Exploring the Psychological Well-Being of Pregnant Women during the Antenatal Period: A Study on Women with Previous Miscarriage

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Abstract. Many couples eagerly anticipate pregnancy as a transformative experience. For pregnant women, particularly those with prior miscarriage histories, this period often involves complex emotional states that significantly influence psychological well-being. This study explores the psychological well-being of pregnant women who have experienced miscarriage, focusing on their emotional adaptation during subsequent pregnancies. Utilizing a qualitative case study design, the research engaged two participants: pregnant women aged 25–30 years, residing in Bangkalan, Madura, Indonesia, with a history of miscarriage prior to their current pregnancy. Data were collected through observations and semi-structured interviews. Findings revealed that participants experienced heightened anxiety, persistent fear of fetal loss, and lingering guilt related to their past miscarriage. Despite these challenges, their psychological well-being was characterized by self-regulation through acceptance of prior experiences, which they framed as learning opportunities to navigate their current pregnancy. Participants also demonstrated emotional autonomy and the ability to cultivate supportive relationships with those around them. Key factors influencing their psychological well-being included spousal support, adaptive coping strategies, and guidance from healthcare professionals in managing pregnancy after miscarriage. This study underscores the dual reality of vulnerability and resilience in pregnant women with miscarriage histories, emphasizing the need for holistic psychosocial care to address their unique emotional needs.

Keywords: Miscarriage, Pregnant women, Psychological well-being.

1 Introduction

Pregnancy represents a pivotal event in a woman's life, profoundly influencing her mental health as a period of transformation, adaptation, and psychological adjustment. These dynamics are particularly pronounced among women who have experienced prior pregnancies and miscarriages. Defined as the loss of a pregnancy before 20 weeks

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of gestation, miscarriage affects approximately 15% to 20% of clinically recognized pregnancies [1-2].

According to data from the Maternal Perinatal Death Notification (MPDN), the Ministry of Health's maternal mortality surveillance system, maternal deaths increased from 4,005 in 2022 to 4,129 in 2023. Similarly, infant mortality rose from 20,882 in 2022 to 29,945 in 2023 [3]. These trends underscore the urgency of addressing the physical and psychological health of pregnant women, as optimal maternal well-being is critical to reducing risks of mortality for both mothers and fetuses. Particular attention is warranted for pregnant women with histories of adverse pregnancy outcomes, such as miscarriage, whose prior experiences may amplify vulnerabilities during subsequent pregnancies.

Miscarriage, defined as the spontaneous loss of a pregnancy before 24 weeks of gestation, occurs in approximately 15% of pregnancies and is associated with significant morbidity and mortality, particularly in resource-limited healthcare systems [4]. Clinically, it is characterized by pregnancy loss before fetal viability, typically prior to the 20th week of gestation or involving a fetus weighing less than 500 grams. This process involves the spontaneous expulsion of an embryo or fetus from the uterus, most commonly occurring within the first 20 weeks of pregnancy [5].

Pregnant women with prior miscarriage histories often endure profound psychological consequences, as pregnancy loss represents the dissolution of hopes and aspirations for both the individual and their partner. Recent research indicates that nearly 18% of mothers exhibit symptoms of post-traumatic stress disorder (PTSD) nine months post-miscarriage [6]. These individuals frequently grapple with intense psychological distress, including grief, isolation, and profound emotional devastation. Recognizing symptoms of mental health disorders is critical for facilitating timely screening and interventions to enhance post-miscarriage well-being. Notably, women with miscarriage histories are disproportionately vulnerable to sustained psychological distress, underscoring the necessity for targeted mental health support [7].

Pregnant women who experience miscarriage demonstrate elevated levels of depression and anxiety persisting for one to three months post-loss, with residual trauma symptoms often remaining [8]. For women with prior miscarriage histories, subsequent pregnancies present significant psychological challenges. The need to reconcile past loss with current pregnancy requires heightened emotional adaptation throughout the gestational period. These mothers frequently report intensified worry and pregnancy-related anxiety, primarily driven by fears of recurrent loss. The psychological sequelae of miscarriage typically encompass clinically significant depression, anxiety symptoms, and profound feelings of diminished control over reproductive outcomes [9].

