

Lived Experiences of Couples Regarding Grief Caused by Recurrent Miscarriages in Infertile Women: A Phenomenological Study

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ABSTRACT

Objective: This study aimed to gain an in-depth understanding of couples' lived experiences of grief caused by recurrent miscarriages in infertile women.

Methods and Materials: This qualitative study was conducted using a descriptive phenomenological approach. Seventeen participants (14 women and 3 men) with a history of at least two consecutive miscarriages and infertility were purposively selected from specialized infertility centers in Tehran and Qom in 2025. Data were collected through semi-structured interviews (individual and couple interviews) and analyzed using Colaizzi's seven-step method.

Findings: Six main themes emerged: emotional turmoil (shock, anxiety, guilt, chronic sorrow, and hopelessness); continuity of loss (multilayered, disenfranchised, and complicated grief); distorted self-concept (sense of bodily defectiveness, doubts about gender identity, and reduced self-esteem); the relationship under the shadow of loss (mutual empathy, distance resulting from differences in grieving styles, and strengthened bond); coping and adaptation (individual strategies, social support, and the role of healthcare staff); and search for meaning (religious meaning-making, post-traumatic growth, and redefinition of goals).

Conclusion: Recurrent miscarriage is an existential, relational, and culture-based phenomenon. Grief in this context is multilayered, chronic, and often overlooked. A deep understanding of this experience can contribute to the design of couple-centered interventions and enhance healthcare providers' sensitivity.

Keywords: recurrent miscarriage, grief, lived experience, phenomenology, couples, infertility.

1. Introduction

Recurrent miscarriage is one of the most emotionally disruptive reproductive experiences because it

combines the biological event of pregnancy loss with repeated exposure to hope, uncertainty, grief, and renewed reproductive effort. Although miscarriage is often approached clinically as an obstetric or biomedical event, its

psychological consequences extend far beyond the moment of fetal loss. Women and couples frequently experience miscarriage as the collapse of an anticipated future, the interruption of an emerging parental identity, and the loss of a meaningful relational bond with an imagined child. This experience becomes more complex when miscarriage occurs repeatedly, because each subsequent loss not only produces a new episode of grief but also reactivates previous losses and intensifies fear regarding future pregnancies. Recent clinical and psychological studies have emphasized that recurrent pregnancy loss should be understood through an integrated biopsychosocial lens, in which epidemiological, hormonal, psychological, relational, and cultural factors interact with one another (Giakoumelou et al., 2023; Loss, 2023; Majalia & Salehb, 2025). In this sense, recurrent miscarriage is not simply a repeated medical complication; it is a cumulative existential and emotional crisis that can reshape women's self-understanding, marital dynamics, social relationships, and meaning-making processes.

The psychological burden of miscarriage has been widely documented in contemporary reproductive mental health literature. Women who experience miscarriage may report anxiety, depressive symptoms, intrusive memories, guilt, shame, sleep disturbances, fear of recurrence, and reduced reproductive confidence. Systematic and narrative reviews indicate that psychological morbidity after miscarriage is clinically significant and may persist for months or even years, particularly when the loss is recurrent, socially unsupported, or medically unexplained (Farren et al., 2022; Meaney et al., 2023; Navabinejad et al., 2024). The emotional impact is also intensified when miscarriage is associated with infertility, because pregnancy is often the result of a long period of treatment, waiting, financial strain, and bodily uncertainty. In such cases, miscarriage may be interpreted not as a single loss but as another confirmation of reproductive failure, bodily vulnerability, and the fragility of hope (Gameiro et al., 2022; Su & Chen, 2022). Psychological aspects of miscarriage may also be shaped by medical explanations or suspected causes, including hormonal, infectious, genetic, immunological, and anatomical factors; however, even when medical causes are identified, the emotional consequences remain deeply personal and may include self-blame and persistent uncertainty (Majalia & Salehb, 2025; Muhaisin et al., 2022).

Recurrent miscarriage carries a distinctive psychological structure because the experience is cyclical. Couples often move through repeated phases of hope, confirmation of pregnancy, vigilance, fear, loss, grief, medical evaluation,

and renewed attempts to conceive. This cycle produces a form of emotional instability in which hope and despair continuously replace one another. Haks et al. described recurrent pregnancy loss as an experience marked by the cyclical movement between anticipation and devastation, where pregnancy becomes simultaneously desired and feared (Haks et al., 2023). Similarly, pregnancy after miscarriage is often accompanied by heightened anxiety, disrupted bonding, and fear that emotional attachment to the fetus will increase the pain of another possible loss (Côté-Arsenault & Denney-Koelsch, 2023; Lok et al., 2024). Therefore, women may struggle to allow themselves to feel joy during subsequent pregnancies, while partners may oscillate between cautious optimism and emotional withdrawal. This state of reproductive uncertainty makes recurrent miscarriage psychologically different from a single miscarriage, because the past loss remains active within the emotional landscape of each new pregnancy.

Grief after miscarriage is frequently characterized as disenfranchised, hidden, or socially unrecognized. Unlike other forms of bereavement, pregnancy loss often lacks public rituals, clear social scripts, and sustained communal support. Many women report that others minimize the loss by referring to the fetus as "tissue," emphasizing the possibility of future pregnancy, or encouraging the woman to "move on." Such responses may intensify grief because they deny the symbolic and relational significance of the pregnancy. Studies on disenfranchised grief following miscarriage show that women often feel unseen, invalidated, and deprived of permission to mourn (Bellhouse et al., 2022; Murphy & Philpin, 2022). Qualitative metasyntheses have similarly shown that early pregnancy loss can produce a hidden form of grief that remains psychologically powerful despite being socially minimized (Burden et al., 2023). This lack of recognition is particularly important in recurrent miscarriage, where repeated losses may paradoxically become even more normalized by others, while for the couple each loss may accumulate and deepen the wound.

The experience of miscarriage is also strongly linked to identity. Pregnancy is not merely a biological state; it often initiates a psychological transition toward parenthood and activates personal, familial, cultural, and gendered meanings. When pregnancy ends in miscarriage, especially repeatedly, women may experience a disturbance in self-concept, body image, femininity, and perceived competence. Asayesh-Oberg et al. emphasized that infertility and pregnancy loss can disrupt women's identity by challenging their sense of bodily integrity and reproductive capability

(Asayesh-Oberg et al., 2023). Purewal et al. also highlighted that parenthood, fertility, and identity are closely intertwined, and that reproductive disruptions can threaten both individual identity and the imagined life course (Purewal et al., 2023). In cultures where motherhood is highly valued, women may interpret miscarriage not only as the loss of a pregnancy but also as evidence of inadequacy or failure in fulfilling an expected feminine role. This may lead to shame, self-blame, social withdrawal, and reduced self-esteem.

