



**Addressing the Sexual Difficulties of Pregnancy Loss for  
Couples in Clinical Care and Research**

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## Addressing the Sexual Difficulties of Pregnancy Loss for Couples in Clinical Care and Research

**Keywords.** sexual behavior; sexuality; sexual partners; miscarriage; abortion, spontaneous; early pregnancy loss; stillbirth; fathers; mothers; grief

We have been interested in studying sexual well-being in reproductive contexts—the transition to parenthood, medically assisted reproduction—for almost a decade. It quickly became evident to us that couples face many challenges to their sexual well-being in their journey toward starting a family. One common experience is pregnancy loss—which is experienced by up to 25% of women<sup>1</sup>. To our surprise, we found this area to be woefully understudied when it comes to sexual health and well-being. This oversight was all the more surprising given the known mental and physical health implications of pregnancy loss and that sexual health and well-being is generally accepted to be a core aspect of overall health and quality of life.

While limited in number, the studies that do exist provide evidence that pregnancy loss is linked with lower sexual function and sexual desire for both couple members (with mixed evidence for decreased sexual desire for individuals who were pregnant) and that individuals report changes to sexuality even years after their losses. Other studies indicate that pregnancy loss is associated with lower sexual intimacy and sexual satisfaction for individuals who were pregnant, and that partners of those who were pregnant report emotional and physiological challenges to sexual well-being <sup>see 2 for review</sup>. However, such studies—only eight total, besides our own work—focus on those who have had multiple losses (typically 3 or more), which happens to only 1% to 5% of couples<sup>3</sup>. Moreover, few of these studies included data from both members of a couple, despite the fact that each member is substantially affected by pregnancy loss<sup>1</sup>. These

24 drawbacks point to a sobering fact: couples and practitioners have little research to help them  
25 understand and adjust to their sexual experiences after a pregnancy loss.

26 In response to the dearth of research on pregnancy loss and sexuality, we launched the  
27 Acknowledging Loss Outcomes and Experiences (ALOE) study in 2020, a longitudinal study in  
28 which couples ( $N = 148$ ) who had a pregnancy loss in the last four months completed four  
29 monthly surveys. We included data from both couple members, with any number of losses, and  
30 excluded couples who were undergoing fertility treatment at the time of their loss (fertility  
31 treatment brings its own sexual challenges). Compared to control couples with no history of  
32 pregnancy loss, we found that both members of couples who had a recent pregnancy loss  
33 reported lower sexual satisfaction at 3–4 months post-loss and increased sexual desire  
34 discrepancies between couple members. Importantly, we did not find any between-group  
35 differences in sexual function, sexual desire, or sexual frequency and found that partners  
36 reported lower sexual distress than their control counterparts, perhaps because they were  
37 deemphasizing sexuality to manage grief and support their romantic partner<sup>2</sup>.

38 Our participants in the ALOE study also shared qualitative responses about the impacts  
39 of pregnancy loss to their sexual well-being. From these responses, we learned that there were  
40 some implications of pregnancy loss not captured in our quantitative measures, such as negative  
41 health and body image changes, sex being mechanical and focused on conception, and the  
42 interference of anxiety, fear, grief, and low mood on sexual well-being. And in fact, some  
43 couples also shared experiences of relationship growth and enhanced intimacy following the loss  
44 (62% of individuals described at least one positive change), though these couples typically  
45 indicated any positives alongside negative factors (87% described negative changes). That  
46 participants reported experiencing changes across biological, psychological, and

47 social/interpersonal dimensions underscores that pregnancy loss does not only impact physical  
48 health, but mental health and the well-being of sexual relationships too. In-From this rich dataset,  
49 we have a fuller analysis of these qualitative data forthcoming, as well as quantitative have  
50 forthcoming findings related to risk (e.g., perinatal grief) and protective (e.g., compassion for  
51 self and one's partner) factors for couples' sexual well-being post-pregnancy loss.

52 Our research has underscored that couples have heterogenous experiences regarding how  
53 their sexual relationships have been affected by pregnancy loss, and that many might benefit  
54 from enhanced support from health care professionals. Unfortunately, in our conversations with  
55 couples who have had an early pregnancy loss, we commonly hear of experiences where  
56 professionals neglected or invalidated couples' psychological and sexual difficulties. After an  
57 early pregnancy loss, practitioners typically express condolences and highlight that pregnancy  
58 loss is common but bring no attention to sexuality. How can practitioners better support couples'  
59 sexual well-being after a pregnancy loss? We offer three suggestions based on our research and  
60 experiences.