A history of miscarriage can create significant psychological distress for mothers during subsequent pregnancies, as the fear of recurrent loss often persists throughout gestation. Women who have experienced pregnancy loss frequently develop psychological complications. Research demonstrates these women show higher rates of depression and anxiety symptoms, particularly among those experiencing threatened abortion or abnormal fetal development [10].

Miscarriage exerts significant psychological consequences on mothers during subsequent pregnancies. Women with a history of pregnancy loss frequently experience compromised mental health in following gestations. Research indicates these women demonstrate more severe symptoms of depression and anxiety compared to those without prior miscarriage experience [11].

Psychological instability in pregnant women, compounded by prior miscarriage experiences, heightens anxiety and distress during subsequent pregnancies due to lingering psychological impacts of past trauma. Research demonstrates that women with miscarriage histories exhibit elevated stress levels, particularly concerning medical risks and fetal health during the first trimester, underscoring the critical need for targeted psychological interventions [12]. This study seeks to comprehensively analyze the psychological well-being of pregnant women with prior miscarriage experiences, aiming to identify key factors influencing their mental health during subsequent pregnancies.

2 Method

This study employs a qualitative case study methodology to investigate individual experiences within complex social contexts. The approach enables in-depth examination of participants' lived realities through systematic analysis of multiple data sources collected over time [13]. Participants comprised two pregnant women selected via purposive sampling based on predefined criteria: aged 25-30 years, currently pregnant with prior miscarriage experience, and residing in Bangkalan, Madura, Indonesia. Data collection integrated observational methods, documenting participants' behaviors and verbal accounts, with semi-structured interviews conducted using flexible protocols adapted to situational dynamics [14]. The interview framework was designed according to Ryff's psychological well-being dimensions, ensuring theoretical alignment [15]. Methodological rigor was ensured through triangulation, cross-verifying data across three sources: direct observations, spousal perspectives, and clinical input from healthcare providers.

3 Result

Participant A is a 27-year-old pregnant housewife residing in a rented residence. Her spouse is employed as an entrepreneur at a private company in Surabaya. This represents her second pregnancy, following a miscarriage during her first gestation two years prior. Participant A married at age 24 and conceived eight months post-marriage. However, the initial pregnancy ended in miscarriage at seven weeks' gestation.

Participant X is a 29-year-old pregnant private sector employee in Surabaya. Her spouse works at a government office, and they routinely commute together. This marks her second pregnancy, following a miscarriage during her first gestation three years prior, which was attributed to uterine cysts. After the miscarriage, she underwent cyst treatment and initiated conception efforts post-recovery, resulting in her current pregnancy at 10 weeks' gestation. Miscarriage remains a multifactorial reproductive challenge, with polycystic ovary syndrome (PCOS) recognized as a significant contributor to recurrent pregnancy loss. Notably, women with PCOS exhibit early pregnancy loss rates of 30% to 50%, substantially exceeding the 10% to 15% prevalence observed in non-PCOS populations [16].

Based on observations and interviews with the research participants, the following findings emerged:

3.1 Aspect of Self-Acceptance

The results indicated that both participants exhibited strong self-acceptance regarding their prior miscarriage experiences. Participant A demonstrated acceptance of her first pregnancy loss, framing it as a learning opportunity to adopt greater caution during her current pregnancy. She expressed gratitude for the experience, acknowledging how it enhanced her preparedness and proactive approach to prenatal care. Participant X attributed her miscarriage to uterine cysts, which facilitated her acceptance of the loss. After undergoing treatment to resolve the cysts, she reported readiness to pursue another pregnancy. She emphasized gratitude for the opportunity to conceive again and maintained diligent care during her current pregnancy, which had reached 10 weeks' gestation. Both participants highlighted gratitude and adaptive reframing of their losses as central to their psychological well-being. Participant A's narrative focused on experiential growth, while Participant X integrated clinical understanding of her miscarriage etiology into her acceptance process. These findings underscore self-acceptance as a critical mechanism for navigating subsequent pregnancies after loss