The identity-related impact of miscarriage is not limited to women. Men may also experience grief, guilt, helplessness, and threats to masculine or paternal identity, although their suffering is often less visible. Recent reviews on men's grief after pregnancy loss indicate that fathers frequently experience emotional pain but may suppress it due to gender norms, the expectation to remain strong, or the perception that the woman's suffering should remain the central focus (Obst et al., 2023; Wright et al., 2024). Kalantari's qualitative exploration of men's silent grief in pregnancy loss also suggests that men may experience intense but concealed grief, often expressed through practical support, emotional restraint, or avoidance (Kalantari, 2023). In this context, the couple's grief may become asymmetrical: women may seek emotional expression and acknowledgment, whereas men may attempt to cope through silence, problem-solving, or protective withdrawal. Such differences may generate misunderstanding, distance, or resentment within the marital relationship.

The couple relationship is a central context in which recurrent miscarriage is experienced, interpreted, and managed. Miscarriage is not only an individual event but also a shared reproductive and relational crisis. Couple-based perspectives show that pregnancy loss can either strengthen the marital bond through mutual empathy or create tension through differences in grieving styles, communication patterns, blame, sexual intimacy, and future reproductive decisions (Jomeen & Tokosi, 2022; McNamee & O'Reilly, 2023). DeMontigny et al. demonstrated that psychological distress following recurrent miscarriage may affect both partners over time and should therefore be examined longitudinally and dyadically rather than exclusively through the woman's individual symptoms (DeMontigny et al., 2023). Marital satisfaction, social support, and coping strategies are also interconnected among couples who experience miscarriage, indicating that relational resources may buffer psychological distress,

whereas poor communication or lack of mutual understanding may intensify it (Kousar et al., 2024). Thus, studying recurrent miscarriage from the perspective of couples can reveal dimensions of grief that remain invisible when research focuses only on women.

Social support is another crucial determinant of adjustment after miscarriage. Support may come from spouses, family members, friends, peer groups, religious communities, and healthcare professionals. However, support is not always helpful; poorly timed advice, minimization of grief, social comparison, and pressure to try again may worsen emotional distress. In many cases, women and couples need empathic acknowledgment, space for mourning, accurate information, and sensitive clinical communication. Barbe et al. highlighted the potential value of early, brief psychological care after early miscarriage, reflecting growing recognition that timely support may reduce emotional complications and facilitate adjustment (Barbe et al., 2023). The role of healthcare providers is especially important because clinical encounters often occur at the moment when the loss is confirmed. Compassionate communication can validate the loss and reduce isolation, whereas cold or purely technical communication can intensify trauma and disenfranchisement. Therefore, the quality of healthcare interactions may become part of the grief experience itself.

Coping with recurrent miscarriage involves emotional, cognitive, behavioral, spiritual, and relational strategies. Some individuals rely on avoidance, work, information seeking, or medical problem-solving; others turn to religious faith, prayer, meaning-making, or peer support. Walsh's systemic-relational framework of family resilience emphasizes that families and couples can recover from adversity through shared belief systems, organizational resources, communication processes, and meaning-oriented adaptation (Walsh, 2021). In the context of pregnancy loss, resilience does not mean the absence of grief but the capacity to integrate loss into life, maintain relational connection, and reconstruct hope. Koert et al. argued that pregnancy loss should be understood as a major life event that challenges assumptions about adjustment and resilience, because responses vary widely depending on social context, life history, reproductive goals, and relational resources (Koert et al., 2022). Therefore, coping after recurrent miscarriage cannot be reduced to individual psychological strength; it is shaped by relational, cultural, medical, and existential conditions.

Meaning-making is one of the most important processes in adaptation to reproductive loss. Pregnancy loss often disrupts fundamental assumptions about the body, justice, divine will, family continuity, and the expected course of adulthood. Meaning reconstruction theories in bereavement suggest that individuals attempt to integrate loss into their personal narratives by revising assumptions, finding explanations, preserving bonds, and redefining life priorities (Holland & Neimeyer, 2023). Park's meaning systems perspective similarly emphasizes that traumatic experiences create distress when they violate global beliefs, goals, and expectations; adaptation requires either reappraising the event or transforming one's broader meaning system (Park, 2022). In recurrent miscarriage, meaning-making may involve religious interpretations, philosophical reflection, post-traumatic growth, acceptance of uncertainty, or redefinition of parenthood. For some couples, meaning is found in faith and endurance; for others, it is constructed through helping others, strengthening marital intimacy, or reorienting life goals.

Cultural context plays a decisive role in shaping the lived experience of miscarriage. In the Iranian cultural context, fertility, motherhood, family continuity, and social expectations surrounding childbearing may strongly influence how miscarriage is interpreted and how grief is expressed. Afshani et al. showed that Iranian women's lived experiences of miscarriage are shaped by cultural meanings, social expectations, and gendered pressures, which may intensify shame and isolation when pregnancy loss is not adequately recognized (Afshani et al., 2022). Hosseininia also emphasized that emotional responses to pregnancy loss in Iran are gendered, with women and men often expressing distress differently under the influence of cultural norms about femininity, masculinity, patience, and family responsibility (Hosseininia, 2022). These findings suggest that the psychological meaning of recurrent miscarriage among Iranian couples cannot be fully understood without attending to cultural narratives of motherhood, religious interpretations of loss, social stigma, and expectations placed on women's reproductive bodies.

Despite the growing body of research on miscarriage, several gaps remain. First, much of the literature focuses on psychological symptoms such as anxiety and depression rather than the deeper lived structure of recurrent miscarriage grief. Second, many studies examine women individually and give less attention to the couple as a relational unit. Third, the voices of men are often underrepresented, even though men may experience silent

grief and relational vulnerability. Fourth, fewer studies have explored recurrent miscarriage in combination with infertility, although this combination may produce a particularly intense form of grief because it links repeated loss with prolonged reproductive struggle. Finally, although Iranian studies have examined women's experiences of miscarriage and gendered emotional responses, there remains a need for phenomenological research that captures the shared, relational, and culture-based meanings of grief among couples facing recurrent miscarriage (Afshani et al., 2022; Hosseininia, 2022; Navabinejad et al., 2024).

A descriptive phenomenological approach is particularly appropriate for addressing these gaps because it allows researchers to return to the participants' lived experiences and describe the essential structure of the phenomenon without reducing it to predetermined diagnostic categories. Recurrent miscarriage involves embodied suffering, disrupted identity, relational tension, silent grief, social invalidation, and the search for meaning. These dimensions cannot be fully captured through quantitative symptom scales alone, although such measures are valuable for estimating psychological burden. Phenomenology enables the researcher to explore how couples experience time, body, hope, fear, loss, marital closeness, social judgment, and spiritual meaning in the context of repeated reproductive loss. Such an approach is especially valuable in culturally situated research, where the meaning of miscarriage is formed at the intersection of personal grief, medical discourse, family expectations, religious beliefs, and gender roles.

Therefore, the aim of the present study was to gain an in-depth understanding of the lived experiences of couples regarding grief caused by recurrent miscarriages in infertile women.

2. Methods and Materials

2.1. Study design and Participant

The present study was conducted using a qualitative approach and descriptive phenomenology, an approach grounded in Husserl's philosophy that aims to return to "the things themselves" and to provide a precise description of lived experience without the interference of preconceptions (Colaizzi, 1978). This approach was selected because of its full consistency with the purpose of the study, namely, to explore the structure of infertile women's and couples' experiences of recurrent miscarriage and to analyze its emotional, cognitive, and relational components. In

accordance with the principle of epoché, the researcher attempted to bracket personal assumptions and receive the participants' experiences directly.

