Comparison of Quality of Life and Marital Adjustment of Pregnant and Non-Pregnant Women with Epilepsy[1]

Epilepsili Gebe ve Gebe Olmayan Kadınların Yaşam Kalitesi ve Evlilik Uyumunun Karşılaştırılması

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ABSTRACT

Introduction: Epilepsy affects not only women themselves but also the baby they carry in a pregnancy situation. In epilepsy, it is thought that marital adjustment during pregnancy will be important in spouses' QoL and healthy pregnancy. For these reasons, the aim of the study was to compare the QoL and marital adjustment of pregnant women with epilepsy (PWE) and non-pregnant women with epilepsy (NPWE).

Methods: This study was conducted between October 2016-2017 on female outpatients with epilepsy who were followed-up two hospital. A diagnostic form for determining their socio-demographic characteristics, a form questioning the characteristics of the disease, a scale of QoL in patients with epilepsy and a marital adjustment scale were administered.

Results: In a sample of 93 NPWE and 31 PWE of respondents reported considering the disease characteristics, it was found that the majority of them had focal epilepsy, used AEDs and took their medication regularly. Most reported that they did not use any birth control method before conception and that their illness would not prevent them from caring for their baby. However, all of them wanted someone to stay with them after they give birth. The PWE's QoL and marital adjustment were better than the NPWE's. The regression analysis that was conducted showed that the PWE's marital adjustment got worsened as their duration of marriage increased (ß=–0.739;R^2=0.413). However, there was no correlation between the duration of marriage and marital adjustment of the NPWE. Improved marital adjustment in both groups improved QoL (PWE's ß=0.299,R^2=0.309;NPWE's ß=2.735, R^2=0.139).

Concluisons: This study provides**,** it is understood that marital adjustment and support of women with epilepsy is effective in improving the QoL. In this regard, it is thought that the inclusion of spouses in prenatal care will contribute to disease management and healthy maintenance of the spouse in providing marital support/adjustment.

Keywords: Quality of life, marital adjustment, epilepsy, pregnancy.

ÖZET

Amaç: Epilepside, gebelik süresince eşlerin birbiriyle uyumu yaşam kalitelerinde ve gebeliğin sağlıklı geçirilmesinde önemli olabilir. Bu nedenlerle çalışmada epilepsili gebe olan (PWE) ve olmayan (NPWE) kadın hastaların yaşam kalitesi ve evlilik uyumlarının karşılaştırılması amaçlandı.

Yöntem: Bu kesitsel çalışma Ekim 2016-2017 tarihleri arasında 2 hastanenin kliniklerinde epilepsi tanısıyla takip edilen hastalarla gerçekleştirildi. Sosyodemografik özellikleri belirlemek için tanılama formu, hastalık özelliklerini sorgulayan form, epilepsili hastalarda yaşam kalitesi ölçeği ve evlilik uyum ölçeği uygulandı.

Bulgular: 93 NPWE ve 31 PWE kişiye ulaşıldı. Hastalık özelliklerine bakıldığında çoğunluğunun fokal epilepsi, AEI kullandığı ve ilaçlarını düzenli aldıkları anlaşıldı. Çoğunluğu gebe kalmadan önce doğum kontrol yöntemi kullanmadığını, hastalığının bebeğine bakmasına engel olmayacağını bildirmiştir. Ancak tamamı doğum yaptıktan sonra yanında birisinin kalmasını istemektedir. PWE'lerin yaşam kalitesi ve evlilik uyumu NPWE'lere göre daha yüksektir ($p<0.05$). Yapılan regresyon analizinde PWE's evlilik süresi uzadıkça evlilik uyumları azalmaktadır (ß= - 0.739; R^2=0.413). Ancak NPWE'li kadınların evlilik süresi ile evlilik uyumu arasında ilişki bulunmadı ($F=3.633$, $p=0.060 >0.05$). Her iki grupta evlilik uyumunun artması yaşam kalitesini arttırmaktadır (PWE's ß=0.299, R^2=0.309; NPWE's (ß=2.735, R^2=0.139).

