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Reconstructing the Self After Miscarriage: Women's Experiences of Loss, Healthcare, Support, and Coping in Iran

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Abstract

Background

Miscarriage is common, yet its consequences extend beyond the resolution of physical symptoms. Women may experience grief, disruption of maternal identity, uncertainty about future pregnancy, and distress related to the care they receive. Understanding these experiences is essential for developing woman-centered care following pregnancy loss.

Aim

To explore women's experiences following miscarriage, with particular attention to physical and emotional suffering, maternal identity, healthcare encounters, social support, and coping.

Methods

A qualitative study using conventional content analysis was conducted at Shahidan Mobini Hospital, affiliated with Sabzevar University of Medical Sciences, Iran. Ten women who had recently experienced miscarriage were recruited using purposive maximum-variation sampling. Individual semi-structured interviews lasting 45–90 min was conducted, audio-recorded,

transcribed verbatim, and analyzed inductively following the conventional content-analysis approach of Graneheim and Lundman. MAXQDA version 12 was used for data management. Rigor was supported through iterative coding, peer discussion, comparison of interpretations with the original transcripts, and an audit trail.

Findings

The overarching theme was **"**Temporary Disintegration and Gradual Reconstruction of Self Following Miscarriage: The Interplay of Suffering, Support, and Coping." Four categories were identified: (1) acute embodied suffering and disruption of everyday life; (2) threatened maternal identity and uncertainty about future fertility; (3) healthcare and social relationships as sources of support or additional suffering; and (4) reconstructing the self through meaning-making and coping. Participants described physical pain and emotional loss as closely intertwined. Supportive relationships and compassionate healthcare facilitated adaptation, whereas insensitive communication, inadequate information, perceived neglect, and distressing care environments intensified suffering.

Conclusion

Women's recovery after miscarriage involves more than physical recovery. Woman-centered miscarriage care should acknowledge the significance of the loss, provide compassionate communication and clear information, address concerns about future pregnancy, and incorporate emotional and social support into follow-up care.

Keywords: miscarriage; pregnancy loss; women's experiences; woman-centered care; maternity care; qualitative research; coping; maternal identity

Introduction

Miscarriage is a common pregnancy complication with consequences that extend beyond the immediate clinical event. Although medical management appropriately prioritizes physical safety, including the assessment and treatment of bleeding, pain, infection, and retained pregnancy tissue, pregnancy loss may also affect women's psychological well-being, interpersonal relationships, and reproductive expectations. Evidence from prospective studies indicates that women may experience clinically significant symptoms of post-traumatic stress, anxiety, and depression following early pregnancy loss, with distress persisting in some women for months after the event(1,2). These findings highlight the importance of understanding miscarriage as both a clinical event and a potentially profound personal experience.

The meaning women attribute to miscarriage varies according to their reproductive histories, personal expectations, relationships, and social contexts. Pregnancy may become incorporated into a woman's anticipated maternal identity and imagined future before the pregnancy ends. Consequently, miscarriage may represent not only the loss of a pregnancy but also the disruption of expectations about motherhood, family life, and the future. Women may struggle to make sense of the loss, question their reproductive capacity, or experience guilt and self-blame. A

comprehensive review of miscarriage-related grief has emphasized that the significance and intensity of grief vary considerably among women, partly reflecting the meanings attached to the pregnancy and its loss(3). More recently, a systematic review of qualitative research identified meaning-making and narrative construction as important, yet insufficiently understood, dimensions of the miscarriage experience. The physical experience of miscarriage may further intensify emotional suffering. Pain, heavy bleeding, weakness, fatigue, anemia, infection, repeated procedures, and hospitalization can make pregnancy loss an intensely embodied experience. Physical symptoms may also serve as reminders of the loss and may prolong distress after the acute clinical event has ended. Thus, physical recovery and emotional recovery cannot necessarily be considered separate processes(4).

The physical experience of miscarriage may further intensify emotional suffering. Bleeding, pain, fatigue, medical procedures, and uncertainty about the course of the miscarriage can make pregnancy loss an intensely embodied experience. In a qualitative study examining women's experiences of miscarriage management, participants described anxiety associated with pain and bleeding, feeling inadequately prepared for the physical process, and changes in the support available to them over time (3). These findings suggest that physical symptoms are not experienced independently of their emotional and interpersonal meanings. Accordingly, physical recovery and emotional adjustment should be understood as related processes, although they may follow different trajectories

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Healthcare encounters constitute another important dimension of women's experiences following miscarriage. Communication, information provision, recognition of the loss, and access to follow-up care may influence how women understand and respond to the experience. In a qualitative investigation of miscarriage care, women reported unmet informational needs, variable standards of care, and concerns that healthcare professionals sometimes normalized the loss without adequately recognizing its emotional significance (5). A subsequent qualitative study using an interpretative phenomenological approach identified acknowledgement of the loss, hospital experiences, support and coping, reproductive history, and implications for future pregnancies as central themes(6). These findings indicate that the quality of care should be evaluated not only in terms of clinical management but also in relation to women's emotional needs and individual interpretations of pregnancy loss.

