Original Article

Women's Experiences of Psychosocial Support after Recurrent Miscarriage: A Qualitative Content Analysis

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Abstract

Background: Psychosocial support is known as a crucial coping mechanism. This qualitative study aims to explore experiences of women with recurrent miscarriage (RM) regarding psychosocial support.

Methods: This qualitative study utilized a content analysis approach and involved 12 women with a history of RM. Participants were recruited from health centers affiliated with Ahvaz Jundishapur University of Medical Sciences, Iran, between October 2024 and January 2025. Also, to further enrich the study data, interviews were conducted with healthcare providers (n=11) and family members (n=4). Twenty-seven semi-structured individual interviews focusing on the psychosocial support of women with RM were conducted. The participants were selected through a purposive sampling method. Interviews were recorded and transcribed verbatim in Persian and analyzed using conventional qualitative content analysis with MAXQDA 2020 software.

Results: Data analysis led to the extraction of three main categories, including interpersonal support in building resilience, structural support for psychological well-being, and educational support for psychological well-being.

Conclusion: Enhancing psychosocial support is essential for women who have experienced RM. These women require comprehensive support from their husbands, families, peers, and healthcare providers. Therefore, future research is recommended to develop a targeted psychosocial intervention program designed to meet their specific needs.

Keywords: Psychosocial support; Qualitative research; Recurrent miscarriage; Women's health

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Introduction

Miscarriage is the most common complication during the first trimester of pregnancy, affecting at least 15% of confirmed pregnancies.[1] Specifically, miscarriage refers to the loss of a natural pregnancy before the 24th week.[2] Recurrent miscarriage (RM), defined as two or more consecutive pregnancy losses, is a significant concern in obstetrics and gynecology, impacting approximately 1-2% of couples.[3] The pooled risk of miscarriage is 15.3% of all recognized pregnancies. The population prevalence of women who have had one miscarriage is 10.8%, two miscarriages is 1.9%, and three or more miscarriages is 0.7%.[1] Women experiencing RM frequently experience profound psychological distress, trauma, grief, and sometimes clinically significant depression and anxiety.[4] These women often face considerable functional impairment and a marked reduction in their overall well-being. The impact of miscarriage extends beyond physical health, negatively affecting various aspects of their lives, including marital health, and potentially leading to adverse outcomes in future conceptions.[5, 6]

Evidence suggests these women typically do not recover without support and require appropriate diagnostic, medical, and psychological care services.[7, 8] Provision of adequate bereavement care through healthcare services is crucial in mitigating short-term and long-term negative consequences for women.[9] Crucially, psychological support is vital for women experiencing RM. It helps them cope with the intense emotional distress, anxiety, and grief of their losses, which can help them build resilience and promote mental well-being.[10] Evidence consistently links the quality and availability of social and emotional support to the mental health outcomes of these women.[11-13] Symptoms of anxiety and depression among women with recurrent pregnancy loss are directly associated with the level and quality of social support received. Support from family and friends serves as a key protective factor, associated with lower levels of depression and anxiety.[14] Moreover, healthcare professionals are often the first point of contact for patients during or after a miscarriage, making their role in providing sensitive support paramount. However, research consistently highlights major gaps in psychosocial miscarriage care, including limited empathy, minimization of the loss, insufficient attention to grief, and poor communication about the event and subsequent steps.[11, 15] Given the significant psychological impact of miscarriage, ensuring adequate psychosocial support is critical for women's recovery and future reproductive health.[13]

Recent research highlights the significant positive impact of psychosocial support on improving the mental health of women with a history of RM.[16] Evidence remains limited on what type of psychosocial care best meets women's needs. Understanding their experiences and expectations particularly in relation to family and healthcare professionals is vital for designing care and communication that are truly responsive to their context. Several qualitative studies have explored women's experiences after RM in different parts of the world.[17, 18] A qualitative study conducted in the United Arab Emirates (UAE) emphasized the urgent need for comprehensive support and preventive measures tailored to the unique challenges and emotional needs faced by women experiencing RM.[12] In a related study utilizing semi-structured in-depth interviews, participants expressed their desire for more sensitive care from medical professionals, couple-centered approaches, timely access to testing and treatment, and thorough information about their condition.[19] These findings indicate the importance of understanding the specific support preferences of women in this vulnerable situation. A qualitative study in Melbourne, Australia, which investigated healthcare providers' experiences, identified compassion fatigue, time constraints, and insufficient training in handling the psychosocial aspects of miscarriage as the