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Sonuç: Bu çalışmayla epilepsili kadınlarda evlilik uyumu ve desteğinin yaşam kalitesinin arttırılmasında etkili olduğu saptandı.

Anahtar Kelimeler: Yaşam kalitesi, evlilik uyumu, epilepsi, gebelik.

INTRODUCTION

Epilepsy is one of the most common neurological disorders across the world, and its incidence increases in women especially during pregnancy[1].

Pregnancy can be a difficult process even in women without epilepsy, whereas seizures increase due to hormonal changes due to pregnancy in epilepsy, and it may become more difficult to maintain pregnancy[2]. Medicines used to control seizures also increase the risk of teratogenicity. The risk of malformations increases in infants of patients receiving polytherapy compared to those receiving monotherapy[3]. Moreover, using AEDs can reduce the effect of oral contraceptives and lead to undesired pregnancies[4.] The other important issue besides drugs is that epilepsy is a genetically transmitted disorder. In mothers with idiopathic generalized epilepsy, the probability of the baby being born with epilepsy is 5–20% if one first-degree relative has epilepsy, and can rise up to more than 25% if two first-degree relatives have epilepsy[5]. For this reason and similar reasons, it is important to plan pregnancy in women with epilepsy. Before pregnancy, counseling services should be offered about issues such as management of seizures, antiepileptic drugs that are used, the possibility of the baby having epilepsy, and baby care[6].

Apart from all these medical reasons, there are also social factors that affect women's pregnancy-related behaviors. These factors include personal experiences, the idea of being ready for motherhood, education, level of happiness in the family, pregnancy-related perceptions, and experiencing planned pregnancy or unwanted pregnancy[7,8].

Pregnancy is a process affecting women, but being pregnant with epilepsy can physically, socially, and psychologically affect a person even more. Therefore, it is reported that epilepsy patients have low quality of life compared to healthy population, especially in underdeveloped societies[9]. Another factor that reduces their quality of life is the epilepsy-related problems that can be experienced during and after pregnancy. Malformations, especially in unplanned pregnancies, the risk of infant loss during pregnancy, and the possibility that the infant needs intensive care after birth are the other factors that reduce their quality of life[10,11]. A decrease in the quality of life of a woman is also reflected in the quality of life of her family. The harmony and support of spouses is especially important in improving the quality of life of the family during pregnancy[12].

Although there has been an increase in recent studies[13,14,15,16] on epilepsy patients, there have been no studies investigating marital adjustment, quality of life and factors affecting these in pregnant and non-pregnant women with epilepsy. However, epilepsy can affect the quality of life of a person even just because of the characteristic features of the disease and can cause problems in the marriage life, especially in married women[12,15]. It is known that the quality of life of women is affected more in chronic diseases that exist in developing societies such as Turkey. Marital adjustment and support are important factors that improve the quality of life[17]. Moreover, in the case of pregnant women with chronic diseases such as epilepsy, not only the patients, but also their families and their babies are affected. Understanding what the disease and pregnancy bring in women with epilepsy, and examining the effect of marital adjustment on their quality of life are important for the family, which is the building block of society. Harmony in the family environment affects the quality of life as well as positively or negatively affecting the severity of existing diseases and may reduce their quality of life[18,19.] For these reasons, it is important to determine marital adjustment, quality of life and factors affecting these in women with epilepsy during and after pregnancy.

The aim in this study was to compare the sociodemographic and disease-specific characteristics of pregnant and non-pregnant women with epilepsy and the relationship between their marital adjustment and quality of life. Understanding quality of life, marital adjustment and the relationship between them in pregnant and non-pregnant women with epilepsy are important for the woman, her family and the society in which she lives. Family is one of the building blocks of society, and the quality of life of women must be improved first in order to improve the quality of life of the society. Therefore, research was conducted to determine whether the perceptions of marital adjustment and quality of life of pregnant women with epilepsy differed from those of non-pregnant women.