Clinical guidance similarly emphasizes respectful communication, individualized information, emotional support, and opportunities for follow-up after early pregnancy loss(7). Nevertheless, the availability of clinical services does not necessarily mean that women's emotional needs are fully recognized or addressed. A woman-centered approach requires healthcare professionals to acknowledge the significance of the loss without assuming that all women experience miscarriage in the same way. It also requires sensitivity to individual preferences regarding information, emotional expression, follow-up, and support.

Social relationships may either facilitate or complicate adjustment after miscarriage. Partners, relatives, and peers may offer emotional validation, practical assistance, and reassurance.

Conversely, limited acknowledgement of the loss, attempts to minimize grief, or expectations that women should quickly resume their usual activities may contribute to feelings of isolation. Qualitative research has demonstrated that support and coping are integral to the miscarriage experience, while the broader literature emphasizes the variability of grief and the importance of allowing women to articulate what the loss means to them. The interpersonal environment therefore represents an important context in which women negotiate their emotional responses and reconstruct their understanding of the experience(3,6).

Coping with miscarriage should not necessarily be understood as a linear progression from distress to recovery. Women may seek explanations for the loss, draw on personal beliefs, engage with supportive relationships, return to work or everyday activities, or direct their attention toward future possibilities. Such responses may help restore a sense of continuity, but they do not necessarily indicate that grief has resolved. The systematic review by Wallis and colleagues highlighted the importance of understanding how individuals construct narratives around miscarriage and how social and healthcare responses shape these accounts(4). This perspective supports an understanding of coping as an evolving process through which women interpret the loss, respond to changing circumstances, and negotiate their sense of self and future(8).

Although qualitative research has examined miscarriage-related grief, healthcare experiences, and coping, further investigation is warranted into how these dimensions interact within particular sociocultural contexts. Existing studies provide important insights into psychological distress, the management of miscarriage, and women's narratives of loss(1,4,6). However, a more integrated understanding is needed of how physical suffering, anticipated maternal identity, healthcare encounters, social relationships, and coping jointly shape women's experiences following miscarriage.

In Iran, women experience pregnancy loss within a sociocultural context in which family relationships, expectations surrounding motherhood, and understandings of fertility may influence the meaning attributed to miscarriage. These contextual influences should not be assumed to affect all women uniformly; rather, they warrant exploration through women's own accounts of their experiences. Contextually grounded qualitative research may help clarify how women interpret their loss, identify sources of support and distress, and understand changes in their sense of identity and future expectations.

Therefore, this study aimed to explore women's experiences following miscarriage, focusing on the interconnected processes of physical and emotional suffering, maternal identity, healthcare encounters, social support, and coping. By examining women's accounts in their sociocultural context, the study sought to understand how miscarriage may disrupt everyday life and a woman's anticipated sense of self, and how she subsequently negotiates and reconstructs meaning and continuity following the loss. The findings are intended to inform more responsive, compassionate, and woman-centered care for women experiencing miscarriage.

Methods

Design

An inductive qualitative study using conventional content analysis was undertaken to explore women's experiences following miscarriage.

The study was designed to capture participants' own interpretations of pregnancy loss rather than test a predetermined theoretical model. Reporting was guided by the principles of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Setting and participants

The study was conducted at Shahidan Mobini Hospital, affiliated with Sabzevar University of Medical Sciences, Iran.

Participants were recruited purposively using maximum-variation sampling. Variation was sought in age, parity, educational level, employment, gestational age at miscarriage, pregnancy intention, and reproductive history.

Women were eligible if they had experienced a recent miscarriage, were able to communicate in Persian, and were willing and able to describe their physical, emotional, social, and healthcare experiences.

Women whose pregnancy loss resulted from a medically indicated termination were excluded. Ten women participated in the final study.

Data collection

Data were collected in 2025 through individual, semi-structured, in-depth interviews. Interviews were conducted in a private setting to facilitate open discussion of potentially sensitive experiences.

The interview guide explored participants' experiences of the circumstances surrounding miscarriage, physical symptoms and recovery, emotional responses to pregnancy loss, perceptions of motherhood and reproductive identity, concerns about subsequent pregnancy, interactions with healthcare professionals, support from partners and significant others, and strategies used to cope with the loss and resume everyday life. Interviews lasted approximately 45–90 minutes. With participants' permission, interviews were audio-recorded and transcribed verbatim.

Data collection and analysis proceeded iteratively. Preliminary findings from earlier interviews were reviewed before subsequent interviews, and emerging concepts were incorporated into subsequent questioning when relevant. This iterative process enabled the researchers to explore issues raised by participants in greater depth while maintaining flexibility for participants to introduce experiences not anticipated in the initial interview guide.

Data analysis

Data were analyzed using conventional qualitative content analysis, following the approach described by Graneheim and Lundman (9). The analysis was conducted inductively, allowing

categories to emerge from the interview data rather than being predetermined by an existing theoretical framework.

