceding the pregnancy loss.

In line with the estimates of mental health, the life satisfaction indicator for men shows no peaks above the baseline around live births and remains consistently below the baseline following the parenthood transition. In contrast, men who experience a pregnancy loss report a decrease in life satisfaction post loss, with significantly negative effects ( $p$ -value  $< 0.05$ ) in the period between "13 and 24 months."

### Sensitivity analyses

To validate the main findings, additional analyses were conducted using the UK General Health Questionnaire (GHQ-12; National Health Service 2013), a composite measure of depressive symptoms (reverted for comparability with the other outcomes; see Figures A.1 and A.2 of the Appendix, and Table S.5 of SI), and an indicator of happiness (see Figures A.3 and A.4 of the Appendix, and Table S.6 of SI). The GHQ scores significantly increase (indicating better well-being conditions) around the time of live birth for women and remain stable for men. In the year of pregnancy loss, depressive symptoms temporarily increase for women (the GHQ score decreases) but return to baseline levels thereafter. Conversely, for men, the score steadily remains below the baseline but never becomes statistically significant. The happiness z-score follows a similar trajectory as the other outcomes for women. For men, the level of happiness constantly remains below the baseline and becomes statistically significant ( $p < 0.10$ ) in the long term.

A time-varying dichotomous factor was introduced to capture the transition to another birth for the "live birth" group and the transition to the first birth for the "pregnancy loss" group. This specification was motivated by the possibility that differences in SWB patterns between the two groups could be influenced by the fact that one group, "live birth," experienced the transition to parenthood, while the other, "pregnancy loss," did not after the first pregnancy. Within the analysis timespan, approximately 65 percent of women who initially reported a miscarriage or stillbirth eventually transitioned to motherhood, while 46 percent of women having a live birth had a second child (Table A.2 in SI). Consequently, the main analyses may not fully capture the effect of the transition to parenthood

for the “pregnancy loss” group after a miscarriage or a stillbirth, as there may be countervailing mechanisms at play. On the one hand, childbearing may enhance couples’ well-being across childbirth, as observed in the “live birth” group in the main analyses. On the other hand, the effect of a live birth could also be negative due to the stress associated with childrearing or postpartum depression. Either way, these countervailing forces may not be accounted for in the main analyses for couples who experience a pregnancy loss. The results of the sensitivity analysis largely aligned with the main findings. The mental health of women and men who reported an involuntary pregnancy termination exhibited a very similar profile as that reported in the main analysis (women panel - Model 4, Tables S.3 and S.4 of SI; Figure A.5 in the Appendix). The results for men showed a significant ( $p < 0.10$ ) decrease in life satisfaction also in the long term (“37 or more months after”; men panel - Model 4, Table S.4 of SI; Figure A.8 in the Appendix). In contrast to the main analysis, a pregnancy loss had a stronger negative impact on men’s life satisfaction but not on mental health. Similarly, a long-term marginally significant decrease in happiness ( $p < 0.10$ ) is also found in the robustness tests (men panel - Model 4, Table A.6 of SI). Thus, the main analyses may have underestimated the long-term scarring effect of a pregnancy loss on some indicators of men’s SWB.

Additional analyses displayed in the SI assessed the robustness of the main study. A test indicated that pregnancy losses more negatively affect women without children compared to those who are mothers, while the cumulative number of miscarriages or stillbirths did not significantly impact mental health (Table A.7 of SI). Further, a gender-specific analysis for couples (pooling women and their partners and excluding single women) revealed distinct mental health patterns around pregnancies: upon pregnancy loss, women’s mental health is significantly lower than men’s, while around the time of childbearing, women’s mental health is significantly higher (Tables A.8 and A.9 of SI). Additionally, the estimated trajectories of the two primary well-being scores in absolute terms are displayed in Figures S.9–S.12 of SI. Further sensitivity analyses—available upon request—explored various specifications, including matching designs to clarify the existence of preconception selection on observables, alternative reference groups, additional groups of non-mothers, different preconception mental health time frames, selective attrition or union dissolution, socioeconomic heterogeneity, and four possible mediators of SWB (income, union dissolution, employment, job separation). All these tests confirmed the appropriateness of the analyses displayed.

