

MISCARRIAGE AS A MULTIDIMENSIONAL EXPERIENCE: A THEMATIC ANALYSIS OF THE PSYCHOLOGICAL, SOCIAL, AND COPING JOURNEY OF PREGNANCY LOSS

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ABSTRACT

Miscarriage is a profound yet often silenced reproductive loss that affects women beyond its biological dimensions. This study explores miscarriage as a multidimensional experience by examining women's psychological, social, and coping journeys. Using a qualitative research design, in-depth semi-structured interviews were conducted with women who had experienced miscarriage. The data were analyzed using thematic analysis, allowing rich, lived experiences to emerge directly from participants' narratives. Braun and Clark (2006) approach was used to analyze the themes. Six major themes were identified: (1) Clinical and Structural Dimensions of Miscarriage, highlighting medical uncertainty, clinical decision-making, and gaps in care; (2) Lived Experience and Embodied Trauma, capturing physical pain, visual memories, and bodily loss; (3) Psychological and Emotional Turbulence, marked by shock, denial, grief, guilt, and intrusive recollections; (4) Social and Cultural Construction of Miscarriage, reflecting blame, stigma, and gendered expectations placed on women; (5) Family Bonds and Relationship Transformation, illustrating shifts in spousal support, isolation, and altered family dynamics; and (6) Pathway to Coping and Recovery, encompassing faith, self-counseling, distraction, routine rebuilding, and social support. The findings address a critical research gap by foregrounding women's voices in contexts where miscarriage is culturally minimized and emotionally unacknowledged. The study underscores the need for holistic miscarriage care that integrates psychological support, culturally sensitive counseling, and family-inclusive interventions. Future research should expand sample diversity and inform policies that recognize miscarriage as not only a medical event but a deeply emotional and social experience requiring structured post-loss care.

I. INTRODUCTION

Miscarriage is one of the most common, but least discussed, reproductive events among women worldwide. Medically, miscarriage refers to the loss of a fetus or embryo at less than 20 weeks of gestation. About 10-20% of recognized pregnancies end in miscarriage (World Health Organization [WHO], 2022). However, miscarriage as a phenomenon is rarely openly discussed, as it is considered a purely physiological and pathological event. From women's perspectives, it is a traumatic experience associated with losing a baby and a sense of motherhood that they imagined. Existing research makes clear that miscarriage can lead to a range of adverse psychological outcomes, including grief, depression, anxiety, guilt, and post-traumatic stress (Brier, 2008; Farren et al., 2016). Many women find themselves dealing with feelings of shock, denial, anger, and sadness long after the miscarriage has happened. Because miscarriage often takes place before a woman has announced her

pregnancy, these women grieve in private and feel isolated in their sorrow (Murphy, 2012). The grief following a miscarriage can be disenfranchised and complicated, and can persist long after the loss, negatively affecting a woman's mental health in the aftermath of the loss (Doka, 1989). Beyond psychological, social, and cultural factors, there are also gender factors that influence the grieving process. Women are taught to think that God rewards or punishes based on what happens in the womb. This is not helpful as it leads to self-blame and judgment. Society is also judgmental of miscarriage. This can leave women feeling shamed and isolated from their community during a time they need support most (Layne, 2003). For example, in many societies, miscarriage is considered a taboo and is not openly talked about. Family members and caregivers often act in judgmental ways or remain silent when a miscarriage occurs (Cacciatore, 2013).