First, the interview transcripts were read repeatedly to gain an overall understanding of participants' experiences of miscarriage. Meaning units relevant to the study aim were identified and defined as words, sentences, or paragraphs related to the same central meaning. These meaning units were then condensed while preserving their essential content and assigned codes that captured their underlying meaning. The codes were compared for similarities and differences and grouped into subcategories based on conceptual and contextual similarities. Related subcategories were subsequently organized into broader categories representing distinct dimensions of participants' experiences.

Throughout the analytical process, the researchers moved iteratively between the original transcripts, condensed meaning units, codes, subcategories, and categories to ensure that the emerging interpretations remained grounded in participants' accounts. The analysis focused primarily on the manifest content of the interviews, while considering latent meanings were supported by the data. Finally, relationships among the categories were examined to develop an overarching interpretation of women's experiences following miscarriage, with particular attention to the interplay of suffering, support, and coping.

MAXQDA version 12 (VERBI Software, Marburg, Germany) was used to organize, code, retrieve, and manage the qualitative data. The software facilitated data management and retrieval; interpretation and analytical decisions remained the responsibility of the research team.

Trustworthiness

Trustworthiness was considered according to credibility, dependability, confirmability, and transferability.

Credibility was enhanced through repeated engagement with transcripts, iterative comparison between codes and original data, peer discussion, and research-team review of emerging interpretations.

Dependability was supported through documentation of analytic decisions and changes in the coding framework.

Confirmability was promoted by grounding interpretations in participants' narratives and repeatedly returning to the original transcripts during analysis.

Transferability was supported through maximum-variation sampling and detailed description of the study context and participants.

Ethical considerations

Ethical approval was obtained from the Ethics Committee of Sabzevar University of Medical Sciences (IR.MEDSAB.REC.1404.037). The study was conducted in accordance with the ethical

principles of the Declaration of Helsinki. Participants received information about the study and were informed that participation was voluntary, that confidentiality would be maintained, and that they could withdraw at any time without consequences for their care. Because pregnancy loss is a potentially distressing topic, interviews were conducted sensitively, and participants were allowed to pause or discontinue the interview if they became distressed.

Findings

Participant characteristics

Ten women who had experienced spontaneous miscarriage participated in the study. Participants were 26–39 years old and represented diverse educational and occupational backgrounds. Gravidity ranged from two to four pregnancies, and participants had between zero and three living children. Three participants described the pregnancy as intended, whereas seven described it as unintended. The interval from the previous pregnancy ranged from one to ten years.

Most miscarriages occurred during the first trimester, although one participant experienced miscarriage at 18 weeks' gestation. The diversity of reproductive histories and circumstances of pregnancy provided variation in how women interpreted and responded to miscarriage. Participant characteristics are presented in Table 1.

Table 1. Characteristics of the participants (n = 10)

Abbreviations: P, participant.

Participant	Age (years)	Education / Occupation	Gravidity	Gestational age at miscarriage (weeks)	Number of living children	Pregnancy intention	Interval from previous pregnancy (years)
P1	33	Bachelor's degree / Psychologist	4	7	2	Intended	3
P2	33	Psychology / Psychologist	3	8	2	Intended	2
P3	26	Diploma / Bag maker	2	8	1	Unintended	2
P4	32	Homemaker	2	18	1	Unintended	6
P5	39	Diploma / Homemaker	3	4	2	Unintended	10

Participant	Age (years)	Education / Occupation	Gravidity	Gestational age at miscarriage (weeks)	Number of living children	Pregnancy intention	Interval from previous pregnancy (years)
P6	34	Secondary education / Homemaker	4	6	3	Unintended	1
P7	32	Homemaker	3	8	2	Unintended	2
P8	33	Employee	2	7	0	Unintended	1
P9	30	Employee	2	6	1	Intended	3
P10	34	Associate degree / Accountant	2	8	0	Unintended	6

Overarching theme: Temporary disintegration and gradual reconstruction of self-following miscarriage

The analysis generated one overarching theme:

"Temporary Disintegration and Gradual Reconstruction of Self Following Miscarriage: The Interplay of Suffering, Support, and Coping."

Participants described miscarriage not as an isolated physical event but as a disruption that affected several interconnected dimensions of their lives. Physical pain and bleeding were accompanied by emotional suffering; the loss could challenge expectations of motherhood and the future; and interactions with healthcare professionals and significant others could either intensify or alleviate distress (table 2).