To ensure the quality of the study, Lincoln and Guba's four criteria, including credibility, transferability, dependability, and confirmability, were applied. For credibility, the researcher remained engaged with the data for more than five months, the interviews were listened to repeatedly, and the analyses were returned to the participants, which led to the revision of some statements. Data coding was performed not only by the researcher but also by an independent coder, and the level of agreement between the two coders was 85%. Diversity among participants, triangulation of data sources, and analysis of discrepant cases were also used to strengthen credibility. For transferability, a rich description of the research context, participant characteristics, and data collection process was provided so that readers could judge the possibility of transferring the findings to similar contexts. For dependability, the research process, audio files, transcribed versions, field notes, and changes made throughout the research process were fully documented. For confirmability, reflexive notes were recorded to control assumptions, and an external auditor reviewed and confirmed the entire analytical process.

The research population included infertile women with experience of recurrent miscarriage (at least two consecutive spontaneous miscarriages) and their husbands who had referred to the Tahoura Infertility Center in Qom and Mahdiah Hospital in Tehran in 2025. Purposive sampling with maximum variation was used to cover a range of experiences, including diversity in age, education, occupation, number of miscarriages, and infertility history. The inclusion criteria were informed consent, at least a high school diploma, primary infertility, at least two miscarriages during the past two years, having no living children, a maximum age of 45 years for women and 55 years for men, and absence of a psychiatric diagnosis based on the DSM-5-TR. The exclusion criteria were unwillingness to continue participation and debilitating chronic diseases. The sample size was determined based on data saturation, the point at which new data no longer added new information.

2.2. Measures

The main data collection instrument was an in-depth semi-structured interview. The interview questions were developed based on the research objectives, literature

review, and expert opinions. Some questions were designed for individual interviews, and some were designed for joint couple interviews. In the individual interviews, participants were asked to narrate their overall experience of recurrent miscarriage. For example, they were asked: "If you were to draw an overall image or feeling of this entire path (recurrent miscarriage) in your mind, what would that image or feeling be? What stands out most for you in this experience?"; "I would like to ask you to return to the experience of one of your miscarriages. Please describe it to me in as much detail as possible, as though you were living through it again"; "If you were to compare your body during those days to something, what would it be? And how was your relationship with your body defined during that period?"; "Please describe your experiences with physicians, nurses, and hospitals throughout these events"; and "Describe the experience of being alongside your spouse during this period. What was this togetherness like for you?"

2.3. Data Analysis

After obtaining the necessary permissions, participants were identified in person, full explanations were provided regarding the purpose and procedure of the study, and written informed consent was obtained. Interviewers of the same gender as the participants were selected, and all interviews were recorded with participants' permission. Immediately after each interview, the texts were transcribed verbatim, and field notes were also recorded. MAXQDA 2020 software was used to organize and code the data.

The analytical method followed Colaizzi's (1978) seven-step procedure. In this method, the researcher first reads and listens to the interview transcripts several times to gain a general understanding of the participant's experience. Then, significant statements directly related to the experienced phenomenon are extracted. In the next stage, the researcher extracts explicit and implicit meanings from these statements and formulates them as conceptual codes. Similar meanings are then organized into meaning clusters and main themes, and in the next stage, these themes are transformed into a comprehensive and integrated description of the phenomenon. This description is then returned to the participants to obtain their views regarding its accuracy and correspondence with their actual experience. Finally, the researcher integrates participants' feedback into the final description and presents the fundamental structure of the experience.

3. Findings and Results

In this section, interviews were conducted with 17 participants (14 women and 3 men), including infertile women with a history of recurrent spontaneous miscarriage

and their husbands, who had referred to the infertility treatment center of Mahdiah Hospital in Tehran from September 2025 to March 2026. Sampling continued until data saturation was reached. The demographic characteristics of the participants are presented in Table 1.

Table 1

Demographic Characteristics of the Participants

No.	Participant Code	Age (years)	Gender	Last Age at Miscarriage (weeks)	Gestational at Miscarriage (weeks)	Time Since Last Miscarriage (months)	Education Level	Number of Miscarriages	Duration of Infertility (years)	Employment Status
1	P1	34	Female	8		4	Bachelor's degree	5	6	Employed
2	P2	37	Female	10		6	Doctorate	4	4	Employed
3	P3	29	Female	7		3	Bachelor's degree	3	3	Homemaker
4	P4	42	Female	12		8	High school diploma	6	8	Employed
5	P5	40	Male	9		5	Master's degree	3	8	Employed
6	P6	32	Female	6		2	Bachelor's degree	2	2	Employed
7	P7	28	Female	8		4	High school diploma	5	3	Homemaker
8	P8	38	Female	11		7	Master's degree	4	5	Employed
9	P9	41	Male	8		6	Bachelor's degree	3	7	Employed
10	P10	36	Female	7		3	Doctorate	2	4	Employed
11	P11	33	Female	9		4	High school diploma	3	3	Homemaker
12	P12	39	Male	10		9	Master's degree	7	6	Employed
13	P13	41	Female	6		15	Master's degree	2	2	Employed
14	P14	44	Female	13		10	High school diploma	5	10	Homemaker
15	P15	35	Female	8		5	Bachelor's degree	3	4	Employed
16	P16	30	Female	9		6	Master's degree	8	3	Employed
17	P17	38	Female	10		7	Bachelor's degree	4	6	Employed

As reported in Table 1, 17 participants took part in this study, including 14 women (82.4%) and 3 men (17.6%), with a mean age of 36.3 years (range: 28 to 44 years). In terms of educational level, most participants had higher education; 6 participants (35.3%) held a bachelor's degree, 5 (29.4%) held a master's degree, 4 (23.5%) had a high school diploma, and 2 (11.8%) held a doctorate. Regarding employment status, 13 participants (76.5%) were employed and 4 (23.5%) were homemakers. The mean number of experienced miscarriages was 4.1 (range: 2 to 8), and the mean time elapsed since the last miscarriage was 6.1 months

(range: 2 to 15 months). The mean last gestational age at miscarriage was 8.9 weeks (range: 6 to 13 weeks), and the mean duration of infertility was 4.9 years (range: 2 to 10 years). After the interviews were carefully transcribed and analyzed using Colaizzi's seven-step method, a total of 342 significant statements were extracted from the data. Through coding and analysis, these statements were reduced to 128 initial concepts, 24 subthemes, and finally 6 main themes. Table 2 presents the main themes, subthemes, and sample quotations derived from the couples' lived experiences.