Women's bodies undergo miscarriage in unique ways that are related to various hormonal and medical factors. At the same time, the impact of miscarriage is determined by women's experience during clinical procedures in connection with diagnostic and therapeutic interventions. Studies have demonstrated that communication breakdown and a woman's lack of emotional support during pregnancy termination increase the risks of negative psychological outcomes (Goldbort et al., 2011; Meaney et al., 2017). Therefore, proper medical care is essential to ensure women receive enough psychotherapeutic help and support. There are various approaches to coping with miscarriage, including emotional release, finding a meaning, seeking spiritual help, reaching out for a social support network, and silent suffering (Lazarus & Folkman, 1984; Swanson, 1999). Coping mechanisms can be different for everyone, as well as the processes of grieving and mechanisms of action. Coping with miscarriage can be non-linear and depend on many factors, such as personal characteristics, culture, family support, and available resources. At the same time, understanding these mechanisms better allows for providing better care and support to women in need. Although there is an increasing number of quantitative studies on the effects of miscarriage, there is a need for qualitative research on the topic. Women's experience of miscarriage in non-Western and low- to middle-income countries remains understudied, and more research is needed to understand how women deal with miscarriage in different cultural contexts. The thematic analysis of the qualitative interviews can help achieve this goal by highlighting common themes and understanding the meanings people attribute to their experiences (Braun & Clarke, 2006). Against this background, the present study aimed to investigate miscarriage as a multidimensional phenomenon encompassing various interrelated aspects. The current research utilized a thematic analysis approach to explore the way women cope with their loss, as well as effectively address the psychological and social challenges associated with the condition. The study pursued the objective of understanding women's perspectives on miscarriage and better appreciating the meaning of the traumatic experience for these individuals to improve the existing support systems.

II. METHOD

Participants

The sample size was determined at 40 participants (N = 40). The researchers implemented purposive sampling to secure a representative distribution of participants with varied experience and professional backgrounds. The study conveniently involved participants such as Women with a history of miscarriage (n = 22), Men (partners) (n = 5), Mothers-in-law (n = 5), Nurses (n = 3), and gynecologists (n = 5). The age of participants varied between approximately 20 and 50 years old. The participants were of different social, economic, and educational backgrounds. Participants were included in the study if they met one or more of the following criteria:

1. Women who had experienced at least one miscarriage.
2. Individuals (men or mothers-in-law) who were closely involved in the experience of miscarriage within the family.
3. Healthcare professionals (nurses and gynecologists) who had provided care to women experiencing pregnancy loss.

Measures

The study utilized semi-structured in-depth interviews. An interview guide consisting of open-ended questions was developed to elicit information from participants about their thoughts, feelings and behaviors, interpersonal interactions, culturally informed ideas, and perceptions on the topic of miscarriage.

Procedure

The study received ethical approval before the research process commenced. The participants were purposefully sampled from various sources: Government and private healthcare institutions, Community networks, Referrals, and Support groups on social media platforms. Each participant was provided with a detailed description of the research procedure and study goals. Interviews were held individually, and each interview lasted 30 to 60 minutes. Probing was done where necessary to get more information and clarification. The interviews went on until the point of saturation was reached. Before each interview started, participants gave their informed consent and were assured of anonymity and confidentiality. All interviews were recorded with permission from the participants.

III. RESULTS

For the current study, the first phase of the analysis commenced after transcription of the audio recorded interviews. The transcripts were read and re-read several times as part of the process of familiarizing with the data. In this stage, I also made reflective notes and underlined sections of texts that, in my view, seemed significant or salient for the participants' experiences of pregnancy loss. I also read verbatim and did a line-by-line analysis to generate initial codes. In the final step, the codes that fell under similar categories were combined and put together to form preliminary categories. Afterward, these categories were further organized into sub-themes and themes. This stage involved a lot of iteration because there was a vast amount of data to go through. The themes had to be consistent across different groups of participants such as women, men, mothers-in-law, nurses, and gynecologists. In this stage, I have reviewed the initial codes, subthemes, and themes developed based on the interview data. By removing and combining codes that were found to be irrelevant, overlapping, or underdeveloped during the evaluation process, it was possible to enhance the quality and precision of the generated themes. In parallel, I engaged in iterative revisions of themes, which entailed eliminating those found to be inappropriate and expanding upon those that were relevant in terms of study goals and research questions.

In the final step, the information was repeatedly analyzed till the point when the themes and subthemes emerged. The themes were further discussed and revised together with the research supervisor to come up with an accurate representation of the identified ideas, models, and perceptions towards the research problem. Consequently, the final set of themes and subthemes were developed and presented after incorporating the supervisor's suggestions. The analysis of the interview data yielded six themes that emerged from the perspectives of women, men, mothers-in-law, nurses, and gynecologists, each of which can be seen as a particular aspect of miscarriage. The six themes are (1) Clinical and Structural Dimensions of Miscarriage, (2) Lived Experience and Embodied Trauma, (3) Psychological and Emotional Turbulence, (4) Social and Cultural Construction of Miscarriage, (5) Family Bonds and Relationship Transformations, and (6) Pathways to Coping and Recovery. The subthemes of these themes are presented in Table 3 below.