Methods

Setting and participants

This research study was conducted between October 2016 and 2017 on female outpatients who were diagnosed with epilepsy and followed-up at the Neurology and Obstetrics Clinics of Faculty of Medicine Hospital of a university and the Obstetrics and Gynecology Clinic of a training and research hospital. The study included 31 pregnant women with epilepsy and 93 non-pregnant women between the ages of 18 and 40 who were married and who presented to the clinics where the study was conducted (Post hoc; Effect size $d = 0.8$; α err prob = 0.05; Power [1 - β err prob] = 0.969, N2/N1 = 3). Age ($Z = -1.712$, $p = 0.087$), duration of marriage ($Z = -1.918$, $p = 0.055$), educational level ($x^2 = 0.980$, $p = 0.806$) and duration of disorder ($Z = -1.333$, $p = 0.183$) of the women participating in the study were similar ($p > .05$). A face-to-face interview was conducted with each participant who was willing to participate in the study. This study was planned as a cross-sectional, correlational and comparative study.

Prior to data collection, ethical consent was obtained from Clinical Research Ethics Committee of the University (No:116). Verbal and written consents were obtained from the participants who agreed to participate in the study.

Instruments

The participants were asked to provide information about socio-demographic characteristics such as age, education, employment status, and income level.

Characteristics specific to the disease (epilepsy type, medications being used, and so forth) and characteristics specific to marriage (marriage duration, support from spouse, and so forth) were inquired.

Quality of Life in Epilepsy Inventory (QOLIE) was adapted from the QOLIE-89 scale by Vickrey et al. (1993)[20]. Cronbach alpha value of the overall scale is 0.91, and alpha values of the sub-dimensions range from 0.67 to 0.84. The validity and reliability of the scale was tested in Turkey by Mollaoğlu et al., and the overall Cronbach alpha value of the scale was found to be 0.91. In this study, it was found to be 0.68. The items that inquire about symptoms that are not specific to patients with epilepsy on the QOLIE-89 scale are not included in this scale. Questions 1, 14 and 31 of the scale have a visual scale. Questions 2–13, and 16–18 have 6-point Likert-type options. Questions 19, 20, and 25–30 have 5-point Likert-type options. Questions 15, 21, 23, and 24 have 4-point Likert-type options. And question 22 has 3-point Likert-type options. The QOLIE-31 scale consists of 7 sub-dimensions about health concepts. It is made up of 31 items which are composed of concerns about seizures (5 items), emotional well-being (5 items), energy/fatigue (4 items), social function (5 items), cognitive function (6 items), effects of medicines (3 items), overall quality of life (2 items) and overall health condition. One can score 0–100 on the scale. The higher the score, the higher the quality of life of the person[21].

Marital Adjustment Test was developed by Locke and Wallace (1959) and tested for validity and reliability for adaption to Turkish society by Tutarel-Kışlak (1999)[22,23]. It aims to measure the satisfaction with and adjustment to marital relations. Overall Cronbach alpha value of the scale was found to be 0.90. Cronbach alpha value was found to be 0.92 in this study. The first question in the scale has a visual scale. Questions 2–9 have 6-point Likert-type options. Question 10 has 3 options, questions 11,13 and 15 have 4 options, and questions 12 and 14 have 2 options. The scale consists of 15 items, and each item is rated 0–6 points based on the number of options. One can score 0–60 on the scale overall. Those who score above 43 points are considered well-adjusted in terms of marital relations and those below that are considered distressed.

Data Analysis

Statistical analyses of data were carried out in IBM Statistical Package for the Social Sciences (Statistics Version 24 program). Descriptive statistical tests (frequency, percentage, mean, standard deviation), Kolmogorov Smirnov tests as a normal distribution analysis, Spearman correlation tests, variance analyses (Mann Whitney-U tests and independent samples t-tests), Cronbach alpha reliability analyses and linear regression analyses were carried out. The level of significance in differences and relationships was accepted as $p< 0.05$.