61 First, *talk about sexuality, not just contraception*. The American College of Obstetricians  
62 and Gynecologists (ACOG) Committee Opinion No. 736 "Optimizing Postpartum Care"  
63 recommends addressing sexuality with those whose pregnancies result in live births. In contrast,  
64 in the ACOG Practice Bulletin No. 200 "Early Pregnancy Loss" and Obstetric Care Consensus  
65 #10 "Management of Stillbirth," there is no mention of sexuality—only contraception is  
66 discussed. We suggest that practitioners directly discuss sexual well-being after a pregnancy loss  
67 and emphasize intimate connection, not just contraception. Practitioners should share that many  
68 couples experience changes to their sexual relationship after a pregnancy loss (including lower  
69 sexual satisfaction and increased differences in sexual desire between couple members<sup>2</sup>), provide

70 opportunities to discuss sexual concerns (if any), and share referrals and resources about sexual  
71 and mental health (including grief) counseling that may benefit couples' sexual well-being.

72         Second, *do not count the losses—make the losses count*. After three miscarriages (losses  
73 prior to 20 weeks), practitioners tend to provide extra resources to couples, with a focus on  
74 investigating causes of recurrent miscarriage and providing “sincere appreciation of the distress  
75 and grief experienced by [a couple]” and “thorough discussions with patient and partner”<sup>3</sup> (p. 293).  
76 However, because three losses is the agreed upon timing of such intervention<sup>3</sup>, couples who  
77 experience one or two losses can be neglected by professionals even though they may experience  
78 sexual difficulties after a single loss<sup>2</sup>. Thus, a couple with even one loss should be given the  
79 opportunity to discuss sexuality.

80         Third, *consider the experiences of partners*. Partners of individuals who were pregnant  
81 report feeling neglected by or invisible from medical professionals in the wake of their losses<sup>4</sup>.  
82 Failing to support partners after a pregnancy loss ignores their sexual challenges and the  
83 struggles that come through interactions between them and the person who was pregnant, like  
84 greater sexual desire discrepancies between couple members<sup>2</sup>. Thus, treatment models that  
85 integrate partners will likely benefit the couple overall.

86         New directions for research on pregnancy loss and sexual well-being are also necessary.

87 First, more basic research in this area would help to **inform potential psychological and**  
88 **relationship targets for intervention, which would allow for more tailored care. Specifically more**  
89 **tailored interventions.** Important directions for basic research include risk and protective  
90 factors for sexual well-being, coping and adaptive mechanisms, differences in sexual outcomes  
91 for those with one versus multiple losses, how pregnancy loss and infertility treatment may  
92 interact to affect sexual well-being, how post-loss sexual well-being may be compounded by

93 financial strain, and the intersections with diverse identities such as couples who identify as  
94 sexual and gender/sex diverse and/or as Black, Indigenous, and people of color (BIPOC). One  
95 limitation of the ALOE study is it featured couples who had early losses (only 14% had losses  
96 after 15-weeks gestation; range = 2 to 41 weeks) and that couples were followed across only 4  
97 months (average timeframe was 10 to 25-weeks post-loss). Thus, research on later pregnancy  
98 losses is needed alongside additional sufficiently powered longitudinal work. In particular,  
99 longitudinal research will inform how sexual well-being changes from the months before the loss  
100 to the months after, if at all, the predictors of any such changes, and the long-term ramifications  
101 of pregnancy loss for sexual well-being. Second, studies on best practices during patient-  
102 practitioner interactions can ensure that care benefits post-loss sexual well-being rather than  
103 ignores or invalidates challenges to it. Third, studies on interventions that target sexual well-  
104 being post-loss —of which none currently exist— can identify effective tools for practitioners to  
105 utilize with couples.

106 In sum, many couples face difficulties with sexual well-being after a pregnancy loss. We  
107 call for a new focus on enhanced understanding of how to support couples with sexual  
108 difficulties post-pregnancy loss by researchers and practitioners alike. As a professional  
109 community, when it comes to sexual well-being and pregnancy loss, let us no longer be at a loss  
110 ourselves.

111

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23-Feb-2024

Dr. Linda Vignozzi  
Deputy Editor in Chief  
*Journal of Sexual Medicine*

Dear Dr. Vignozzi,

Thank you for the invitation to submit a revision of our expert opinion article “Addressing the Sexual Difficulties of Pregnancy Loss for Couples in Clinical Care and Research” to *The Journal of Sexual Medicine*. We have addressed each point of feedback provided by the associate editor and the reviewers, as described in our response letter. The changes to our manuscript are shown with track changes and highlighting.