Table 2

Main Themes, Subthemes, and Sample Quotations Derived from the Couples' Lived Experiences

Main Theme	Subthemes	Sample Quotations from Participants
Emotional turmoil: psychological reactions to recurrent loss (describing the range and intensity of negative emotional reactions when facing recurrent miscarriage)	1-1 Initial shock and disbelief 1-2 Generalized anxiety and fear of recurrence 1-3 Anger and frustration 1-4 Guilt and self-blame 1-5 Deep sadness and chronic sorrow 1-6 Hopelessness and despair	"...It is frightening. You cannot believe it is real... It is just fear, anxiety. You just sit and wait for something to happen" (P8).
Continuity of loss: multilayered and disenfranchised grief (referring to the complex and persistent nature of grief beyond immediate loss)	2-1 Multilayered grief (loss of the fetus, loss of the parental role, loss of the future) 2-2 Disenfranchised grief 2-3 Complicated and prolonged grief	"For others, it was just a medical event. A lost tissue. But for me, it was my child. Being ignored like that multiplied the pain" (P1).
Distorted self-concept: identity and bodily challenges in recurrent loss (referring to the effect of miscarriage on identity, body image, and self-worth)	3-1 Sense of bodily defectiveness and inefficacy 3-2 Doubt in feminine/masculine identity 3-3 Reduced self-esteem and self-efficacy	"I was always distrustful of my body's ability to do anything properly... I felt that I had failed as a woman" (P8, P3).
Relationship under the shadow of loss: dynamics and challenges of the couple relationship (addressing the reciprocal effect of miscarriage experience on communication, intimacy, and power dynamics in the couple relationship)	4-1 Empathy and mutual support: "shared grief" 4-2 Distance and tension caused by differences in grieving styles 4-3 Communication challenges and heavy silences 4-4 Strengthening of the couple bond following the shared experience	"My husband would not talk about it at all. He would say, let us forget it and move on. For me, that was not possible. His silence hurt me even more" (P1). / "We cried together and tried to be strong together" (P2).
Coping and adaptation: from individual resources to social support (addressing individual and interpersonal coping mechanisms and the role of support systems)	5-1 Individual coping strategies (religious, psychological, behavioral) 5-2 Social support (family, friends, peer groups) 5-3 Role of healthcare staff: accompanying or detached from the experience 5-4 Barriers to support: social stigma and others' lack of understanding	"I knew I had [the clinic's] support... I think that is how we made the decision" (P4). / "A well-intentioned recommendation that is completely inappropriate... unhelpful" (P10).
In search of meaning: reconstruction and growth after loss (referring to cognitive-emotional processes for finding meaning in the experience of loss and achieving growth)	6-1 Meaning-making of loss through religious and philosophical beliefs 6-2 Post-traumatic growth 6-3 Redefinition of life goals and values	"I tell myself maybe God wanted these children to be with Him... Maybe our patience through these hardships will lead to our growth and elevation" (P8). / "After these miscarriages, I became a different person. I became more sensitive to other people's pain" (P10).

As reported in Table 2, analysis of the lived experiences of couples who had experienced recurrent spontaneous miscarriage led to the identification of six main themes. First, emotional turmoil: psychological reactions to recurrent loss, with the subthemes of initial shock and disbelief, generalized anxiety and fear of recurrence, anger and frustration, guilt and self-blame, deep sadness and chronic

sorrow, and hopelessness and despair, described a wide range of negative emotional reactions when facing recurrent miscarriage. Second, continuity of loss: multilayered and disenfranchised grief, with the subthemes of multilayered grief (including loss of the fetus, loss of the parental role, and loss of the future), disenfranchised grief, and complicated and prolonged grief, referred to the complex

and persistent nature of grief beyond immediate loss. Third, distorted self-concept: identity and bodily challenges in recurrent loss, with the subthemes of sense of bodily defectiveness and inefficacy, doubt in feminine/masculine identity, and reduced self-esteem and self-efficacy, referred to the effect of miscarriage on identity, body image, and self-worth. Fourth, relationship under the shadow of loss: dynamics and challenges of the couple relationship, with the subthemes of empathy and mutual support (shared grief), distance and tension caused by differences in grieving styles, communication challenges and heavy silences, and strengthening of the couple bond following the shared experience, addressed the reciprocal effect of miscarriage experience on communication, intimacy, and the dynamics of the couple relationship. Fifth, coping and adaptation: from individual resources to social support, with the subthemes of individual coping strategies (including religious, psychological, and behavioral strategies), social support (from family, friends, and peer groups), the role of healthcare staff (accompanying or detached from the experience), and barriers to support (social stigma and others' lack of understanding), addressed individual and interpersonal coping mechanisms and the role of support systems. Finally, the sixth theme, in search of meaning: reconstruction and growth after loss, with the subthemes of meaning-making of loss through religious and philosophical beliefs, post-traumatic growth, and redefinition of life goals and values, referred to cognitive-emotional processes for finding meaning in the experience of loss and achieving growth. These findings indicate the complexity and multilayered nature of grief among couples with recurrent miscarriage and the necessity of attending to individual, couple-based, and social dimensions when designing supportive interventions. In the following section, each of these themes is presented along with its related subthemes and quotations extracted from the interviews, with reference to the researcher's observations of the participants' states and emotions during the interviews. These observations contribute to a deeper understanding of the emotional and psychological context of the lived experiences.

Emotional Turmoil: Psychological Reactions to Recurrent Loss

This theme reflects the broad and intense spectrum of negative emotions that couples experience when facing recurrent miscarriages. These emotions are often unexpected, overwhelming, and accompanied by severe mood fluctuations. What was prominent in the participants' narratives was not only the intensity of these emotions but

also their sequence and, at times, their overlap in facing successive losses.

Most participants, especially in their first experience of miscarriage, spoke of intense shock and disbelief. This feeling remained present in subsequent miscarriages because of the recurrence of loss, although with somewhat less intensity. It was as though, each time, the hope that the pregnancy would survive was struck again by the bitter reality of loss. Participant P2, a 37-year-old woman with four miscarriages, while appearing to review her memories with humility and deep sorrow, described her first experience as follows. Her voice lowered when speaking about the first miscarriage, as though, even years later, that moment was still difficult for her to believe: "The first time it happened, I could not believe it. I always thought these things happened to other people, not to me. I was in shock and could not believe that I had lost my child" (P2, female, four miscarriages). Participant P8, a 38-year-old woman with four miscarriages, recounted that bitter moment to the researcher with eyes fixed on an unknown point and a tone filled with distress. Her long pauses between words indicated the depth of the psychological blow she had experienced: "I remember during the ultrasound, the doctor said there was no heartbeat. It was as if the world collapsed on me. I could not speak. I just stared at the monitor and could not believe it" (P8, female, four miscarriages).

With repeated miscarriage, anxiety becomes a constant and pervasive feeling. This anxiety reaches its peak in subsequent pregnancies and involves both women and men. Women referred to every bodily symptom as a warning sign of recurrent loss, while men also lived with constant concern for their wives' physical and psychological health. Participant P1, a 34-year-old woman with five miscarriages, spoke of these stressful periods in a tone mixed with anxiety and exhaustion. She clasped her hands together, and it seemed that even recalling those days brought the tension back to her: "After the second miscarriage, with every pregnancy, until the second trimester, I was constantly anxious. Every spotting, every small pain led me to the conclusion that I was going to miscarry again" (P1, female, five miscarriages). Participant P9, a 41-year-old man with three miscarriages, spoke about his experience as a husband with great concern and compassion for his wife. His voice was filled with a sense of responsibility and helplessness in the face of the situation: "The situation was very difficult for me as a husband too. I was constantly worried about my wife, both physically and emotionally. Every time she said

she felt something, my heart dropped” (P9, male, three miscarriages).