Table 2. Categories and Subcategories of Women's Experiences of Reconstructing the Self After Miscarriage

Overarching theme	Category	Subcategory
Temporary Disintegration and Gradual Reconstruction of Self Following Miscarriage	Acute embodied suffering and disruption of everyday life	Acute psychological and physical distress
		Convergence of physical pain and emotional loss

Overarching theme	Category	Subcategory
		Persistent physical consequences
		Fear of the healthcare environment
		Attachment to pregnancy and experience of loss
	Threatened maternal identity and uncertainty about the reproductive future	Fear of recurrent miscarriage
		Desire for motherhood versus avoidance of pregnancy
		Guilt, regret and self-blame
		Threatened feminine identity and social stigma
		Meaning-making as death and loss
	Healthcare and social relationships as sources of support or additional suffering	Partner/family/peer support
		Absence of support and unmet emotional needs
		Unsupportive healthcare encounters
		Perceived failures in diagnosis/treatment/discharge
		Inadequate facilities and supportive care
	Reconstructing the self through meaning-making and coping	Spiritual/religious coping
		Re-engagement with everyday life
		Cognitive reconstruction and future orientation
		Avoidance and forgetting
		Limits of coping strategies

Across the narratives, participants described an initial period characterized by bodily and emotional disruption, followed by attempts to restore continuity through interpersonal support, spirituality, everyday activities, cognitive reframing, and future-oriented thinking. This process was not linear. Women sometimes moved between confronting the loss, attempting to make sense of it, returning to everyday life, and avoiding painful memories.

Four interrelated categories constituted this overarching process.

Category 1: Acute embodied suffering and disruption of everyday life

Participants described miscarriage as an intensely embodied experience in which physical symptoms and emotional suffering were closely intertwined.

Acute psychological and physical distress

The immediate experience of miscarriage was associated with intense emotional distress for several participants. The loss of a wanted pregnancy could generate profound sadness and disappointment.

One participant explained:

“I was very upset. I wanted to have my baby, but it didn't happen; perhaps it wasn't meant to be.” (P1)

Physical symptoms could simultaneously be severe. Participants described pain, heavy bleeding, weakness, fatigue, and other physical consequences. One participant compared her experience of miscarriage with childbirth:

“Miscarriage was much harder than giving birth. When I gave birth, I wasn't this distressed, but when I had the miscarriage, my whole body was affected and I had a lot of bleeding and became anemic.” (P1)

These accounts indicate that participants experienced the physical and emotional dimensions of miscarriage as interconnected rather than as separate forms of suffering.

Persistent physical consequences

For some participants, physical consequences continued after the immediate event. Prolonged pain, bleeding, weakness, and other symptoms contributed to the persistence of distress and interfered with normal activities.

One participant described experiencing significant pain during the night for approximately 15 days. Another described hair loss and anemia following the miscarriage.

These experiences extended the impact of miscarriage beyond the moment of pregnancy loss and contributed to a perception that recovery was incomplete even after the acute clinical episode had ended.

The healthcare environment as a source of fear

Hospitalization itself could be associated with uncertainty and fear. Participants described entering an unfamiliar healthcare environment while experiencing pain, bleeding, and emotional vulnerability.

For some women, uncertainty about what would happen after admission increased their distress. Thus, the hospital was experienced simultaneously as a place where care was sought and as an environment that could evoke fear.

Attachment to pregnancy and the meaning of loss

The intensity of emotional responses was related to the meaning participants attached to the pregnancy. For some women, miscarriage represented the loss of a child rather than simply the termination of a physiological process.

One participant described the loss in terms of human life. Such interpretations appeared to contribute to the depth of grief and help explain why participants continued to experience the event as significant after the physical symptoms had subsided.

Category 2: Threatened maternal identity and uncertainty about the reproductive future

The miscarriage affected how some participants understood themselves as women and potential mothers. The loss interrupted expectations concerning motherhood and generated uncertainty about future pregnancy.

Fear of recurrent miscarriage

Some participants became concerned that a future pregnancy might end in another miscarriage. This fear could persist even when they continued to desire motherhood.

The possibility of recurrence therefore created a tension between the desire for another pregnancy and fear of experiencing the same loss again.

Desire for motherhood versus avoidance of pregnancy

Participants did not necessarily respond to miscarriage by rejecting motherhood. Rather, some simultaneously expressed a strong desire for motherhood and reluctance to become pregnant again.

One participant described loving motherhood while avoiding another pregnancy because of concerns about her physical condition.

This tension illustrates how miscarriage could alter women's relationship with future reproductive decisions without necessarily changing their underlying desire for motherhood.

Guilt, regret, and self-blame

Some participants searched for explanations for why the miscarriage had occurred. In doing so, they sometimes considered whether their own behavior or circumstances had contributed to the loss.

These narratives reflected attempts to establish causality and regain a sense of control following an event that had otherwise appeared unpredictable.

Importantly, these accounts represent participants' perceptions and should not be interpreted as evidence that their behavior caused the miscarriage.

Threatened feminine identity and social judgement

For some participants, miscarriage affected their perception of themselves as women. One participant described feeling that she was not a “complete woman.”

Another participant expressed concern about being perceived by others as infertile.

These accounts suggest that miscarriage could affect reproductive identity even in the absence of clinically established infertility. Women's concerns were therefore shaped not only by their own expectations but also by anticipated social judgement.