Theme I: Clinical and Structural Dimensions of Miscarriage

This indicates that the theme of miscarriage was interpreted through medical explanations while being subjected to diagnostic, socioeconomic, and ideological factors. The participants associated miscarriage with fetal developments and abnormalities such as those detected during anomaly scans. For instance, one participant stated, *"Everything was normal, when the anomaly scan was done, the doctor told us that there was excess fluid in the baby's brain"* (P2), while another reported, *"it was discovered during the anomaly scan that the baby had disability"* (P8). Experiences associated with clinical signs and diagnostic routes were characterized by reliance on ultrasounds and delayed loss detection, as demonstrated by the halted growth or lack of heartbeat, for instance, *"the doctor said that baby's growth had stopped and that no heart beat was detected"* (P1).

Some participants also mentioned cases of women who remained unaware of their pregnancy due to irregular cycles or a condition and said, *"I had no idea that my pregnancy was going on"* (P20). Care access barriers such as financial difficulties, travel-related stress, and delays in treatment affected care during pregnancy, for instance,

“each operation cost between 6 to 7 lacs and my husband was un employed at that time” (P18), *“we used to travel by buses, the journey was extremely hectic and exhausting”* (P21). Besides medical facts or reasons, the participants mentioned different reasons, including weakness, a bad lifestyle, stress, and even some supernatural intervention. For example, one participant stated, *“they said to me, you have lots of weakness, so that is a reason for miscarriage,”* (P1), while another said, *“people used to say that a saya had fallen on me and that I should get dam (spiritual healing) done”* (P40). Altogether, this theme shows that miscarriage is a tragic event in women’s lives that is influenced by many factors, including medical, social, and even supernatural.

Theme II: Lived Experience and Embodied Trauma

This theme reflects the women’s recollections of miscarriage as a significant traumatic event in their bodies, feelings, relationships, and security. In the context of experiencing trauma, participants mention individual and interpersonal trauma through severe medical complications during the procedure. For example, some participants describe the extended and troubling miscarriage, *“my period after the abortion had been prolonged for more than a month, and I keep remembering that whole time”* (P16), while others mention the extreme cases of medical trauma, *“the doctors once called my husband and told him, she is gone”* (P21).

The trauma was not only a physical but a psychological one, as the participants described the experience as overwhelming, *“it was a trauma for me, quite heavy”* (P37). There was a subtheme of disclosure and secrecy as many participants mentioned deciding to disclose their loss and who they decided to tell. This ranged from telling only their spouses *“No one in my family knows, only my husband is aware”* (P3) to deciding not to disclose the loss at all due to the fear of others finding out, *“we decided not to tell anyone, otherwise they would have become worried”* (P20). This was done to prevent the feeling of families and friends blaming themselves, *“I didn’t experience any pressure and blame because we didn’t disclose it”* (P20). The subtheme of medical procedures and treatment was characterized by the inclusion of intrusive procedures, difficult decision-making, and mixed experiences with healthcare providers. The participants described various procedures, such as vacuum aspiration, injection, long gynecological examinations, and multiple consultations, which were accompanied by pain and suffering, for instance, *“The pain was really intense, even after the operation, my condition remained serious”* (P1). Others mentioned mixed medical advice and the traumatic experience connected with repeated recommendations to terminate the pregnancy, *“the panel of doctors sat together and everyone advised to terminate the pregnancy”* (P18). Together, these factors show that miscarriage is presented as an embodied, medicalized experience, which is characterized by secrecy, procedures, and prolonged suffering.

Theme III: Psychological and Emotional Turbulence

This theme comprises the deep feelings of grief, pain, shock, and anger associated with miscarriage as well as the sense of isolation and depression it brings about. The respondents talked of the sense of loss and devastation they felt in the wake of their experience. One respondent articulated that feeling as follows: *“I was just crying, I cried for many days,”* (P4) while another respondent said, *“I was in so much pain, that thing just wouldn’t leave my mind,”* (P12). Others experienced shock and disbelief at the news of the loss which sometimes made them unable to grasp what was happening. *“I was shocked in the beginning, in denial, disbelief,”* (P7) said one respondent, *“At first, I couldn’t even understand what they were saying,”* (P40).