Anger was often directed toward the self, the spouse, physicians, or sometimes fate and destiny. Frustration over not receiving convincing answers from the healthcare system was also prominent in the narratives. This anger and frustration sometimes appeared explosively and sometimes emerged in their speech as silent hopelessness. Participant P14, a 44-year-old woman with five miscarriages and 10 years of infertility, spoke about her anger in a nervous and tearful tone. It seemed that she had carried this suppressed anger within herself for years and had now found an opportunity to release it: “I was very angry. At myself, at God, at everyone. I kept saying, why me? Why do I have to lose my children so many times?” (P14, female, five miscarriages). Participant P4, a 42-year-old woman with six miscarriages, spoke with evident hopelessness and frustration about the performance of the healthcare system. She seemed to have repeated this story to herself many times and reached an impasse: “I became frustrated with doctors. No one could give me a convincing answer. They said the cause was unknown, that it was random. But that was not convincing for me” (P4, female, six miscarriages).

Many women considered themselves responsible for the miscarriages and struggled with the question, “What did I do to cause this?” This guilt was sometimes so intense that it affected all dimensions of their lives and appeared as obsessive thinking about daily actions. Participant P6, a 32-year-old woman with two miscarriages, blamed herself while crying intensely. It seemed that this question had always been circulating in her mind and that she had now found an opportunity to express it: “I constantly thought, where did I go wrong? Wasn’t I supposed to be able to keep my child? So why didn’t it happen? I must be to blame” (P6, female, two miscarriages). Participant P11, a 33-year-old homemaker with three miscarriages, spoke in a tone marked by guilt about her obsessive thoughts regarding daily actions. It was as though any movement she made could end in a catastrophe: “For a while, everything I ate, everything I did, I connected it to the miscarriage. I thought maybe that day when I went out and got a little tired, I caused this to happen” (P11, female, three miscarriages).

The sadness and grief of loss were present in the participants’ lives not as a transient reaction but as a persistent state. They described this grief using words such as “deep,” “devastating,” and “everlasting,” and said that it sometimes returned like a sudden wave. Participant P10, a 36-year-old woman with two miscarriages, spoke with

suppressed sobs and tearful eyes about a grief that still gripped her years later. Her voice trembled, and she pronounced each word with difficulty: “It was a strange grief. Not like any other grief. A deep and devastating sadness that sometimes truly took my breath away. Even now, years later, it still comes back to me sometimes” (P10, female, two miscarriages). Participant P17, a 38-year-old woman with four miscarriages, spoke with deep reflection and a distant gaze about an everlasting emptiness within herself. She seemed to have learned to live with these losses in some way, but she had never forgotten them: “I feel that a part of me will always remain empty. Those children whom I never saw, their absence is always felt” (P17, female, four miscarriages).

With repeated losses, and especially after several unsuccessful attempts to achieve a successful pregnancy, some participants had developed feelings of hopelessness and despair. This hopelessness sometimes appeared as numbness and sometimes as profound depression. Participant P3, a 29-year-old homemaker with three miscarriages, spoke of her hopelessness in a tired and lifeless voice. Her gaze was fixed on the floor, as though she no longer saw any light at the end of this tunnel: “I have almost lost hope. Every time I think this time will work, but again we fail. I feel like I will never be able to have a child” (P3, female, three miscarriages).

Multilayered Grief: Successive and Invisible Losses

This theme refers to the multifaceted and continuous nature of grief, which extends beyond the initial loss and affects all dimensions of the person’s life. The loss of the fetus is only one layer of this grief, while deeper layers also exist, such as the loss of the future, the loss of parental identity, and the loss of sweet maternal/paternal experiences.

Participants spoke of the loss of the parental role, the loss of the future they had imagined for their child, and the loss of an experience that could have transformed their lives. They mourned not only the fetus but also all the dreams it carried with it. Participant P13, a 41-year-old woman with two miscarriages, spoke with tearful eyes and a trembling voice about all the dreams that had been lost with each miscarriage. It was as though each miscarriage also took away a part of her imagined future: “I did not just lose a fetus. I lost all my dreams. The child I was supposed to hold, breastfeed, and watch grow up” (P13, female, two miscarriages).

Many participants complained that others, and even healthcare staff, did not understand the intensity and depth of their grief. This disregard multiplied the pain of loss and

pushed them into deep isolation. It was as though society and even those close to them had denied them the right to grieve this loss. Participant P7, a 28-year-old homemaker with five miscarriages, spoke with a tone mixed with frustration about others' reactions. It seemed that she had endured this disregard for years and had now found an opportunity to object: "When I told many people, they said it does not matter, try again, you are young. As if that child had never existed at all. No one understood what deep pain I had" (P7, female, five miscarriages). Participant P1, a 34-year-old woman with five miscarriages, referred with deep sorrow and regret to the reduction of her loss by others to a "medical event." Her well-known statement clearly reflects the disenfranchised grief experienced by these women: "For others, it was just a medical event. A lost tissue. But for me, it was my child. Being ignored like that multiplied the pain" (P1, female, five miscarriages).

In some cases, grief symptoms continued for a long time (more than one year) and were accompanied by signs such as intense yearning, inability to accept the loss, and feelings of emptiness. This type of grief disrupted the person's daily life and required more specialized interventions. Participant P14, a 44-year-old woman with five miscarriages, spoke with suppressed sobs and a voice that reflected the depth of her sorrow about a grief that had still not healed after two years. Her tears while speaking testified to this: "It has been more than two years since my last miscarriage, but I still have not been able to come to terms with it. I still cry, I still dream about them, I still miss them" (P14, female, five miscarriages).

Distorted Self-Concept: Identity and Bodily Challenges in Recurrent Loss

Recurrent miscarriages deeply affect the identity and self-concept of women and men. They face not only the loss of a child but also the loss of a positive image of themselves as a fertile woman, a supportive man, and a capable human being.

Women often described their bodies as "failed," "defective," and "incapable" of performing their main function. This sense of defectiveness sometimes led to alienation from and hatred of their own bodies. Participant P8, a 38-year-old woman with four miscarriages, referred to her body as "useless" in a tone mixed with shame and sorrow. It was as though she had lived with this label for years and had come to believe it: "I felt that my body was a useless body. What all women's bodies can do, I cannot do. I felt like I was a defective being" (P8, female, four miscarriages).

For women, fertility was intertwined with feminine identity, and the inability to maintain pregnancy challenged their feminine identity. Men also sometimes felt that they had failed in their role of supporting and protecting their wife and child. Participant P6, a 32-year-old woman with two miscarriages, described the loss of her sense of being a woman with deep sadness and a choked voice. Silent tears while speaking revealed the depth of this feeling: "As a woman, I felt worthless. It was as if I had lost the main part of my womanhood" (P6, female, two miscarriages). Participant P5, a 40-year-old man with three miscarriages, spoke about his failure in the role of family protector with obvious guilt and helplessness on his face. He seemed to be carrying the burden of this responsibility: "I was supposed to protect my family. Both my wife and my child. But I could not. This feeling hurt me very much" (P5, male, three miscarriages).