## Discussion

This study provided a comprehensive analysis of the SWB trajectories of women and their partners around their first pregnancies, whether these

result in a live birth or a pregnancy loss. Using data from the UKHLS, a British longitudinal survey, the study examined mental health and life satisfaction outcomes, showing insights into how individuals adjust psychologically before and after pregnancy. By accounting for individual and partner characteristics, such as demographics and socioeconomic factors, and employing fixed-effects models to control for unobserved, time-invariant influences, this research shed light on the experiences of couples transitioning to parenthood or coping with the grief of pregnancy loss.

Previous research examined the trajectories of couples' well-being during the period preceding and following the parenthood transition (Clark and Georgellis 2013; Myrskylä and Margolis 2014). However, these studies overlooked the experience of a pregnancy loss. Miscarriages and stillbirths, which affect approximately one in six pregnancies (Ammon Avalos, Galindo, and Li 2012), are significant but underexplored public health issues. The advancing age of conception, associated with heightened risks of pregnancy loss (Dimitriadis et al. 2020), further underscores the need to understand its long-term psychological impacts. While previous research has primarily focused on postpregnancy well-being changes, especially in women, this study extended the scope to include pre-pregnancy dynamics and long-term changes in male partners. Additionally, by including a group of women transitioning to motherhood, this research distinguished the implications of pregnancy loss from the specific well-being changes associated with live birth, such as anxiety or postpartum depression (Carter, Misri, and Tomfohr 2007). Despite the challenges of under- or misreporting in survey data (S. O. Bell and Fissell 2021), this study aligned with the prevalence reported in prior research (Bruckner and Catalano 2018) and contributed valuable information on early miscarriages that often go undocumented in public registers.

The study found that SWB around pregnancy varies with the outcome. Women transitioning to motherhood experienced a temporary improvement in mental health and life satisfaction before and after birth, consistent with prior studies (Kohler, Behrman, and Skytthe 2005; Myrskylä and Margolis 2014; Tosi and Goisis 2021). Conversely, women who experienced a pregnancy loss encountered a decline in well-being scores before and upon the involuntary interruption, in line with *Hypothesis 1a*, which proposed that women experiencing pregnancy loss would not exhibit the same short-term increase in SWB typically observed during the transition to parenthood. Although this decrease was short-lived, it was substantial in magnitude by the 12th month from pregnancy end. *Hypothesis 1b* predicted that well-being in the "pregnancy loss" group would consistently remain below pre-pregnancy benchmarks in the long term. However, the results showed that the outcomes of both groups of women returned to baseline levels after a 12-month span, offering a nuanced perspective on the resilience of well-being trajectories following these events.

Women who reported a pregnancy loss did not exhibit the preconception improvements observed among their counterparts who delivered a child. This subgroup of women may have already faced negative experiences related to subfertility or MAR (Köksal and Goisis 2023). The possibility of reverse causality cannot be entirely ruled out, as stress and anxiety, reflected in MCS scores, might negatively impact pregnancy outcomes (Maconochie et al. 2007; Nepomnaschy et al. 2006). Further, the baseline return of mental health scores within a year might be influenced by unmeasured factors, such as antidepressant use or therapy, especially as recent studies suggest women with subfertility are more likely to use antidepressants compared to those who had a live birth (Goisis et al. 2023). This analysis could not separate the reasons for the decline in women's SWB before pregnancy and its recovery postpregnancy nor establish a causal link between pregnancy loss and psychological conditions. However, it highlights the need for more research on how pre-pregnancy well-being is associated with fecundity and conception.

The analysis revealed distinct gender patterns in response to live births and pregnancy losses. In contrast to women, men did not report any improvement in SWB upon live birth, aligning with *Hypothesis 2a*, which posited that men would not experience the same increase in SWB observed in women during the transition to parenthood. An involuntary termination also displayed gender disparities as men's scores exhibited a less pronounced response, confirming *Hypothesis 2b*. This hypothesis suggested that women experiencing pregnancy losses would exhibit a significant decline in well-being, whereas men would remain relatively unaffected compared to their baseline. The magnitude of this effect, although smaller compared to that observed in women, suggests that men are not as affected psychologically. This finding could be attributed to the physiological absence of experiencing the loss of a child for men (Beutel et al. 1996), or potentially their ability to cope more effectively with grief upon loss (Due, Chiarolli, and Riggs 2017). Additionally, the findings showed that women and men do exhibit different SWB dynamics prior to pregnancy. In the "live birth" group, women display a positive anticipation effect ("12–1 months before"), whereas men do not. In the "pregnancy loss" group, women's anticipation is *negative* ( $p < 0.10$ ), while men do not exhibit any change.