Miscarriage as death and loss

For some participants, the pregnancy was experienced as an emerging human life, and its loss was understood in terms of death.

This interpretation gave miscarriage profound existential meaning and shaped the emotional response to the event. It also influenced the ways in which participants attempted to understand and accept what had happened.

Category 3: Healthcare and social relationships as sources of support or additional suffering

Participants' experiences demonstrated that relationships surrounding miscarriage could function either as protective resources or as additional sources of distress.

Partner, family, and peer support

Supportive relationships provided emotional reassurance, companionship, and practical assistance.

Several participants described support from their husbands or family members as important during the period following miscarriage. Peer interaction could also provide a sense that their emotional reactions were understandable and shared.

These supportive relationships appeared to reduce feelings of isolation and helped some women regain emotional stability.

Absence of support and unmet emotional needs

Not all participants experienced adequate support. Some described limited emotional availability from close family members or partners.

The absence of someone who would listen or acknowledge the significance of the loss could intensify loneliness. Participants' narratives therefore suggested that the presence of other people did not necessarily equate to meaningful social support.

Unsupportive healthcare encounters

Healthcare interactions were a particularly salient component of participants' narratives.

One participant described prolonged bleeding while feeling that her concerns were not adequately addressed:

“I was bleeding from about 6 in the evening until 3 in the morning, and they kept telling me to go to bed.” (P7)

Another participant described some nurses as harsh in their interactions.

Such experiences contributed to a perception that women's emotional and physical vulnerability was not always adequately recognized.

Perceived problems in diagnosis, treatment, and discharge

Some participants described experiences that they perceived as inadequate or distressing clinical management.

One participant reported a particularly difficult hospital experience that was followed by another procedure:

“What happened to me at Mobini Hospital was so difficult that I had to go back and undergo curettage again.” (P4)

Rather than being remembered solely as treatment events, these experiences became part of participants' narratives of the miscarriage itself.

Inadequate facilities and supportive care

Participants also referred to aspects of the physical and organizational environment of care that affected their experience.

The availability of a supportive environment, attentive staff, privacy, and respectful interaction appeared important to how women interpreted their care.

The findings suggest that the quality of the healthcare environment can either provide a sense of safety during a vulnerable period or compound women's distress.

Category 4: Reconstructing the self through meaning-making and coping

Following the acute disruption of miscarriage, participants described different ways of restoring continuity in their lives. No single coping strategy was used by all women, and coping appeared to change over time.

Spiritual and religious coping

Some participants drew on religious or spiritual beliefs to interpret the miscarriage. Understanding the event in terms of fate or divine will appeared to provide an explanation for an otherwise difficult-to-understand loss.

For some women, this interpretation reduced self-blame and facilitated acceptance.

Re-engagement with everyday life

Returning to ordinary activities provided structure and distraction.

For some participants, returning to work helped them redirect attention away from the loss and regain a sense of normality. Music, reading, social interaction, and other everyday activities were also described as ways of occupying attention and gradually resuming ordinary life.

Cognitive reconstruction and future orientation

Some women attempted to reconstruct their understanding of the event and focus on the future.

Future pregnancy, family life, work, and personal goals provided alternative sources of meaning and encouraged participants to move beyond the immediate experience of loss.

This future-oriented perspective did not necessarily imply that the miscarriage had been forgotten. Rather, it appeared to represent an attempt to incorporate the event into an ongoing life narrative.

Avoidance and forgetting

Some participants deliberately avoided thinking about the miscarriage or attempted to forget what had happened.

Avoidance appeared to provide temporary protection from painful memories. However, participants' narratives suggested that avoiding the experience did not necessarily mean that its emotional significance had disappeared.

Limits of coping strategies

Coping strategies were not uniformly successful. Activities that provided distraction or temporary relief did not always resolve physical or emotional difficulties.

For example, one participant described undertaking a trip in the hope of feeling better but continued to experience physical difficulties.

These accounts suggest that adaptation after miscarriage was neither immediate nor linear. Women moved between confronting the loss, seeking meaning, engaging with everyday life, and temporarily distancing themselves from painful memories.

Synthesis of findings

Taken together, the four categories describe a process rather than four independent domains.

The experience began with embodied physical and emotional disruption, which could extend into uncertainty about motherhood and future pregnancy. Women's subsequent experiences were shaped by whether healthcare professionals and significant others provided recognition, support, and reassurance or, alternatively, contributed to additional distress. Women then drew on different forms of meaning-making and coping to restore continuity.

Thus, the findings suggest the following experiential process:

This process was dynamic rather than linear. Participants could move back and forth between distress, support-seeking, avoidance, meaning-making, and re-engagement with everyday life.

Discussion

This qualitative study explored women’s experiences following spontaneous miscarriage and identified an overarching process of temporary disintegration and gradual reconstruction of the self through the interplay of suffering, support, and coping. Four interconnected categories characterized this process: embodied suffering and disruption of everyday life; threatened maternal identity and uncertainty about future pregnancy; healthcare and social relationships as sources of support or additional suffering; and reconstruction of the self through meaning-making and coping. Collectively, these findings suggest that recovery following miscarriage extends beyond the resolution of physical symptoms and involves the renegotiation of personal identity, reproductive expectations, interpersonal relationships, and emotional wellbeing.