Repeated failures in achieving the goal of a successful pregnancy gradually reduced participants' self-esteem and sense of self-efficacy. They also began to question their previous successes in other dimensions of life and experienced a general sense of incompetence. Participant P4, a 42-year-old woman with six miscarriages, spoke with hopelessness and regret about the collapse of her successful self-image in life. She seemed to have generalized these losses to all aspects of her identity: "I used to be a successful person, in my work, in my life. But these miscarriages called everything into question. It was as if I was a failed person who could not do anything properly" (P4, female, six miscarriages).

Relationship Under the Shadow of Loss: Dynamics and Challenges of the Couple Relationship

Recurrent miscarriages strongly affect the dynamics of the couple relationship; they sometimes lead to greater cohesion and sometimes to tension and distance. This shared experience can function both as a bonding factor and as a source of strain.

Some couples turned the shared experience of loss into an opportunity for greater closeness. Through empathy and mutual support, they reduced the emotional burden. This empathy sometimes appeared in words and sometimes in immediate presence beside one another. Participant P2, a 37-year-old woman with four miscarriages, spoke about her husband's support with a sorrowful smile and eyes wet with tears of gratitude. It seemed that this empathy was one of the few bright points on this dark path: "My husband was truly empathetic with me. Whenever I cried, he hugged me and said, your grief is my grief. We cried together and tried to be

strong together” (P2, female, four miscarriages). Participant P10, a 36-year-old woman with two miscarriages, spoke with a tone full of gratitude about the deepening of their relationship after this experience. It was as though this harsh fire had purified the gold of their existence: “This experience taught us how to talk to each other, how to support each other. I think it made our relationship deeper” (P10, female, two miscarriages).

Differences in the way grief was expressed and in emotional needs between women and men sometimes led to misunderstanding, distance, and tension. Women often needed to talk and express emotions, whereas men tended to remain silent and withdraw. Participant P1, a 34-year-old woman with five miscarriages, spoke with complaint and sadness about her husband’s silence. For her, this silence was not a sign of calmness but a sign of indifference and distance: “My husband would not talk about it at all. He would say, let us forget it and move on. For me, that was not possible. His silence hurt me even more and made me feel lonely” (P1, female, five miscarriages). Participant P12, a 39-year-old man with seven miscarriages, spoke with a sorrowful and somewhat helpless tone about his attempt to hide his feelings. He mistakenly believed that being strong meant not showing weakness: “I tried to be strong and not cry in front of my wife because I thought that if she saw me broken, she would become more upset. But it seems this made her think that I was not upset at all” (P12, male, seven miscarriages).

Effective communication about loss, emotions, and needs was often difficult, and heavy silences replaced dialogue. These silences resulted from fear of hurting the other person or from an inability to find the right words. Participant P3, a 29-year-old homemaker with three miscarriages, described the atmosphere of the home during that period as a heavy silence that seemed to swallow everything: “There was a heavy silence at home. Out of fear that the other person might become upset, no one dared to talk about the child or pregnancy” (P3, female, three miscarriages).

Despite all the challenges, many couples believed that the shared experience of loss had ultimately strengthened their bond. From the depth of this darkness, they found a light for their relationship. Participant P13, a 31-year-old woman with two miscarriages, spoke from a philosophical and mature perspective about the growth that had occurred in their relationship. She had been able to extract a positive meaning for her marital life from a bitter experience: “I think from all this darkness, a light also emerged, and that was our stronger relationship. Something we might never have

experienced in this way otherwise” (P13, female, two miscarriages).

Coping and Adaptation: From Individual Resources to Social Support

To manage this overwhelming experience, couples used various coping strategies and different support resources. These strategies ranged from individual actions to social interactions.

These strategies included religious strategies (trust in God, prayer, seeking divine intercession), psychological strategies (avoidance, denial, positive thinking), and behavioral strategies (exercise, work, travel). Each person, according to their personality and beliefs, found a way to survive in this storm. Participant P7, a 28-year-old homemaker with five miscarriages, spoke with firm faith and calmness in her voice about trust in God as her only path to survival. She seemed to have found a safe refuge in faith: “The only thing that kept me standing was my faith. Trusting in God and knowing that this was divine destiny gave me peace” (P7, female, five miscarriages). Participant P15, a 35-year-old woman with three miscarriages, spoke in a tired but determined tone about immersing herself in work as a way of escaping distressing thoughts. She seemed to be trying with all her strength to avoid confronting the pain: “I would drown myself in work so that I would not have time to think. I worked 12 hours so that there would be no time left for grieving” (P15, female, three miscarriages).

Support from the spouse, family, friends, and especially acquaintance with people who had similar experiences played an important role in reducing feelings of loneliness and isolation. These forms of support were like a rescuer that saved the person from drowning in a sea of sorrow. Participant P1, a 34-year-old woman with five miscarriages, spoke with great gratitude about a friend who had a similar experience. It seemed that being understood by someone who truly “understands” had a value beyond any advice or sympathy: “One of my friends who had recurrent miscarriage herself really helped me. She talked to me, shared her experience, and proved to me that I was not alone and that it was possible to pass through this crisis” (P1, female, five miscarriages). Participant P6, a 32-year-old woman with two miscarriages, spoke with a calm smile about the unconditional support of her family, especially her mother. This support had brought her incomparable security and peace: “My family really stood behind me. My mother always said, whenever you need me, I am here. This sense of security helped me a lot” (P6, female, two miscarriages).

The behavior and attitude of healthcare staff had a profound effect on the couples' experience. Compassionate and supportive encounters brought comfort, whereas cold and indifferent encounters intensified distress. A simple sentence from a nurse could sometimes be healing and sometimes could leave a deeper wound on their soul. Participant P4, a 42-year-old woman with six miscarriages, recalled with tearful eyes a kind nurse who, in the hardest moments, appeared like a saving angel: "There was a nurse who held my hand in those difficult moments and said, do not worry, God is great. That simple sentence meant the world to me" (P4, female, six miscarriages). Participant P9, a 41-year-old man with three miscarriages, spoke with frustration and anger about the cold and emotionless behavior of some physicians. This behavior had added to their psychological burden: "Unfortunately, some doctors did not take any time to talk. They would just look at the ultrasound and say it is gone, go home. It was very cold and emotionless" (P9, male, three miscarriages).

Many participants referred to judgmental attitudes, inappropriate advice, and others' lack of understanding of the depth of the loss as barriers to support. These factors not only failed to help but also intensified their feelings of loneliness and isolation. Participant P2, a 37-year-old woman with four miscarriages, spoke with regret and sadness about others' inappropriate advice. Instead of comforting her, such advice aroused anger and distress: "Some people said, why are you so sad? You are still young; you will get pregnant again. These words not only did not calm me down, but made me more angry and upset" (P2, female, four miscarriages). Participant P11, a 33-year-old homemaker with three miscarriages, spoke with shame and sadness about the label of "failed woman" that society had placed on her. This social stigma was one of the heaviest barriers in her recovery process: "The stigma of miscarriage is very bad. Sometimes I felt that people were labeling me as a failed woman" (P11, female, three miscarriages).