Emotions such as anger and frustration were commonly expressed by the participants. Frustration was often targeted against oneself or the situation, or the multiple procedures undergone, *“I was very frustrated, back-to-back ultrasounds and tests were happening”* (P16). The predominant feeling experienced was guilt and self-blame, due to a perception that the loss was a result of their own shortcomings, such as physical weakness, overwork or negligence, *“I felt this happened because of my own carelessness.”* (P15), *“I started blaming myself”* (P20). Moreover, the participants experienced intrusive thoughts or flashbacks about the loss, with certain scenes or memories replaying in their minds repeatedly, *“The scenes kept coming back to my mind repeatedly”* (P4). Experiences of loneliness and detachment were prevalent among the participants, with several reporting self-imposed isolation and disengagement from close relationships, *“I even started avoiding my closest people”* (P19), *“I felt completely alone”* (P8). In general, this theme captures the notion of miscarriage as a highly

distressing experience that provokes dysfunctional emotional responses and challenges an individual's capacity for social connections and relationships.

Theme IV: Social and Cultural Construction of miscarriage

The theme revolves around social stigma, blame, the influence of gender norms, religion, and healthcare on miscarriage. The participants mostly talked about social stigma, blame, and judgment, with miscarriage often being attributed to women. Several participants relayed stories of hearing negative comments from family members and in-laws, such as, *"People often blame the women, saying it happened because of her"* (P1) and *"My mother-in-law said I was sick"* (P10). In certain instances, women were labeled as weak, careless and incapable of motherhood. One participant recalled, *"It was even said that there was something wrong with me, and that's why the baby couldn't survive"* (P17). In combination with stigma, cultural and religious beliefs played an important role in the meaning-making and coping process. The majority of participants coped with miscarriage by making sense of it in terms of fate, Gods' will and acceptance. *"It was Allah's will; it was Allah's trust."*(P1), *"What is not in one's destiny, will never happen."* (P3). In addition, some participants relied on religion to help them cope with miscarriage. *"I prayed and read verses from the Quran gave me peace"* (P20).

The fact that cultural expectations around fertility and the speed of conception put additional pressure on women added to the negative perception around miscarriage. Another theme that emerged from the collected testimonies was the notion of social construction around the experience. Interviewed women shared their views on the way society treats/miscarriage and the way healthcare professionals addressed the issue. Respondents spoke of feeling dismissed and mistreated by medical professionals who show no interest in their condition. One participant said, *"The doctor did not check me personally; the assistant did, and I was not satisfied"* (P1). Others reported having received inconsistent answers and poor treatment from doctors, *"even the doctors themselves were not clear about what was happening"* (P16). Overall, the theme of social construction is closely linked with the impact of stigma and cultural expectations on women who experience miscarriage. The way this demographic has to deal with the ordeal is heavily affected by external factors such as societal judgment, lack of support from authorities, etc.

Theme V: Family Bonds and Relationship Transformation

The theme of this study emerged to illustrate the implications of miscarriage on the couples' relationships, attachment to the lost child, and parenting experiences in the families. In terms of marriage, the participants discussed how the loss affected their interaction with their partner, attachment, and adaptation to a new situation with grief. They noted that spouses played a significant role in their coping and support, especially husbands' involvement. For instance, P2 said that *'when I was crying my husband would sit beside me... he also felt it deeply'* while others described the event as an opportunity to increase their intimacy: *'my relationship became better after this, I have a very good support from my husband'* (P15). At the same time, some participants reported negative changes in their relationships due to miscarriage: *'I couldn't even share my emotions with my husband... I felt completely alone'* (P19).