This interpretation is consistent with qualitative research and evidence syntheses demonstrating that miscarriage may have interconnected physical, psychological, relational, and existential

consequences. Recent reviews have also highlighted the importance of recognizing women's individual experiences, provided compassionate healthcare, and understood the diverse ways in which women make sense of pregnancy loss(10–13) . The contribution of the present study is to bring these dimensions together within an experiential process that illustrates how suffering, social responses, healthcare encounters, and coping may jointly shape women's attempts to reconstruct a sense of self and future.

Embodied suffering and disruption of everyday life

Participants described miscarriage as an embodied experience in which physical symptoms and emotional suffering were closely intertwined. Pain, bleeding, weakness, persistent physical discomfort, and fear were not experienced as isolated clinical problems but were associated with distress and continuing reminders of the pregnancy loss. These accounts suggest that physical recovery and emotional recovery may follow different trajectories and that the completion of acute medical treatment does not necessarily correspond to the restoration of wellbeing.

Kukulskienė and Žemaitienė, in their qualitative study of late miscarriage, described disruptions in bodily experience, loss of control, and difficulties reconnecting with the body following pregnancy loss. Although their study focused on later miscarriage, its findings provide a useful point of comparison with the present study. The experiences reported by our participants suggest that bodily disruption may also be meaningful following spontaneous miscarriage earlier in pregnancy. However, the similarities should not be interpreted as evidence that women experience these events identically, because gestational age, pregnancy expectations, previous reproductive experiences, and individual circumstances may shape the nature of the loss(10).

The psychological significance of miscarriage is further supported by Mergl et al, whose systematic review found that pronounced grief was common following miscarriage or stillbirth, although the intensity and course of grief varied considerably across studies. Cuenca similarly emphasized that pregnancy loss may be associated with anxiety, depressive symptoms, and other psychological consequences. These findings reinforce the importance of considering emotional wellbeing alongside physical symptoms. Nevertheless, the present qualitative study was not designed to diagnose psychological disorders or estimate their prevalence; its contribution lies in showing how physical and emotional experiences were intertwined in participants' accounts(11,12).

From a women's health perspective, these findings challenge approaches in which successful treatment is defined primarily by the resolution of bleeding, pain, or other immediate complications. Discharge and follow-up procedures should address physical warning signs while also providing opportunities for women to discuss persistent discomfort, fear, and emotional concerns. Such an approach would recognize recovery as an individualized process rather than a single clinical endpoint.

Threatened maternal identity and uncertainty about future pregnancy

A second major finding concerned the disruption of maternal identity and uncertainty about the reproductive future. For some participants, miscarriage represented not only the end of a pregnancy

but also the loss of anticipated motherhood and an imagined future. Feelings of guilt, regret, self-blame, and fear of another pregnancy illustrated the ways in which the loss could challenge women's understandings of themselves and their reproductive possibilities.

These findings are consistent with Fairchild and Arrington's qualitative analysis of miscarriage narratives, which explored identity changes and the potential for stigma following pregnancy loss. Their work highlights the importance of considering miscarriage as an experience that may affect how women understand and communicate their identities, rather than exclusively as a medical event. In the present study, this disruption was not universal or uniform. Some participants remained strongly oriented toward future motherhood, whereas others expressed apprehension about becoming pregnant again or preferred to avoid thinking about another pregnancy(13).

The findings therefore support a contextual understanding of maternal identity. The significance of miscarriage may depend on pregnancy intentions, emotional attachment, previous reproductive experiences, family expectations, and the meanings women associate with motherhood. It would be inappropriate to assume that every woman experiences miscarriage as a loss of maternal identity or that future pregnancy is necessarily the desired outcome.

Self-blame was another important dimension of participants' experiences. Attempts to identify a cause or attribute the miscarriage to personal actions appeared to contribute to uncertainty and emotional distress. Wallis et al., in their systematic review of qualitative literature on how people narrate miscarriage, identified meaning-making as an important but insufficiently explored dimension of pregnancy loss. Their findings highlight the need to understand how women interpret what has happened rather than assuming that providing a clinical explanation alone resolves the emotional consequences(4).

Healthcare professionals should therefore provide clear, comprehensible information about miscarriage, address misconceptions and unwarranted self-blame, and discuss future pregnancy in accordance with each woman's preferences. Information should support informed decision-making without imposing expectations about when, whether, or how women should pursue another pregnancy.

Healthcare encounters as part of the experience of loss

One of the most salient findings was that healthcare encounters formed part of the experience through which women interpreted and remembered miscarriage. Participants described both supportive interactions and distressing experiences involving communication, pain management, information provision, and perceived shortcomings in care. These accounts suggest that healthcare is not merely the setting in which miscarriage is treated; it may also influence how women experience the loss and understand the responses of others to their suffering.