primary causes for these care limitations.[20] Previous qualitative research has revealed the profound emotional toll and unmet supportive needs that follow RM, yet it has largely described these experiences without clarifying how they are shaped by contextual and systemic conditions.[19, 21] Most existing evidence arises from high-income or clinic-based settings, providing only a partial understanding of how women access and negotiate care when formal psychosocial services are scarce.[12, 19] Although qualitative studies in other countries have explored similar experiences, they were conducted in distinct cultural contexts and rarely examined the complex interplay between women, families, and healthcare professionals.[12, 19, 22] In Iran, most studies have focused on physical outcomes or the screening of risk factors, while the psychosocial dimensions and the specific support needs of this group particularly from the combined perspectives of women and healthcare providers have largely been overlooked.[23, 24] This gap makes it difficult to identify women's psychosocial needs or determine effective interventions to improve their experiences. Understanding these needs is an essential first step in developing clinical interventions.[25] The absence of qualitative research on RM in Iran creates a critical gap in identifying psychosocial needs and guiding effective support strategies. Addressing this gap requires context-sensitive inquiry into how support is provided and sustained within families, communities, and healthcare systems issues that cannot be fully captured by quantitative approaches. Therefore, this study aimed to explore women's experiences of psychosocial support after RM.

Materials and Methods

This qualitative study, part of a larger mixed-methods PhD dissertation in midwifery, explores experiences of psychosocial support in women with RM. We collected data from October 2024 to January 2025 at gynecology wards and outpatient gynecology clinics of Razi Hospital and Imam Khomeini Hospital affiliated with Ahvaz Jundishapur University of Medical Sciences, Iran. We used purposive sampling to recruit 12 married women, aged 20 to 45, who had a documented history of at least two confirmed miscarriages. Women were eligible to participate if they were willing to participate and could speak Persian; had no history of chronic physical illnesses like diabetes or high blood pressure, or mental illness; were non-smokers and had experienced two or more consecutive miscarriage; had experienced no visible fetal abnormalities in their most recent pregnancy; had experienced their most recent miscarriage one to six months before enrollment or had been hospitalized due to RM; and either had no living children or had children born before their lost pregnancies. We excluded individuals who had recently experienced major stressful life events or were currently pregnant from the study.

The first author (AT), a PhD candidate in midwifery, recruited the participants. Following a thorough explanation of the research objectives, all participants provided written informed consent. Data were primarily collected through in-depth and semi-structured interviews conducted in a private and quiet room. The researcher fostered a trusting environment through establishing rapport with each participant.

Participants were asked about their age, number of children, number and timing of miscarriages, education level, and occupation. They were then asked an open-ended question about their miscarriage experiences, such as "What was your experience of support after your miscarriage?" Researchers used follow-up questions like, "Can you explain this in more detail?" and "Can you give an example?" to further explore and clarify the participants' responses. Interviews lasted 30-60 minutes. To enrich the study data, we interviewed 11 healthcare providers and 4 women's families. Healthcare provider informants included obstetricians, midwives, nurses, reproductive health specialists, and psychologists. Interviews with healthcare providers explored the support they provide

to women with a history of RM, including specific practices ("What support do you provide?") and their perceptions of patients' needs ("What do you think they want from you?"). Sampling continued till data saturation.

To facilitate analysis, we audio-recorded all interviews with participants' consent and transcribed verbatim as soon as possible. Data collection and analysis occurred concurrently using MAXQDA 2020 software. Data analysis was guided by the conventional content analysis approach described by Graneheim and Lundman following a five-step process: 1) verbatim transcription of each interview immediately following its completion; 2) immersion in the full transcripts through repeated readings to develop a comprehensive understanding; 3) identification of meaning units and initial codes; 4) categorization of similar initial codes into broader, more encompassing categories; and 5) interpretation of the latent content to identify overarching themes.[26] The first author immersed herself in the data by repeatedly reading the transcripts to gain a holistic understanding. Subsequently, the first author and the corresponding author collaboratively extracted semantic units and carried out the initial coding, refining them after discussion and comparison. At this stage, the third author independently reviewed and evaluated the coding process. Any disagreements or discrepancies observed in the coding among the authors were addressed through constructive discussion sessions, ultimately leading to consensus and final coding approved by all members.

We assessed the trustworthiness of our qualitative data using four criteria: credibility, dependability, confirmability and transferability.[27] To ensure credibility, we prioritized selecting participants with diverse demographic characteristics. We also used member checking, where participants reviewed selected coded interviews in separate sessions to provide feedback. Specifically, we sent several initial interviews to participants to verify that our assigned codes accurately reflected their intended meanings. For dependability, three experts were consulted to confirm the consistency between the coded data and participants' narratives. To strengthen transferability, we shared our study findings with six participants to find out how well the results resonated with their lived experiences. Throughout the data analysis, we consulted qualitative research experts and specialists at each stage to validate the accuracy of meaning units, developed codes, and emergent concepts, thereby confirming the confirmability and appropriateness of the meanings derived from the data.