The subtheme of attachment to the unborn child emerged as participants described feeling connected to their child even at the earliest stages of pregnancy. They also expressed a range of intense emotions and thoughts about miscarriage, for instance, *"I felt as if I was holding my baby in my hands"* (P2) and *"For a mother, her baby is a part of her body"* (P8). Looking at the fetus intensified their feelings: *"If I hadn't seen it myself, maybe I wouldn't have felt it so intensely"* (P12). How the loss of a child affects their children and parenting was another theme that emerged from the interviews? The women talked about the difficulties they faced trying to manage their grief and loss alongside their children. For example, they said that they began neglecting their other children as they grieved, *"I started ignoring my other children... I would just lie in bed and cry"* (P2). Others tried to put on a brave face so that they could continue providing for their children, *"I had to get up only for my son"* (P3). Children were described as being emotionally hurt, raising questions and confusion about loss, and asked, *"He would ask why everyone else has siblings, but he doesn't"* (P3). Altogether, the theme suggests that a miscarriage is a relationship experience that significantly affects marital adaptation, parent, and family functions.

Theme 6: Pathway to Coping and Recovery

In this theme, the participants discussed the various ways in which they coped with their loss and distress following miscarriage to restore their lives to normal. In individual coping, the participants coped with their loss by expressing their grief privately and seeking to find meaning in the event. *"I cry a lot when I am alone, maybe to feel some relief"* (P2). Also, *"I counseled myself on my own"* (P16). The participants coped with the loss using their faith and spirituality by praying and reading the Quran. *"When I talk to Allah, I feel peace"* (P20). *"Faith in Allah helped me cope"* (P17). In addition, the participants coped with their problems through behavioral and activity-oriented approaches such as staying busy with chores, engaging in creative work, reading, exercising, or working. As one patient explained, *"I started reading novels and keeping myself busy"* (P18) and *"Morning walks gave me relief"* (P38). Similarly, patients received much-needed support from social networks, including spouses, parents, siblings, friends, and peer-support groups, or even professionals. One of the participants stated, *"If those people were not there, maybe I would not have been able to stand"* (P3). Others described how social support helped them overcome challenges by giving courage, especially when they realized that they were not alone in facing similar problems: *"I gained courage knowing that I am not alone"* (P22).

Finally, daily functioning and recovery were described as a slow process that was initially associated with physical pain, sleep disturbances, lack of appetite, impaired concentration, and decreased productivity, and then gradually returned to normal as participants reported, *"In the beginning, my routine was completely disturbed"* (P1) but later stated, *"With time, things started to return to normal"* (P24). This theme encompasses the gradual improvement of bodily and mental functions as a result of personal, religious, and social support, and time factors.

IV. DISCUSSION

The present study aimed to discover the multidimensional nature of miscarriage as an experience involving various aspects of women's lives. The study revealed six themes related to miscarriage, indicating that this event goes beyond clinical and biomedical care and involves social, cultural, psychological, and interpersonal aspects. The findings of this study contribute to the existing literature by providing a comprehensive view of miscarriage and its impact on women's daily life and lives from different perspectives. Theme 1 reflects a common understanding of miscarriage as a result of medical complications such as fetal deformities, growth restriction, and absence of a fetal heartbeat detected during an anomaly scan. This perspective is consistent with biomedical understandings of miscarriage as a manifestation of chromosomal or developmental abnormalities (Gaboony et al., 2015). Nevertheless, this theme also highlights the impact of delayed diagnosis, the availability of diagnostic services, and financial accessibility on women's experiences. In line with previous research, the themes of ultrasound scanning, private care, and traveling stress the role of healthcare services in increasing uncertainty and distress surrounding miscarriage (Meaney et al., 2017). Similarly, recent studies note the contribution of the healthcare system to women's confusion and grief following miscarriage (Meaney et al., 2017; Campillo, Meaney & O'Donoghue, 2019). At the same time, some participants attributed miscarriage to weakness, stress, and supernatural causes. This reflects the tendency to understand miscarriage via a combination of medical and cultural explanations (Layne, 2003).