This finding is consistent with Lee et al., whose integrative review identified acknowledgment of the loss and the need for adequate information as central components of emotional care. Their review also highlighted the challenges healthcare professionals experience when providing emotional support. Similarly, Filippa et al. in a scoping review of miscarriage care, identified information provision, emotional support, accessibility, decision-making, and follow-up as

important dimensions of care. The authors also emphasized the gap that may exist between recommended practices and the care women actually receive(14,15).

The present study adds to this literature by illustrating how participants incorporated particular healthcare encounters into their accounts of the loss. When women felt that their concerns were not adequately addressed, the resulting distress appeared to extend beyond the immediate physical event. Conversely, kindness, reassurance, and opportunities to communicate concerns were described as supportive experiences. These findings do not establish a causal relationship between healthcare quality and subsequent psychological outcomes; rather, they suggest that healthcare interactions are important elements of women's subjective experiences and meaning-making processes.

The importance of communication and care environments is also evident in the qualitative study by Crous et al, which explored women's experiences of healthcare following incomplete spontaneous miscarriage in South Africa. Participants described needs related to safety, pain management, staff attitudes, communication, and continuity of care. These concerns closely resemble those reported in the present study, despite differences in healthcare settings and cultural contexts(16).

The physical environment and institutional practices may also communicate whether a woman's loss is acknowledged. Privacy, respectful language, sensitive handling of pregnancy tissue, and the avoidance of dismissive comments may contribute to a more supportive experience. These issues are particularly important because women experiencing miscarriage may be physically vulnerable while simultaneously attempting to understand an emotionally significant event.

For women's health services, the findings indicate that technically appropriate treatment should be accompanied by respectful communication, timely attention to symptoms, clear information, and continuity of care. Staff education should address not only the clinical management of miscarriage but also the interpersonal skills required to respond sensitively to women experiencing pregnancy loss.

Social support: presence is not enough

Participants described social relationships as potential sources of reassurance, understanding, and practical assistance, but also as sources of additional distress. Support from husbands, family members, and friends helped some women feel less isolated. In contrast, dismissive responses, limited emotional availability, or pressure to move on appeared to leave some participants feeling misunderstood.

The findings suggest that the perceived quality of support may be more important than its mere availability. This interpretation is consistent with the synthesis by Zhuang et al., which identified individualized emotional, social, informational, clinical, and spiritual needs among women experiencing perinatal loss. It also aligns with Lee et al. who emphasized the importance of acknowledgment and empathic treatment in miscarriage care(17,18).

The present findings further suggest that social support should be understood as an interaction between the woman and her social environment. Well-intentioned reassurance may not be experienced as supportive when it minimizes the significance of the loss or discourages the expression of grief. Conversely, listening without judgment and allowing women to describe their experiences in their own terms may provide meaningful emotional validation.

These observations have practical implications for women's health services. Healthcare professionals could ask women whether they feel supported at home, whether they have someone with whom they can discuss the loss, and whether family or social expectations are making it difficult to express their feelings. With the woman's consent, partners or family members may also benefit from guidance on providing appropriate support. Such guidance should respect individual preferences and avoid assuming that every woman wishes to discuss her miscarriage with others.

Coping and meaning-making as pathways toward reconstruction

The fourth category demonstrated that participants used diverse strategies to manage the consequences of miscarriage. These included spirituality and religious beliefs, returning to work, engaging in everyday activities, reading or listening to music, focusing on future plans, and attempting to avoid painful memories. These strategies were not necessarily mutually exclusive, and their perceived usefulness varied across participants.

Recent evidence supports this interpretation of coping as heterogeneous and context-dependent. Lee, Feeley, and Wyatt, in their systematic review and thematic synthesis of women's coping strategies following miscarriage, identified patterns involving remembrance or denial, changed perspectives, seeking causes or meaning, and social interactions that could be either supportive or painful. Their findings suggest that coping cannot be understood as a uniform sequence of stages through which all women progress(19).

The accounts in the present study similarly suggest that reconstruction did not necessarily mean returning to a previous state or completely resolving grief. Instead, women appeared to seek ways of continuing everyday life while negotiating the meaning of what had happened. Spiritual beliefs could provide a framework for understanding the loss; engagement in everyday activities could restore a sense of continuity; and future orientation could help some women regain a sense of possibility. Other women attempted to limit exposure to painful memories.

These strategies should not automatically be classified as adaptive or maladaptive. Avoidance may provide temporary relief, although persistent avoidance could potentially interfere with emotional processing in some circumstances. Likewise, spiritual interpretations may be comforting for some women but may not be meaningful or appropriate for others. The significance of each strategy depends on individual circumstances, personal beliefs, and whether it supports the woman's wellbeing and daily functioning.