Gender differences were apparent also in the mid and long term. While women did not exhibit any significant deviations from their baseline in either outcome, men experienced a decline in life satisfaction ( $p < 0.05$ ) starting from the 13th month after the pregnancy ended, while their happiness indicator also showed a significant long-term decrease. Additional analyses examining the impact of a live birth following an initial pregnancy loss (Tables A.3–A.6 of SI) confirmed that the coefficients associated with men's mental health were negative and nonsignificant in the short and long term, while the coefficients associated with life satisfaction and happiness

remained negative and statistically significant ( $p < 0.10$ ) also in the long term. These findings do not conclusively clarify whether transitioning to parenthood following an involuntarily interrupted pregnancy has a negative effect on men's well-being.

Men may experience a delayed or attenuated emotional response to pregnancy loss for several reasons. First, men's attachment to the pregnancy often develops later, typically when they see physical signs of development or take on a more active caregiving role (Peppers and Knapp 1980). As a result, the emotional impact may take longer to manifest as the reality of the loss sets in. Second, societal norms around masculinity discourage men from openly expressing grief, leading them to suppress emotions and internalize their grief, resulting in a delayed response (Obst et al. 2020; Wendołowska et al. 2022). Additionally, men may initially cope through action-oriented strategies, such as focusing on work or supporting their partner, which can further delay the emotional toll (Horstman, Holman, and McBride 2020). Nevertheless, increased stress due to changes in domestic tasks, the decline in partners' mutual empathy and relationship quality, and partners' selective survey dropout may also explain these patterns in the aftermath of pregnancy loss.

The gender differences in SWB dynamics may have significant implications. The contrasting well-being outcomes observed in women and men after a pregnancy loss may give rise to misunderstandings and conflicts within couples (Holter et al. 2006). This could potentially account for the increased levels of relationship dissatisfaction reported by couples who have suffered the unintended loss of a child (Kersting and Wagner 2012) as well as the heightened risk of relationship dissolution (Gold, Sen, and Hayward 2010).

Despite the extensive use of confounders, most fluctuations in the outcomes were not mediated by these factors (Tables S.3–S.6 of SI). This finding can be primarily attributed to the significance of conception and gestation in couples' life course. Another plausible explanation, though untestable with the available data, is the protective impact of pregnancy-induced hormones, which positively affect women's health and overall well-being (Ryan and Deci 2001). This would also help clarify why men's scores do not improve to the same extent as women's around pregnancy. The anticipated decline in women's mental health prior to pregnancy loss may be attributed to other factors, such as pre-existing unobservable predispositions to stress and anxiety (Maconochie et al. 2006), unexpected and stressful events (Bruckner and Catalano 2018), the social stigma linked to subfertility, or, in the case of women already undergoing fertility treatments prior to their first conception, the stress of attempts that did not result in live birth (Köksal and Goisis 2023). However, this anticipated decline is not observed in other outcomes, such as life satisfaction. The latter is a cognitive measure of SWB that reflects an overall evaluation of life and more rational judgment about life circumstances (Diener, Inglehart, and

Tay 2013). This measure tends to capture a more stable, long-term perspective, while mental health (or happiness or the GHQ score of depression) is an emotional-affective measure of SWB and focuses on short-term, fluctuating emotional responses to life events. These measures are more influenced by momentary moods or specific experiences, capturing the dynamic emotional states in response to daily experiences (Ware, Kosinski, and Keller 1996). Further research is necessary to examine the mechanisms that could explain the prepregnancy disparity in SWB between women who have a child and those who report a pregnancy loss.