Results

Descriptive Analyses

A total of 93 NPWE, 31 PWE participated in this study. It was found that the PWE's mean age was 29.19 ± 4.42 years, and the NPWE's mean age was 30.89 ± 5.73 years. It was found that 32.3% of the PWE were university graduates or had higher education, 77.4% were unemployed, 51.6% were at a moderate/low income level. And 35.5% of the NPWE were literate, 71% were unemployed, and 53.8% at a moderate/low income level.

When the marital characteristics were examined, it was found that the average duration of marriage of the PWE was 4.94 ± 3.723 years, and 83.9% of them were supported by their spouses. The average duration of marriage of the NPWE was found to be 8.37 ± 6.68 years, and 68.8% of them stated that their spouses supported them.

When the characteristics specific to epilepsy were examined, it was found that the average duration of the disease of PWE was 11.87 ± 7.256 years, 67.8% of them had focal epilepsy, 83.9% used AEDs, and 90.3% of them used AEDs regularly. The average duration of the disease of the NPWE was 11.018 ± 10.60 years, 76.4% of them had focal epilepsy, 90.3 used AEDs, and 88.2% of them used AEDs regularly (Table 1).

Table 1. Descriptive Characteristics of PWE and NPWE

The following were found when the PWE's views on pregnancy were examined: 74.2% of them thought that AEDs would not affect pregnancy, 71% thought AEDs would not affect the baby; 54.8% did not use any birth control method before conception; 22.6% stated they would have more children and 32.3% stated they would have children earlier if they did not have epilepsy; and 90.3% of them thought that the disease did not prevent them from taking care of their baby, nevertheless, 100% of them said they wanted someone close to them to stay with them after giving birth (Table 2).

Table 2. PWE's views on pregnancy

Quality of Life

When the quality of life of the PWE and that of the NPWE were compared, the overall quality of life score ($p = 0.003$) and emotional well-being ($p = 0.002$), social function ($p = 0.012$), cognitive function ($p = 0.019$) and effects of drugs ($p = 0.017$) sub-dimension scores of the PWE were higher than

those of the NPWE, and there were significant differences between the scores ($p < .05$) (Table 3).

Table 3. Comparisons of QOLIE scale scores of PWE and NPWE

Marital adjustment of PWE was found to be better than that of NPWE, and the difference between them was significant ($p = 0.003$) (Table 4).

Table 4. Comparison of Marital Adjustment Scale Scores of PWE and NPWE

Comparison of Correlations Between PWE and NPWE Groups

Advanced regression analysis that was conducted to examine the relationship between marital adjustment and duration of marriage revealed that in PWE, marital adjustment decreased as duration of marriage increased (ß = –0.739), and the variance explained was 41.3% (PWE: $t = –2.441$, $p = 0.021$, $R^2 = 0.413$). There was no relationship between the duration of marriage and the marital adjustment of the NPWE (NPWE: $t = –1.906$, $p = 0.060$, $R^2 = 0.038$).

Advanced regression analysis that was conducted to examine the relationship between marital adjustment and duration of marriage determined that quality of life increased as marital adjustment increased in both groups. The explained variance values for the PWE and NPWE were 30.8% and 13.9%, respectively. A unit increase in quality of life increased the marital adjustment of the NPWE (ß = 2.735) more than that of the PWE (ß = 0.299) (Table 5).

Table 5. Comparison of correlations between PWE and NPWE groups

Discussion

This study showed that the pregnant women with epilepsy had better marital adjustment and quality of life than the non-pregnant women with epilepsy. Additionally, the longer the duration of marriage of the pregnant women with epilepsy, the worse their marital adjustment and quality of life.