In Search of Meaning: Reconstruction and Growth After Loss

Ultimately, many participants, in the process of coping with loss, sought to find meaning and even to experience growth and transformation in their lives. This stage indicates the remarkable human capacity for healing and for finding light in darkness.

Many participants made sense of the loss by relying on their religious beliefs. Concepts such as "divine test," "God's wisdom," and "reward in the hereafter" were prominent in their narratives. These beliefs allowed them to

view pain within a framework larger than their worldly life. Participant P8, a 38-year-old woman with four miscarriages, referred to God's wisdom in these losses with deep calmness and firm faith. She seemed to have achieved a kind of acceptance and peace by relying on faith: "I tell myself maybe God wanted these children to be with Him and that it was better for them. Maybe our patience through these hardships will lead to our growth and elevation" (P8, female, four miscarriages).

Some participants spoke of positive changes in themselves after this experience, including increased empathy, greater appreciation of life, and transformation in priorities and values. These individuals, like a phoenix rising from the ashes of loss, had become more mature and profound human beings. Participant P10, a 36-year-old woman with two miscarriages, spoke with deep insight and a meaning-filled gaze about becoming a better person after these experiences. She clearly felt growth and maturity within herself: "After these miscarriages, I became a different person. I became more sensitive to other people's pain. I value moments more. Maybe this bitter experience somehow made me a better person" (P10, female, two miscarriages).

The experience of recurrent losses led many participants to redefine their life goals and values. They sometimes moved toward new activities, such as helping others, volunteer work, or paying greater attention to existing relationships. This redefinition gave them a new purpose and meaning in life. Participant P13, a 41-year-old woman with two miscarriages, spoke with firm determination and a light of hope in her eyes about finding a new meaning in her life through helping others. She showed that even from the depths of despair, new hope and purpose can be created: "When I saw that I might not be able to become a mother, I decided to put my energy into other things. I registered with a charity association to help children without guardians. This work gave me purpose and meaning" (P13, female, 15 miscarriages).

4. Discussion

The present study aimed to understand the lived experiences of couples regarding grief caused by recurrent miscarriages in infertile women. The findings showed that recurrent miscarriage is not experienced merely as a medical event or a temporary reproductive complication; rather, it emerges as a multilayered psychological, relational, existential, and culturally embedded phenomenon. The

analysis of interviews led to six main themes: emotional turmoil, continuity of loss, distorted self-concept, relationship under the shadow of loss, coping and adaptation, and the search for meaning. Together, these themes indicate that recurrent miscarriage creates a cumulative form of grief in which repeated bodily loss, repeated collapse of hope, disrupted parental identity, marital vulnerability, and social invisibility are intertwined. This pattern is consistent with contemporary literature showing that miscarriage, especially when recurrent, has profound psychological consequences and may produce persistent anxiety, depressive symptoms, traumatic stress, and complicated grief (Farren et al., 2022; Meaney et al., 2023; Navabinejad et al., 2024). The findings also support the view that recurrent pregnancy loss must be examined beyond biomedical causality, because even when clinical, hormonal, infectious, or reproductive explanations are considered, the subjective meaning of loss remains central to couples' adjustment (Giakoumelou et al., 2023; Loss, 2023; Majalia & Salehb, 2025; Muhaisin et al., 2022).

The first theme, emotional turmoil, reflected the intense psychological reactions of participants after repeated miscarriages. Shock, disbelief, anxiety, fear of recurrence, anger, self-blame, chronic sorrow, and hopelessness were repeatedly expressed in the narratives. These findings indicate that recurrent miscarriage generates an emotional field in which grief is not linear but cyclical and reactivated with each pregnancy attempt. Participants described how every subsequent pregnancy became associated with vigilance, bodily monitoring, and fear that the loss would happen again. This result aligns with Haks et al., who emphasized the cyclical nature of hope and despair in recurrent pregnancy loss, where pregnancy is experienced as both a source of possibility and a trigger for fear (Haks et al., 2023). It is also consistent with studies on pregnancy after loss showing that women often experience heightened anxiety, impaired emotional bonding, and persistent fear regarding fetal survival (Côté-Arsenault & Denney-Koelsch, 2023; Lok et al., 2024). The presence of guilt and self-blame in the participants' accounts also corresponds with previous findings that women frequently search for behavioral or bodily explanations for miscarriage, even when the cause is medically unclear (Farren et al., 2022; Meaney et al., 2023). Therefore, emotional turmoil in recurrent miscarriage should not be interpreted as a brief grief response, but as an accumulating psychological burden intensified by uncertainty, repeated reproductive failure, and lack of control.

The second theme, continuity of loss, showed that the participants' grief was multilayered, prolonged, and frequently disenfranchised. Participants did not grieve only the biological loss of a fetus; they mourned the loss of imagined motherhood or fatherhood, the loss of a future child, the loss of family continuity, and the loss of anticipated life narratives. This finding supports research indicating that miscarriage grief is often socially hidden and insufficiently recognized, because others may minimize the event or frame it as a routine medical occurrence (Bellhouse et al., 2022; Burden et al., 2023; Murphy & Philpin, 2022). In the present study, several participants reported that relatives or healthcare providers treated the miscarriage as "tissue loss" or encouraged them to try again, thereby denying the emotional reality of the lost pregnancy. This is consistent with studies on disenfranchised grief, which show that when grief is not socially validated, mourners may feel isolated, silenced, and deprived of legitimate mourning practices (Bellhouse et al., 2022; Murphy & Philpin, 2022). The finding also corresponds with Koert et al.'s argument that pregnancy loss should be reconsidered as a major life event rather than a minor reproductive setback, because its meaning depends on personal history, reproductive expectations, and social recognition (Koert et al., 2022). In recurrent miscarriage, this disenfranchisement becomes more complex because each loss is both new and cumulative, making the grief simultaneously repeated, unresolved, and socially invisible.

The third theme, distorted self-concept, revealed that recurrent miscarriage deeply affected participants' identity, body image, self-worth, and perceived gender role. Women often described their bodies as defective, incapable, or unreliable, while men described helplessness and failure in their perceived role as protectors and supporters. These findings are strongly aligned with research showing that infertility and pregnancy loss can disrupt women's identity by undermining their sense of bodily competence and reproductive selfhood (Asayesh-Oberg et al., 2023; Purewal et al., 2023). In contexts where womanhood is closely associated with motherhood and fertility, recurrent miscarriage may be experienced as a threat to feminine identity, not only as a reproductive event. Iranian qualitative research similarly indicates that women's miscarriage experiences are shaped by cultural expectations of motherhood and social pressure surrounding childbearing (Afshani et al., 2022). The present findings extend this insight by showing that men also experience identity-related distress, although often in a more silent or indirect form. This

is consistent with studies on men's grief following pregnancy loss, which show that men may feel sadness, guilt, and helplessness while suppressing emotional expression due to gendered expectations of strength (Kalantari, 2023; Obst et al., 2023; Wright et al., 2024). Therefore, distorted self-concept after recurrent miscarriage is a gendered but shared phenomenon, affecting both women's embodied sense of reproductive adequacy and men's perceived capacity to protect and sustain the family.