The concept of reconstruction therefore provides a useful interpretive contribution. Rather than suggesting that all women reach a definitive state of recovery, it emphasizes the ongoing and individualized work through which women may re-establish a sense of continuity, identity, and future possibility after pregnancy loss. This interpretation extends existing research on miscarriage

narratives and coping by integrating these processes with embodied suffering and the responses women receive from healthcare professionals and social networks(4,14) .

Implications for women-centered healthcare

The findings have several implications for women's health practice. First, healthcare professionals should acknowledge miscarriage as a potentially significant personal experience without assuming that all women will respond in the same way. Respectful language, active listening, and opportunities to express concerns may help women feel that their experiences are recognized.

Second, physical and emotional assessment should be considered together. Follow-up should address ongoing physical symptoms and provide opportunities to discuss emotional distress, uncertainty, and concerns about future pregnancy. The evidence reviewed by Filippa et al suggests that information provision and emotional support remain important dimensions of miscarriage care(15).

Third, communication should be individualized and understandable. Women may need information about the circumstances of miscarriage, expected physical recovery, warning signs, and future reproductive options. Clinicians should acknowledge uncertainty when the cause of miscarriage cannot be established and avoid implying that women are responsible for the loss without medical evidence.

Fourth, healthcare services should strengthen continuity of care and access to additional support when needed. Depending on individual preferences and circumstances, this may include further clinical assessment, psychological support, peer support, or culturally and spiritually appropriate resources. These options should be offered without prescribing a particular way of grieving or recovering.

Finally, professional education should address the emotional and relational dimensions of miscarriage alongside clinical management. The findings of Lee et al. and Crous et al. support the importance of staff preparedness, empathic communication, and attention to women's informational and emotional needs(16,20).

Contribution, strengths, and limitations

The principal contribution of this study is the integration of embodied suffering, threatened reproductive identity, healthcare and social relationships, and coping within a single experiential process. The findings suggest that these dimensions are interconnected rather than independent outcomes. Miscarriage may disrupt bodily experience and anticipated futures; responses from healthcare professionals and social networks may alleviate or intensify this disruption; and women may subsequently draw on different coping strategies to re-establish a workable sense of self and future.

The study also contributes contextually grounded evidence from Iran, where women's experiences are situated within particular family, cultural, and spiritual environments. However, the findings should not be interpreted as representing all Iranian women or as demonstrating that culture

determines how women experience miscarriage. Rather, they illustrate the importance of understanding individual experiences within their specific social and healthcare contexts.

Several strengths merit consideration. The inductive qualitative design enabled participants to describe their experiences in their own terms. Maximum-variation purposive sampling provided diversity in participants' backgrounds and reproductive experiences, while iterative interviewing enabled further exploration of issues emerging during data collection.

The limitations should also be acknowledged. The study included only 10 women recruited from a single hospital, limiting the range of experiences represented. The time elapsed between miscarriage and interview may have influenced participants' recollections and interpretations. The study also focused exclusively on women's perspectives and did not include partners or healthcare professionals, whose accounts might have provided additional insight into support and care processes. Finally, the context-specific findings are intended to support understanding and transferability rather than statistical generalization.

Future research could explore these processes across multiple healthcare settings and among women with different reproductive histories, gestational ages, and support needs. Research involving partners and healthcare professionals could further clarify how communication, social relationships, and institutional practices shape women's experiences. Longitudinal qualitative research could also examine how the meaning of miscarriage and strategies for reconstructing the self-evolve over time.

Conclusion

This study suggests that recovery following spontaneous miscarriage involves more than the resolution of physical symptoms. Women described an interconnected experience of embodied suffering, disruption of maternal and reproductive identity, supportive or distressing healthcare and social encounters, and diverse attempts to reconstruct meaning and resume everyday life. The findings support a women-centered approach to miscarriage care that recognizes the physical, emotional, relational, and existential dimensions of pregnancy loss.

Healthcare professionals should acknowledge women's experiences, communicate sensitively, provide clear information, address physical and emotional needs together, and facilitate access to individualized support. Importantly, women should not be considered fully recovered solely because the acute clinical episode has ended. Care should instead recognize that the process of rebuilding wellbeing and a sense of self may differ substantially between individuals.

Declarations

Ethics approval and consent to participate

The study was approved by the Ethics Committee of Sabzevar University of Medical Sciences, Iran (IR.MEDSAB.REC.1404.037). Written informed consent was obtained from all participants.

Consent for publication

Not applicable. No identifying information is presented.

Availability of data and materials

Because the interview data contain sensitive personal information, the datasets are not publicly available. Data may be available from the corresponding author upon reasonable request and subject to ethical and confidentiality restrictions.

Competing interests

The authors declare no competing interests.

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Authors' contributions

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Mojtaba Rad and Hamideh Yazdimoghadam conceived and designed the study, developed the research proposal, and drafted the manuscript. Hamideh Goli and Hamideh Yazdimoghadam collected the data. Mojtaba Rad and Hamideh Yazdimoghadam analyzed and interpreted the data. All authors reviewed and approved the final manuscript.

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