Chronic diseases such as epilepsy can be influenced by many variables such as sociodemographic characteristics, marital adjustment, and cultural/behavioral characteristics brought about by geography. These characteristics become of more importance especially during pregnancy, in the process of bringing a new living thing to life. Therefore, the results from the study on the pregnant and non-pregnant women with epilepsy were discussed in this direction.

The majority of the PWE and NPWE included in the study were found to have low levels of education, were unemployed and defined their economic status as moderate/low. It is stated in studies with epilepsy patients that epilepsy patients are unable to work and their socio-economic status are bad because of the beliefs, behaviors and attitudes of the society about the disease[24].

Although the results of the present study parallel the literature, it should not be forgotten that women's education and employment rates are low in developing countries, such as Turkey. According to TUIK 2017 data, the rate of educated women in Turkey is 14.2%, while it is 58% in European countries, which is much higher[25,26]. Moreover, in Turkey, the rate of women joining the workforce is 32.5%, while this rate rises to 66.5% in European countries[27]. Therefore, it is thought that the fact that the women in the study had a low educational level and they joined the workforce at a low rate should be judged not only by the existing disorders of the women participating in the study, but also by the general reality of the country.

Most of the PWE who participated in the study stated that they were using AEDs and that they thought the drugs they were using would not harm the fetus. It is also understood that their pregnancies were unplanned because they had not used any birth control methods even though they had used AEDs. Considering the studies on the subject, it is known that the use of AEDs during pregnancy leads to the development of severe congenital malformations in infants[28].

Moreover, in women with epilepsy, unplanned pregnancies carry much greater risks for both women and infants than for those who do not have epilepsy. Preterm delivery, preeclampsia, gestational hypertension, and miscarriage are more common during pregnancy in the case of unplanned pregnancy, and hemorrhage and fetal distress can often occur after birth[29,30]. It is thought that the reason why the PWE who participated in the study took risks for themselves and their unborn babies was not only that their educational levels were low but also that their awareness of the disease was inadequate — as also shown in studies on epilepsy patients[31,32]. However, sufficient knowledge of the disease helps patients to participate actively in the treatment and care process, get rid of their anxiety and cope with the disease more easily[33,34]. The inability of the PWE to cope with the disease was also evident in the fact that they definitely needed someone to stay with them after delivering their baby. Women with epilepsy are known to experience more depression, anxiety and fear of losing their babies than those without epilepsy[35,36]. It is thought that the reasons for not wanting to be alone are due to their inability to cope with the disease and their fear of losing their baby.

The women who participated in the study reported that they would not have as many children and at an earlier age if they did not have epilepsy. Although it has been reported in studies on women with epilepsy that their illnesses are effective in their decision to have children, the family is influenced by the structure of society in general[37]. As in Turkey, the number of women giving birth in developing and developed countries is decreasing and maternal age at first delivery is increasing[38,39]. Therefore, it is thought that the underlying reason why women do not have more children

and at an earlier age is the general structural characteristics of society.

Marriages are often known to begin with pleasure. However, women with epilepsy have more difficulty to get married than women with other chronic diseases in society and have more problems in maintaining their marriage[40].

Studies with epilepsy patients have shown such as that the number of AEDs, duration of use of the drug negatively affect marital adjustment. As the duration of marriage increases, the duration of disease-related problems is prolonged and can be challenging for both spouses[41,42]. It was observed that marital adjustment decreased as the duration of marriage was prolonged especially in PWE. According to the literature, PWE's average duration of marriage is shorter than that of NPWE, so PWE are unable to adapt to marriage, and therefore their marital adjustment is thought to have decreases.