Interview Results: Participant A

Participant A:
"Yes, at that time I was afraid and felt guilty, but I learned a lot from my first pregnancy. The miscarriage I experienced was a learning experience for me." (A.SA.12.R)
"At this time, I am very grateful that I have been given the opportunity to get pregnant again. This pregnancy was planned with my husband, and I am extremely cautious now. My husband is also very attentive to my nutritional intake." (A.SA.18.R)

Participant A's Husband:
"Yes, sir, the first miscarriage made us anxious, but it became a lesson to prioritize caution." (S.A.SA.9.R)
"I now closely monitor my wife's diet and lifestyle due to our prior experience." (S.A.SA.13.R)
"Alhamdulillah, we are grateful for this new chance to conceive. We planned this pregnancy carefully and are more mindful of our health." (S.A.SA.19.R)

Interview Results: Participant X

Participant X:
"Yes, I felt sadness, fear, and emotional conflict after the miscarriage, but I came to accept it because that experience revealed my uterine cyst." (X.SA.11.R)
"Alhamdulillah, sir, I am now pregnant again. Despite the prior loss, I have fully accepted it. My husband and I prioritize caution, including regular consultations with our obstetrician." (X.SA.17.R)

Participant X's Husband:
"Alhamdulillah, sir, we felt profound relief when my wife conceived again after her cyst removal." (S.X.SA.8.R)
"I consistently ensure my wife attends all prenatal appointments to safeguard this pregnancy." (S.X.SA.15.R)

The interview findings reveal that both participants experienced anxiety, fear, and guilt following their miscarriages. However, these emotions catalyzed a process of experiential learning and constructive acceptance, enabling psychological readiness for their current pregnancies. Both women now demonstrate heightened vigilance in prenatal care, adopting risk-mitigation strategies informed by prior loss. Their husbands fulfill integral supportive roles through consistent partnership in pregnancy management, including proactive involvement in medical consultations and lifestyle adjustments to safeguard gestational health.

3.2 Aspects of Positive Relationships with Others

Observational and interview data indicated that both participants maintained constructive interpersonal relationships characterized by mutual respect and social resilience. Despite encountering gossip from relatives or community members, they demonstrated emotional composure and adherence to social norms. Each participant sustained positive rapport with neighbors and colleagues while remaining engaged in social and occupational activities, albeit with modified participation levels during pregnancy.

Participant A:
"Yes, I try to interact with my neighbors and relatives." (A.PR.23.R)
"I appreciate them, even though sometimes they share stories about difficult pregnancies. I choose not to internalize these narratives to protect my current pregnancy's well-being." (A.PR.28.R)

Participant X:

"I continue working, sir, and fortunately, my colleagues are supportive." (X.PR.20.R)

"Thank God, I remain active in daily activities, though I've slightly reduced my workload during this pregnancy due to my prior experience." (X.PR.24.R)

The interview findings demonstrate that both participants cultivated constructive social bonds within their communities. They prioritized safeguarding their current pregnancies despite encountering unsolicited commentary about their reproductive histories. Mutual respect characterized their interpersonal engagements, coupled with deliberate efforts to employ cognitive reframing strategies during daily activities. Notably, colleagues emerged as psychosocial supports following their miscarriages, actively collaborating to preserve gestational well-being through practical assistance and emotional reinforcement.

3.3 Aspect of Autonomy

Observational and interview data revealed both participants exercised decisional autonomy in navigating pregnancy-related challenges. They demonstrated independence in daily choices while strategically managing social expectations, balancing self-reliance with collaborative spousal consultation for risk mitigation.

Participant A:

"I frequently consult my husband about dietary decisions, particularly given my lingering concerns from past nutritional impacts on pregnancy." (A.O.30.R)

Participant A's Husband:
"My wife now actively involves me in meal planning due to persistent anxiety about dietary adequacy for fetal health." (S.A.O.20.R)

Participant X:
"I typically commute to work with my husband, but when he works overtime, I independently use motorcycle taxi services." (X.O.24.R)
"We attend prenatal consultations together to monitor this pregnancy's progression." (X.O.28.R)

Participant X's Husband:
"My wife values independence, but I've assumed a more protective role during this pregnancy to address our prior miscarriage risks." (S.X.O.20.R)

The findings demonstrate that participants continue to experience lingering anxiety, fear, and guilt stemming from prior miscarriages. However, they actively regulate these emotions through consistent spousal communication. Both women exhibit functional independence in managing daily responsibilities during periods of spousal absence. Additionally, rigorous adherence to prenatal medical consultations emerges as a deliberate strategy to safeguard their current pregnancies.