This study has limitations. First, the sample size of the “pregnancy loss” group was small. Additionally, the analysis could not distinguish between miscarriages and stillbirths, potentially masking important variations in the psychological responses of couples depending on the type and timing of the loss. Previous research suggests that couples who experienced stillbirth often have more severe emotional responses compared to those who experience miscarriage (Beutel et al. 1996; Gold, Sen, and Hayward 2010). Second, the data did not provide information on prior episodes of pregnancy loss before the initial interview with UKHLS. Consequently, it was not possible to determine whether couples reporting a miscarriage or stillbirth were already aware of preexisting subfertility experiences or whether they were undergoing fertility treatments prior to the loss. Third, the possibility of contextual self-selection into the risk of pregnancy loss and lower well-being cannot be entirely ruled out. Couples in which at least one partner had pre-existing physical or mental health issues may be more vulnerable to pregnancy loss (Maconochie et al. 2006) or to stressors like demanding work schedules and job losses, both of which have been linked to pregnancy disruptions (Di Nallo and Köksal 2023; Whelan et al. 2007). To address potential selection bias, additional analyses using propensity score matching were conducted to account for observed selection factors associated with pregnancy loss. These analyses, available upon request, showed that selection effects were minimal beyond age differences, and the findings closely aligned with those reported in the main analyses. Nonetheless, selection bias based on unobserved factors, such as underlying health or lifestyle variables not captured in the data, may still affect the results. Fourth, the data did not allow for testing whether pregnancy loss was influenced by prior or contextual health issues experienced by the women or their partners, nor whether partnership satisfaction played a role, as this variable was not consistently available across survey waves. Fifth, previous research has shown that pregnancy outcomes are significantly affected by the type of conception, including repeated unsuccessful attempts at natural conceptions and MAR (Tosi and Goisis 2021). Unfortunately, the available data did not provide precise information on the timing of MAR, making it challenging to isolate its effects from other stressful experiences preceding a pregnancy loss. Future studies should aim to

clarify the relationship between conception circumstances and pregnancy outcomes.

This study has important implications. The findings provide a nuanced understanding of the social implications of live births and pregnancy loss. The analysis reveals that while pregnancy outcomes significantly influence women's responses—whether the outcome is a live birth or a pregnancy loss—the impact on men is somewhat less pronounced. This differential response underscores the pivotal role that gender plays in shaping reproductive experiences. Therefore, it is important to recognize that partners may experience different societal expectations and potential stigmas related to parenthood and the loss of a child.

From a research viewpoint, future studies on reproductive health should adopt a dyadic perspective, focusing on couples as well, and investigate other couple-level outcomes, such as fertility intentions, partnership satisfaction, and stability. This comprehensive approach ensures that the male perspective, often overlooked, remains integral to discussions and studies on reproductive experiences and health. At a broader level, these findings reiterate the significance of social bonds and societal norms in framing experiences related to reproductive health (Umberson and Karas Montez 2010).

From a policy viewpoint, the evidence on gendered pathways also underscores the importance of offering more gender-egalitarian support to grieving partners. Previous literature suggests that healthcare services typically prioritize individual-level support for women while neglecting to provide suitable options for men's individual needs (Obst et al. 2020). To address this gap, it is crucial to implement strategies that promote male-inclusive practices and facilitate the meaningful involvement of men as equal partners throughout pregnancy, delivery, and the postgestation period. By promoting activity-based support and individual counseling, couples may better navigate potential issues arising from divergent expressions of grief (Obst et al. 2020). Ultimately, these measures may have positive repercussions on grief management and the overall well-being of couples.

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### Data availability statement

This study is based on data from *Understanding Society's* "UK Household Longitudinal Study" (UKHLS), Waves 1–13 (2009–2022). The data are publicly available for registered researchers through the UK Data Service (<https://beta.ukdataservice.ac.uk/datacatalogue/studies/study?id=6614>). Access to these data requires registration and approval from the data provider.

### Note

1 A pregnancy loss is a term used to describe a gestation that does not end in a live birth and can occur during the pregnancy (Flenady et al. 2016; Quenby et al. 2021). In the United Kingdom, the country under investigation, the National Health Service (NHS) categorizes it as a "miscarriage" before the 24th week of gestation and as a "stillbirth" thereafter (Quenby et al. 2021). In high-income countries, approximately 11% to 21% of clinically detected pregnancies end in miscarriage (Ammon Avalos et al. 2012), while stillbirths account for 0.4%–0.5% per total births (Lawn et al. 2016); Office for National Statistics, 2023).

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