Marital adjustment is more important in chronic diseases such as epilepsy, especially during pregnancy. Indeed, it is stated that in couples with low marital adjustment, spouses less frequently attempt to resolve problems, and both spouses are unhappier during marriage[43,44]. Marital adjustment also affects the quality of life. Having a harmonious marriage in the facilitation of the adaptation of the mother and father candidates to their new roles especially during pregnancy also increases the quality of their lives[45]. High marital adjustment of the women participating in the study improves their quality of life by enhancing their ability to cope with problems. However, considering the studies conducted with epilepsy patients in general, it is stated that the patients' quality of life is low[46,47]. However, the high quality of life of the women in the study may be due to the high support they received from their spouses and their high marital adjustment. Another reason for their high quality of life may be that they feel good psychologically and physiologically. Especially pregnant women's being hopeful for the future positively impacts their overall health perception on the one hand; and on the other, helps them feel good psychologically and physiologically. A positive perception of one's overall health perception improves the quality of her life[48]. Another reason why pregnant patients had a high marital adjustment may be that women are strong and positive by nature. It is known that women in Turkey more hopefully look to the future than men. Although it is reported that women have a high quality of life depending on geography, marital adjustment is directly associated with quality of life. An unhappy marriage has devastating effects on people and reduces the quality of their lives[49.]

In this cross-sectional study, it was found that pregnant and non-pregnant women with similar socio demographic characteristics had higher marital adjustment and quality of life compared to non-pregnant women.

In order to compare the quality of life and marital adjustment of pregnant and non-pregnant women data were collected through questionnaires in this study on epilepsy patients. Due to the limitations of quantitative research, only the relationships between variables were examined, but it was not possible to obtain in-depth information.

One of the advantages of being a woman is the ability to conceive and give birth. However, the possibility of a woman being concerned about pregnancy for any reason required the researchers to be more sensitive. It was challenging for the researchers to direct to the women with epilepsy questions on the effects of pregnancy or the disease.

There are some limitations to the study. First of all, the fact that the study was carried out in the clinics of a university and a research hospital makes it difficult to generalize the results to the population. On the other hand, the fact that the study was carried out in the most populous city in Turkey has provided the ability to reach a wide range of sample group. The women were 18–40 years old according to the inclusion criteria of the study. In these criteria, the average fertility age of women was taken into consideration. Today, however, it is known that women under the age of 18 and over 40 also give birth. For this reason, a small number of women under the age of 18 and over 40 were not included in the study.

Conclusions

Based on this study, it was understood that it was important for the women with epilepsy to receive support from their husbands and to have a good marital harmony, especially during pregnancy. The pregnant women with epilepsy were found to have higher quality of life and better marital adjustment than the non-pregnant women. It is important to have marital adjustment and spousal support in the management of a disease that may have negative effects on the mother and the fetus during pregnancy, such as epilepsy.

Marital adjustment and spousal support are important in improving the quality of life in the disease which may have negative effects on the expectant mother-to-be and fetus during pregnancy like epilepsy.

Conflict of interest

None

Sources of funding

None

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Table 1. Descriptive Characteristics of PWE and NPWE

Demographic characteristics	PWE (n=31)		NPWE (n=93)	
Age (x̄±SD, Range)	29.19±4.42		30.89±5.73	
	n	%	n	%
Education				
Illiterate	9	29	33	35.5
Primary school	5	16.1	16	17.2
High school	7	22.6	22	23.7
University	10	32.3	22	23.7
Employment status				
Yes	7	22.6	27	29
No	24	77.4	66	71
Income				
High	16	48.4	43	42.6
Moderate/Low	18	51.6	50	53.8
Marital characteristics	**PWE**		**NPWE**	
Duration of marriage (x̄±SD, Range)	4.94±3.72		8.37±6.68	
	n	%	n	%
Husband's working status				
Yes	31	100	80	86
No	0	0	13	14
Get support from her husband				
Yes	26	83.9	64	68.8
No	5	16.1	29	31.2
Epilepsy characteristics	**PWE**		**NPWE**	
Lenght of disease (x̄±SD, Range) (Year)	11.87±7.256		11.018±10.60	
	n	%	n	%
Type of epilepsy				
Focal	21	67.8	71	76.4
Generalized	8	25.8	18	19.3
Unknown	2	6.4	4	4.3
Does she take AED's?				
Yes	26	83.9	84	90.3
No	5	16.1	9	9.7
Does she take AED's regularly?				
Yes	28	90.3	82	88.2
No	3	9.7	11	11.8