3.4 Aspect of Environmental Mastery

Observational and interview data indicate that participants demonstrated agency in orchestrating daily activities to align with gestational health objectives. Both women exhibited capacity to structure environments conducive to achieving targeted pregnancy outcomes through deliberate behavioral modifications.

Participant A:

"Previously, adhering to my neighbor's nutritional advice became a valuable lesson." (A.EM.26.R)

"I now meticulously follow prenatal protocols and consistently engage in spiritual practices for pregnancy continuity." (A.EM.28.R).

Participant X:

"Fortunately, my colleagues are accommodating; they often assist with workload adjustments during my pregnancy." (X.ME.22.R)

These narratives highlight participants' strategic awareness of gestational risk factors, manifested through ritualized spiritual observances and environmental adaptations. Both leveraged communal support systems while maintaining personal accountability for health optimization.

3.5 Aspect of Purpose of Life

Observational and interview data revealed participants demonstrated purposeful living through acceptance of life events and proactive pursuit of reproductive aspirations. Both women anchored their psychological resilience in gratitude practices and intentional efforts to align actions with their goals.

Participant A:

"As a family, we aspire to have children, which is why we carefully planned this pregnancy." (A.PL.30.R)

"I educate myself via healthcare podcasts about pregnancy maintenance strategies to safeguard this gestation." (A.PL.34.R)

Participant A's Husband:

"Marriage naturally includes the desire for children, so I prioritize my wife's prenatal care given our miscarriage history." (S.PL.25.R)

Participant X:

"Life demands gratitude and persistent effort—I embrace both." (X.PL.25.R)

"The miscarriage and cyst diagnosis were devastating, but I resolved to pursue parenthood after addressing the medical barrier." (X.PL.29.R)

These narratives underscore participants' life purposes centered on family-building and growth through adversity. Gratitude functioned as both a coping mechanism and ethical framework, while structured planning (medical interventions, educational engagement) operationalized their aspirations.

3.6 Aspect of Personal Growth

Observational and interview data revealed participants exhibited self-directed growth through continuous learning and adaptive strategies informed by prior pregnancy loss. Both women demonstrated proactive engagement with educational resources to optimize current gestational outcomes.

Participant A:

"This pregnancy requires renewed adaptation, particularly since my miscarriage taught me to prioritize caution." (A.PG.33.R)

"I focus on the constructive lessons from my loss, which drives me to research extensively about pregnancy management." (A.PG.38.R)

Participant X:

"Despite my cyst removal, I maintain rigorous prenatal monitoring during this pregnancy." (X.PG.30.R)

"I now regularly attend online antenatal classes recommended by colleagues." (X.PG.34.R)

These narratives highlight participants' commitment to iterative self-improvement, framing adversity as a catalyst for skill acquisition. Positive cognitive reframing of past trauma facilitated purposeful behavioral changes, while sustained motivation for pregnancy continuity reinforced resilience.

4 Discussion

Pregnancy represents a transformative journey marked by profound physical, emotional, and psychological adaptations. Women navigating this gestational transition often contend with fluctuating affective states, spanning anticipatory joy to pregnancy-specific anxiety, as they confront the multidimensional challenges of this critical life

stage. Psychological well-being emerges as a critical determinant of perinatal outcomes, with implications extending to both maternal health and fetal development. Existing evidence highlights heightened vulnerability among pregnant women with prior miscarriage histories, who face amplified psychological complexities [9]. Their mental health profile encompasses a dynamic interplay of factors including anxiety, depression, perceived control, quality of life, sleep patterns, and self-esteem, collectively shaping their gestational experience [9].