Theme 2 deals with women's experiences of miscarriage as an inherently traumatic event associated with significant physical discomfort, intrusive interventions, and psychological trauma. The qualitative data describing miscarriage as a result of bleeding and emergency interventions and the danger to the mother's health are consistent with a range of studies that identify miscarriage as a potentially traumatic experience and one that may lead to post-traumatic stress (Farren et al., 2016). Finally, participants' stories and concerns about discretion and secrecy around miscarriage and the perceived lack of sympathy from society align with the concept of disenfranchised grief (Doka, 1989; Murphy, 2012). Theme 3 emphasizes the range and depth of the emotional trauma associated with miscarriage: grief, shock, anger, self-blame, intrusive thoughts, and depression. Theme 3 is in line with the results of earlier studies that also report that miscarriage leads to severe mental health problems as a result of grief, which is similar to bereavement experiences (Brier, 2008; Cacciatore, 2013; Gold et al., 2016). In several cases, the participants attribute their loss to their own "failures," which reflect the social expectation of women to be able to control their bodies and achieve positive maternity outcomes (Layne, 2003; Shakespeare et al., 2019; Geller et al., 2010). Moreover, the prevalence of negative

intrusive thoughts, hypervigilance, and avoidant coping mechanisms indicates that women often experience miscarriage as a traumatic event. Therefore, Theme 3 supports the need to view miscarriage as a potentially traumatic experience associated with severe mental health issues that require timely professional intervention (Farren et al., 2016; Bennett et al., 2005; Lok & Neugebauer, 2007).

Theme 4 depicts the social construction of miscarriage via stigma, gendered blame, cultural norms, and religious beliefs. In line with the themes found in the works of feminist and sociological researchers, the women interviewed in the study were subject to judgment from their family members and in-laws for failing to meet their expectations (Cacciatore, 2013). In particular, cultural and religious beliefs were used to justify the loss of pregnancy, which could either facilitate emotional adjustment after miscarriage or aggravate negative feelings following the loss. Notably, the coping mechanism was similar to the one identified by Koenig (2012), who discovered that religious beliefs could make women prone to suppression of emotions as a coping strategy. At the same time, the theme found resonance with the findings by Goldbort et al. (2011), who revealed the detrimental effect of the communication framework used by healthcare professionals on women's mental health after miscarriage. Theme 5 indicates that miscarriage is a relational experience that has an impact on the marital status of the woman and her partners, as well as the family's functionality. The most common protective factor identified in the study is spousal support. Indeed, studies have shown that the best remedy for couple distress following a miscarriage is a partner's empathy (Swanson, 1999). At the same time, several sources indicate that a lack of understanding or poor communication could worsen the loss for the couple, as partners could interpret each other's grief in different ways. The affective bond between a mother and the fetus is very strong, even at an early stage of pregnancy; therefore, the loss of the baby affects women even before birth takes place (Brier, 2008). Another point to be considered is the impact of miscarriage on the couple's other children, if any.

Theme 6 demonstrated that coping and recovery from a loss were non-linear processes that involved personal, faith, social support, and temporal factors. The participants coped with miscarriage by using emotion-focused (e.g., crying, seeking meaning, and praying) and problem-focused coping strategies (e.g., being busy and returning to normal routines) in line with Lazarus and Folkman's (1984) cognitive transactional coping model. The study found that women coped with miscarriage through faith-based actions, which could be explained by their cultural background. This finding aligns with the literature indicating that non-Western women are more likely to use spirituality as a coping mechanism following their reproductive loss (Koenig, 2012). Social support was also significant in the recovery process from a miscarriage, with spouses and close people being important sources of help and comfort. This result is consistent with the finding that social support facilitates healing by providing validation and opportunities for sharing a meaningful story about the loss (Cacciatore, 2013). Overall, these findings highlight the importance of culturally sensitive support systems that recognize women's individual coping strategies, spiritual beliefs, and social relationships during recovery from miscarriage.

V. CONCLUSION

The study highlights miscarriage as a complex psychosocial experience shaped by healthcare practices, cultural beliefs, and personal perspectives, with recovery varying across women. The findings emphasize the need for compassionate, culturally sensitive healthcare, accessible psychological support, and improved professional training. However, purposive sampling, retrospective self-reports, limited participant diversity, and the cross-sectional design restrict generalizability and understanding of changes over time. Future research should adopt longitudinal and mixed-methods designs, include partners and healthcare professionals, examine cultural and socioeconomic differences, and evaluate psychological interventions to improve miscarriage-related care.

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