We look forward to your response to our revised manuscript. Thank you for your work on our behalf.

Sincerely,

[The Authors]

For Peer Review

Associate Editor

Comments to the Author:

This expert opinion “Addressing the Sexual Difficulties of Pregnancy Loss for Couples in Clinical Care and Research” is an interesting and well-written piece on the effect of pregnancy loss on the sexual function of couples. This is still a topic that has been relatively underexplored in the literature, and the studies conducted so far have methodological limitations that need to be addressed to reach a definitive conclusion about the impact of this condition on the sexual health of couples. The discussion about promoting intimacy for couples affected by this traumatic event is interesting. It should be evaluated from a longitudinal design perspective to identify this variable’s turning point.

>>>Thank you for reviewing our manuscript and for the point about the need for studies with a longitudinal design. In the revised manuscript, we added material about the need for longitudinal research. The new material (page 5, lines 94–101) reads: “One limitation of the ALOE study is it featured couples who had early losses (only 14% had losses after 15-weeks gestation; range = 2 to 41 weeks) and that couples were followed across only 4 months (average timeframe was 10 to 25-weeks post-loss). Thus, research on later pregnancy losses is needed alongside additional sufficiently powered longitudinal work. In particular, longitudinal research will inform how sexual well-being changes from the months before the loss to the months after, if at all, the predictors of any such changes, and the long-term ramifications of pregnancy loss for sexual well-being.”

Please display the meaning in full for the first time before using the acronym BIPOC

>>>Thank you for catching this omission. We now spell out the acronym in the revised manuscript on page 5 at line 94.

Reviewer Comments to Author:

Reviewer: 1

Comments to the Author

This expert opinion “Addressing the Sexual Difficulties of Pregnancy Loss for Couples in Clinical Care and Research” is an interesting and well-written piece on the effect of pregnancy loss on the sexual function of couples. This is still a topic that has been relatively underexplored in the literature, and the studies conducted so far have methodological limitations that need to be addressed in order to reach a definitive conclusion about the impact of this condition on the sexual health of couples. The discussion about promoting intimacy for couples affected by this traumatic event is interesting and should be evaluated from the perspective of a longitudinal design to identify the turning point of this variable.

Please display the meaning in full for the first time before using the acronym BIPOC

>>>Please refer to earlier responses to Associate Editor (Reviewer 1's comments are a duplicate of the Associate Editor's).

Reviewer: 2

Comments to the Author

Review for expert opinion on JSM

Thank you for the invitation to review this expert opinion, which I enjoyed reading. The article presents a significant contribution to the underexplored realm of sexual well-being after pregnancy loss. While commendable in its attempt to shed light on this important aspect, the article exhibits both strengths and areas for improvement.

The article effectively highlights the existing gap in research concerning the sexual well-being of couples experiencing pregnancy loss. By pointing out the limited number of studies and their focus on those with multiple losses, the author/s underscore the need for broader and more inclusive investigations. The inclusion of findings from the Acknowledging Loss Outcomes and Experiences (ALOE) study is a strength. The quantitative data on sexual satisfaction and desire discrepancies, coupled with qualitative insights, enrich the understanding of the complex and varied experiences of couples post-pregnancy loss. I also very much appreciate/like, that the article provides practical suggestions for clinicians and researchers to enhance support for couples dealing with pregnancy loss. The call to address sexuality directly, support couples regardless of the number of losses, and consider the experiences of partners reflects a pragmatic approach to improving clinical care. Besides, this expert opinion, emphasizes the importance of a holistic approach to sexual well-being, integrating both partners into the narrative. This acknowledgment aligns with the broader understanding of the interconnectedness of physical, mental, and emotional aspects of reproductive health and to study sexual health in the relationship, as this I agree does not occur in a vacuum.

>>> We are glad the reviewer enjoyed the article and thank them for their time reviewing it. We appreciate their comments that identify the article's strengths.

While the ALOE study is a valuable addition, the limited scope in terms of the number of participants (N = 148) and the relatively short follow-up period (four months) raises questions about the generalizability and long-term implications of the findings. Expanding the sample size and extending the follow-up period could strengthen the study's impact or at least making this 'limitation' more explicit than it is.