Table 2. PWE's views on pregnancy

PWE's views on pregnancy	n	%
Does AED's affect pregnancy?		
Yes	5	16.1
Partially	3	9.7
No	23	74.2
Does AED's affect baby?		
Yes	5	16.1
Partially	4	12.9
No	22	71
Did you use any contraception before conception?		
Yes	14	45.2
No	17	54.8
Would you have more children without epilepsy?		
Yes	7	22.6
No	24	77.4
Would you have children earlier without epilepsy?		
Yes	10	32.3
No	21	67.7
Does epilepsy prevent you from caring your baby?		
Yes	3	9.7
No	28	90.3
Would you like to stay close with you after birth?		
Yes	31	100
No	0	0

Table 3. Comparisons of QOLIE scale scores of PWE and NPWE

QOLIE subscales	PWE (n=31)		NPWE (n=93)		U / t*	Z	p
	X±SD (Median)	Mean Rank	X±SD (Median)	Mean Rank			
Seizure worry	62.70±27.15 (69)	-	51.86±28.88 (52)	-	1.835*	-	0.069
Emotional well-being	71.48±18.17 (76)	80.15	58.54±20.57 (64)	56.62	894.50	-3,164	**0.002**
Energy/Fatigue	29.66±11.79 (29.50)	64.15	28.64±13.05 (29.50)	61.95	1390.50	-0.296	0.767
Social function	81.48±18.52 (86)	76.47	70.27±21.80 (70)	57.84	1008.50	-2.511	**0.012**
Cognitive	78.52±18.40 (78.88)	75.63	66.08±23.91 (69.45)	58.12	1034.50	-2.351	**0.019**
Medication effects	74.55±27.12 (83.33)	75.74	60.72±28.38 (61.10)	58.09	1031.00	-2.384	**0.017**
Overall quality of life	37.47±7.24 (41)	72.85	32.70±11.94 (29)	59.05	1120.50	-1.862	0.063
Overall score	64.38±12.38 (66.14)	78.84	54.78±15.04 (57.36)	57.05	935.00	-2.923	**0.003**

Table 4. Comparison of Marital Adjustment Scale Scores of PWE and NPWE

Pregnancy status	Marital Adjustment Scale		U	Z	p
	X±SD (Median)	Mean Rank			
PWE	50.74±6.66 (52)	79.16	925.00	-2.984	**0.003**
NPWE	43.45±12.25 (45)	56.95			

Table 5. Comparison of correlations between PWE and NPWE groups

Model 1	**PWE**	**Dependent variable**	**Independentnt iable**	**ß**	**t**	**p**	**F**	**Model (p)**	**R^2**
		Marital adjustment	Constant	54.391	29.216	0.000	5.959	**0.021**	0.413
			Duration of marriage	-0.739	-2.441	0.021			
		Durbib-Watson:1.967							
	NPWE	**Dependent variable**	**Independent variable**	**ß**	**t**	**p**	**F**	**Model (p)**	**R^2**
		Marital adjustment	Constant	46.460	23.053	0.000	3.633	0.060	0.038
			Duration of marriage	-0.360	-1.906	0,060			
		Durbib-Watson:1.689							
Model 2	**PWE**	**Dependent variable**	**Independent variable**	**ß**	**t**	**p**	**F**	**Model (p)**	**R^2**
		Marital adjustment	Constant	31.488	5.778	0.000	12.931	**0.001**	0.308
			Total QOLIE	0.299	3.596	0.001			
		Durbib-Watson:2.114							
	NPWE	**Dependent variable**	**Independent variable**	**ß**	**t**	**p**	**F**	**Model (p)**	**R^2**
		Marital adjustment	Constant	30.930	8.906	0.000	14.715	**0.000**	0.139
			Total QOLIE	2.735	3.836	0.000			
		Durbib-Watson:1.692							