The fourth theme, relationship under the shadow of loss, demonstrated that recurrent miscarriage can both strengthen and strain the couple relationship. Some couples described mutual empathy, shared grief, and deeper emotional intimacy, whereas others reported distance, silence, communication difficulties, and tension caused by different grieving styles. This dual pattern is consistent with couple-based literature showing that miscarriage may function as either a bonding experience or a relational stressor depending on communication, emotional responsiveness, and mutual support (Jomeen & Tokosi, 2022; McNamee & O'Reilly, 2023). The findings also support DeMontigny et al.'s longitudinal perspective that recurrent miscarriage affects both partners and should be studied as a dyadic experience rather than solely as an individual psychological outcome (DeMontigny et al., 2023). In the present study, women often interpreted men's silence as emotional distance or lack of concern, while men sometimes reported that they remained silent to avoid increasing their wives' distress. This pattern corresponds with previous findings on gendered emotional responses to pregnancy loss, particularly in Iranian contexts, where women may be more likely to verbalize grief and men may express distress through restraint, practical support, or emotional concealment (Hosseini, 2022; Kalantari, 2023). The findings also align with research indicating that marital satisfaction, social support, and coping strategies are closely connected among couples who have experienced miscarriage (Kousar et al., 2024). Thus, recurrent miscarriage should be understood as a relational crisis that requires couple-sensitive assessment and intervention.

The fifth theme, coping and adaptation, showed that participants used multiple individual and interpersonal strategies to manage the distress of recurrent miscarriage. These strategies included religious coping, prayer, trust in God, work engagement, avoidance, peer support, family support, and reliance on healthcare staff. The diversity of coping strategies observed in the present study is consistent with Walsh's systemic-relational framework of family

resilience, which emphasizes shared belief systems, relational support, communication, and adaptive reorganization as central pathways of recovery after adversity (Walsh, 2021). The findings also align with studies showing that social support can reduce isolation and facilitate psychological adjustment after miscarriage, whereas unhelpful advice, minimization, and judgment can intensify distress (Kousar et al., 2024; Murphy & Philpin, 2022). The role of healthcare staff was particularly important in participants' narratives. Compassionate communication from nurses or physicians was experienced as soothing and validating, while cold or purely technical communication intensified pain. This finding supports the rationale for early and brief psychological care after miscarriage and confirms the need for emotionally sensitive clinical encounters during reproductive loss (Barbe et al., 2023). It also indicates that support after miscarriage must be both informational and emotional; couples need medical clarity, but they also need recognition of the loss as meaningful.

The sixth theme, search for meaning, reflected participants' attempts to reconstruct life after repeated loss. Many participants used religious or philosophical frameworks to interpret miscarriage as divine wisdom, a test, or a source of spiritual growth. Others described post-traumatic growth, increased empathy, greater appreciation of life, and redefinition of personal values. These findings are consistent with meaning reconstruction approaches in bereavement, which argue that loss disrupts assumptive worlds and requires individuals to rebuild meaning through revised narratives, symbolic continuity, and redefined goals (Holland & Neimeyer, 2023). Park's meaning systems perspective also explains that stressful and traumatic experiences become psychologically distressing when they violate global beliefs and life goals; recovery requires either reinterpreting the event or modifying the broader meaning system (Park, 2022). In the context of recurrent miscarriage, meaning-making may be especially important because repeated loss challenges assumptions about bodily reliability, divine justice, family formation, and the expected life course. Previous research on unsuccessful fertility treatment similarly shows that individuals often reconstruct meaning after reproductive disappointment by redefining identity, relationships, and future possibilities (Gameiro et al., 2022; Su & Chen, 2022). In the present study, meaning-making did not eliminate grief, but it helped some participants integrate the loss into a broader narrative of endurance, spiritual growth, relational maturity, or service to others.

5. Conclusion

Overall, the findings of this study confirm and extend previous research by showing that recurrent miscarriage among infertile women and their spouses is a multilayered phenomenon involving psychological distress, disenfranchised grief, identity disruption, relational vulnerability, social support challenges, and existential reconstruction. The results are consistent with international studies emphasizing the psychological consequences of miscarriage and recurrent pregnancy loss (Farren et al., 2022; Giakoumelou et al., 2023; Meaney et al., 2023), while also reinforcing the importance of cultural context in shaping how grief is interpreted and expressed (Afshani et al., 2022; Hosseininia, 2022; Navabinejad et al., 2024). The study also adds to the literature by placing couples' shared experiences at the center of analysis and by showing that men's grief, although often silent, is an important part of the relational field of recurrent miscarriage (Kalantari, 2023; Obst et al., 2023; Wright et al., 2024). The integration of individual, couple-based, cultural, and meaning-oriented dimensions suggests that interventions for recurrent miscarriage should move beyond symptom reduction and should address the lived reality of loss as experienced within bodies, relationships, families, healthcare systems, and cultural expectations.

6. Limitations and Suggestions

One limitation of the present study was its qualitative and phenomenological design, which allowed for deep exploration of lived experience but does not support statistical generalization to all couples experiencing recurrent miscarriage. The participants were selected from infertility treatment centers in Tehran and Qom, and their experiences may differ from those of couples in other cities, rural areas, different socioeconomic contexts, or healthcare systems. Another limitation was the unequal number of female and male participants, as women were more represented than men; therefore, although men's silent grief emerged in the findings, the male perspective requires broader exploration. In addition, the retrospective nature of the interviews may have influenced the way participants reconstructed their experiences, because memories of miscarriage can change over time and may be shaped by subsequent pregnancies, treatment outcomes, marital changes, or current emotional states.

Future studies are suggested to examine recurrent miscarriage through longitudinal and dyadic designs in order

to follow both partners from the time of loss through subsequent treatment, future pregnancies, or decisions to discontinue reproductive attempts. Comparative studies across different cultural, religious, and socioeconomic groups may also clarify how cultural norms shape grief expression, self-blame, marital communication, and help-seeking. Future research should include a larger number of male participants to explore paternal grief, emotional suppression, and masculine identity more comprehensively. It would also be valuable to combine qualitative interviews with validated psychological measures of grief, anxiety, depression, marital satisfaction, trauma symptoms, and post-traumatic growth so that both subjective meanings and psychological outcomes can be examined together.

In practice, the findings suggest that healthcare systems should recognize recurrent miscarriage as a psychological and relational crisis, not merely as an obstetric complication. Infertility clinics and hospitals should provide structured emotional support, grief counseling, and couple-centered psychoeducation after miscarriage. Healthcare professionals need training in sensitive communication, validation of grief, and awareness of disenfranchised loss so that clinical encounters do not unintentionally intensify distress. Couple-based interventions should help partners understand differences in grieving styles, express emotions safely, reduce self-blame, and reconstruct shared meaning after loss. Support groups for women and couples with recurrent miscarriage may also reduce isolation and provide a space where grief is acknowledged, normalized, and integrated into a broader process of recovery.

Authors' Contributions

Authors equally contributed to this article.

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In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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