>>>These points about sample size and extending the follow-up timeframe are helpful. The Associate Editor raised a similar point about the need for more longitudinal research, which we paired with your suggestion about sample size when we added new text (page 5, lines 94–101) which reads: "One limitation of the ALOE study is it featured couples who had early losses (only 14% had losses after 15-weeks gestation; range = 2 to 41 weeks) and that couples were followed across only 4 months (average timeframe was 10 to 25-weeks post-loss). Thus, research on later pregnancy losses is needed alongside additional sufficiently powered longitudinal work. In particular, longitudinal research will inform how sexual well-being changes from the months

before the loss to the months after, if at all, the predictors of any such changes, and the long-term ramifications of pregnancy loss for sexual well-being.” Regarding the ALOE study, we conducted an a priori power analysis for our research questions to ensure that the study was sufficiently powered (e.g., see section 7 of a pre-registration at <https://osf.io/6excg>). Unfortunately, it is not feasible at this point to extend the follow-up interval given that our data collection is complete, despite how valuable that would be. For the reviewer’s interest, we targeted data collection during the time from about 4 to 7 months post-loss given prior work that indicates perinatal grief is most intense and changes the most during this timeframe, and we expected perinatal grief to be a key factor related to sexual well-being during this time. As is described in the quote earlier in the paragraph, we have added material that discusses the limitations of the ALOE study’s timeframe.

In the same vein, the article could benefit from a more in-depth exploration and analysis of these qualitative findings. I am very much aware of the word space limitation, however, if possible, a dedicated section discussing the nuances of these responses could enhance the overall depth of the study.

>>>Thank you for your feedback. We added some additional depth to our qualitative findings, while taking into account the word space limitations. We do intend to publish the qualitative findings shortly (the paper is almost ready for submission) and expect that interested readers of this paper will be able to find it by searching for the authors’ names. The revised text on pages 2–3 at lines 44–49 reads (new additions are [placed between brackets and underlined]): “And in fact, some couples also shared experiences of relationship growth and enhanced intimacy following the loss [(62% of individuals described at least one positive change)], though these couples typically indicated any positives alongside negative factors [(87% described negative changes)]. [That participants reported experiencing changes across biological, psychological, and social/interpersonal dimensions underscores that pregnancy loss does not only impact physical health, but mental health and the well-being of sexual relationships too.] From this rich dataset, we [have a fuller analysis of these qualitative data forthcoming, as well as quantitative] findings related to risk (e.g., perinatal grief) and protective (e.g., compassion for self and one’s partner) factors for couples’ sexual well-being post-pregnancy loss.”

The article mentions the necessity of studies on interventions but provides limited guidance on potential strategies. A more detailed discussion or reference to existing interventions for post-pregnancy loss sexual well-being could strengthen the practical implications of the article.

>>>Thank you for this suggestion. Unfortunately, to our knowledge, there are no existing studies that focus on interventions for post-pregnancy loss to promote sexual well-being. We now highlight this significant gap on page 5 at lines 102–103 (new additions are [placed between brackets and underlined]): “Third, studies on interventions that target sexual well-being post-loss[—of which none currently exist, to our knowledge—]can identify effective tools for practitioners to utilize with couples.” Regarding the point about providing guidance on potential strategies that could be targeted in intervention, it is difficult to provide an evidence-based factor to target given the limited empirical research on pregnancy loss and sexual well-being. Thus, we are hesitant to suggest potential targets until more research in this area unfolds. We have revised text in the manuscript on pages 4–5 at lines 87–94 (new additions are [placed between brackets

and underlined) to better reflect this sentiment: “First, more basic research in this area would help to inform [potential psychological and relationship targets for intervention, which would allow for more tailored care. Specifically,] important directions for basic research include risk and protective factors for sexual well-being, coping and adaptive mechanisms, differences in sexual outcomes for those with one versus multiple losses, how pregnancy loss and infertility treatment may interact to affect sexual well-being, how post-loss sexual well-being may be compounded by financial strain, and the intersections with diverse identities such as couples who identify as sexual and gender/sex diverse and/or as [Black, Indigenous, and people of color] (BIPOC).”

In conclusion, this article brings attention to a crucial but overlooked aspect of reproductive health. Addressing the identified areas for improvement could enhance the robustness and applicability of the study’s findings, providing a more comprehensive guide for clinicians and researchers working in this challenging field. I hope these points would be helpful to strengthen this opinion piece and to put your theme more central to sexual health and sexual medicine.

>>> Thank you again for your feedback.