Miscarriage constitutes a profoundly distressing experience marked by diagnostic shock and emotional destabilization, necessitating targeted psychological support for women in subsequent pregnancies. Following pregnancy loss, mothers frequently describe visceral somatic emptiness, contrasting sharply with their prior embodied experience of gestation [17]. Empirical evidence underscores the critical role of spousal support, adaptive coping mechanisms, and health literacy in cultivating psychological resilience among pregnant women with miscarriage histories. These psychosocial resources emerge as pivotal mediators of well-being during post-loss gestations. The psychological welfare of this population demands prioritized clinical attention, with research investigating diverse therapeutic modalities. Current interventions demonstrating efficacy include psychoeducational programs to enhance reproductive health agency and mindfulness-based practices to regulate trauma-associated distress [18].

The study findings reveal that pregnant women with prior miscarriage histories continue to experience persistent fear, anxiety, and guilt during subsequent pregnancies. Notably, women with threatened miscarriage exhibit diminished psychological well-being, characterized by elevated stress levels, anxiety, and uncertainty intolerance, compared to those without such complications [19]. For participants in this research, pregnancy after loss remains fraught with lingering trepidation, though these emotional responses are recognized as clinically normative and subject to self-regulation. Empirical evidence further indicates that women with miscarriage histories demonstrate heightened susceptibility to anxiety, depressive symptoms, and post-traumatic stress disorder relative to their counterparts without prior pregnancy loss [20].

Pregnant women with prior miscarriage histories face heightened risks of adverse psychological consequences during subsequent pregnancies. The findings further indicate that robust social support systems enable these women to exercise heightened vigilance in managing post-miscarriage pregnancies. Empirical evidence underscores that this population exhibits elevated psychological distress levels, necessitating early clinical interventions and sustained psychosocial support to optimize emotional well-being [7].

Spousal support emerges as a critical adaptive coping mechanism for pregnant women navigating subsequent pregnancies after miscarriage. Proactive spousal engagement enhances maternal emotional regulation, fostering psychological stability during gestation. Empirical evidence indicates that supportive partners strengthen maternal-fetal attachment, reinforcing prenatal bonding mechanisms [21]. Concurrently, healthcare providers play a pivotal role in optimizing pregnancy outcomes through clinical guidance and psychosocial interventions. By addressing the unique needs of women with miscarriage histories, clinicians enhance pregnancy literacy and therapeutic alliance. Systematic integration of psychological care into obstetric practice enables healthcare teams to improve perinatal well-being and cultivate positive gestational experiences [22].

The study findings further reveal that pregnant women demonstrate renewed gratitude for conception following prior miscarriage, with spiritual practices serving as a resilience-building mechanism during subsequent gestations. These observations align with established evidence indicating that structured spiritual engagement mitigates pregnancy-specific stress and enhances psychological well-being through meaning-making frameworks [23].

The study participants demonstrated adaptive self-acceptance regarding their current pregnancies despite prior miscarriage experiences. They exhibited gratitude while adopting risk-averse prenatal practices to safeguard gestational outcomes. This adaptive mindset enhances self-perception, aligning with evidence that positive maternal body image correlates with elevated self-esteem, reduced depressive symptoms, and strengthened prenatal attachment—factors critical to fostering maternal-fetal bonding [24]. Key study limitations include a restricted sample size, singular variable focus constraining exploratory scope, and temporal constraints during data collection. Future investigations should incorporate multidimensional variables and longitudinal designs to deepen understanding of psychological trajectories in post-miscarriage pregnancies.

5 Conclusion

This study concludes that pregnant women with prior miscarriage histories experience persistent fear, anxiety, and guilt during subsequent pregnancies, with these emotions resurfacing periodically as clinically recognized responses. Participants demonstrated adaptive coping mechanisms by cultivating self-acceptance of past losses, which they reframed as instructive lessons for managing their current pregnancies. Key psychological strengths included maintaining functional independence in decision-making, fostering supportive social relationships, establishing purposeful life goals informed by past experiences, and pursuing personal growth through adversity.

The findings underscore the critical role of spousal support in providing emotional stability and practical assistance, alongside clinical guidance from healthcare professionals delivering evidence-based risk management strategies. By integrating these internal and external resources, participants implemented vigilant prenatal practices to mitigate risks, avoid triggers associated with prior loss, and optimize gestational outcomes. The ability to transform miscarriage experiences into a framework for proactive pregnancy management emerged as a pivotal factor in enhancing psychological well-being, highlighting the interplay between resilience-building and structured support systems in post-miscarriage care.

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