The study was conducted in accordance with the Declaration of Helsinki; it was approved by the Ethics Committee of Ahvaz Jundishapur University of Medical Sciences, Iran (Ethical code: IR.AJUMS.REC.1402.347). Participants were provided with a thorough explanation regarding the research team members, study objectives, confidentiality of information, and their freedom to choose whether to participate. Furthermore, they were required to complete a written informed consent form to participate in the study and to permit audio recording of the interviews. During the transcription process, the data from the interviews were anonymized, and the audio recordings were securely stored to ensure strict confidentiality. Participants were informed that the results of the interviews would be presented in a non-identifiable manner and that any specific information related to the interviews would remain confidential.

Results

This study investigated the experiences of women with RM from psychosocial support. Semi-structured interviews were conducted with 12 women, 4 family members, and 11 healthcare professionals to gather diverse perspectives and achieve data saturation. The mean and standard deviation of the women' age was 27.91±4.57. The characteristics of the participants are summarized in Tables 1, 2, and 3.

Table 1: Demographic characteristics of women with recurrent miscarriage (n=12)

Women No.	Age (year)	Educational attainment	Employment status	Duration of Marriage (year)	Number of children	Number of Miscarriage	Gestational age at the time of the last miscarriage (weeks)	Time of last miscarriage (month)
W1	31	Primary school	Housewife	8	0	4	10	4
W2	34	Secondary school	Housewife	12	1	4	8	5
W3	27	Bachelor	Employee	5	0	2	8	0
W4	27	Bachelor	Employee	5	2	2	12	6
W5	26	Secondary school	Housewife	10	1	5	16	0
W6	24	High school	Self-employed	7	3	2	19	4
W7	23	High school	Housewife	5	0	3	7	6
W8	22	High school	Housewife	2	0	2	7	2
W9	37	Bachelor	Employee	8	1	2	11	2
W10	26	Bachelor	Housewife	6	1	3	14	5
W11	26	Bachelor	Housewife	5	0	2	13	3
W12	32	Bachelor	Employee	6	0	2	16	2

Table 2: Demographic characteristics of family members (n=4)

Family members No.	Family relationship	Age	Educational attainment	Occupation	Number of miscarriages in women
FM1	Husband 1	31	High school	Self-employed	4
FM2	Husband 2	29	High school	Self-employed	5
FM3	Mother 1	51	Primary school	Housewife	2
FM4	Mother 2	48	Secondary school	Housewife	3

Table 3: Demographic characteristics of health providers participating in the study (n=11)

Health providers No.	Degree	Age (year)	Position	Work experience (year)
HP1	BS in Midwifery	23	Maternity officer	2
HP2	BS in Midwifery	44	Health center staff member	22
HP3	BS in Midwifery	45	Health center staff member	22
HP4	MSc in Midwifery	41	Head of maternity hospital	18
HP5	MSc in Midwifery	38	Midwifery school instructor	15
HP6	Psychologist	37	Health center staff member	14
HP7	MSc in Clinical Psychology	42	Health center staff member	18
HP8	MSc in Clinical Psychology	43	High-risk ward staff	21
HP9	BS in Nursing	40	Gynecology ward staff	18
HP10	PhD in Reproductive Health	42	University professor	18
HP11	Obstetrician	38	Head of gynecology and obstetrics department	10

The psychosocial experiences of women with recurrent pregnancy loss were categorized into three main categories based on the interview data: "Interpersonal support in building resilience", "Structural support for psychological well-being", and "Educational support for psychological well-being" (Table 4). The subsequent sections detail each of these categories and their constituent subcategories, drawing upon participants' statements for illustration.

Table 4: Sub-categories and categories extracted from data analysis

Subcategory	Main category
Husband and family emotional companionship Gaps in emotional support from medical staff Peer support and shared experience	Interpersonal support in building resilience
Supportive and compassionate care in health centers The role of organizations in providing financial and counseling support	Structural support for psychological well-being
Education for mothers' psychological readiness Family education for women's support Educating staff in compassionate care	Educational support for psychological well-being

1. Interpersonal Support in Building Resilience

Interpersonal support was the first category that emerged from the data. This category has the following three subcategories: "Husband and family emotional companionship", "Gaps in emotional support from medical staff", and "Peer support and shared experience".

1.a. Husband and Family Emotional Companionship

Most of the women with RM stated that family support particularly husband support was the most crucial source of assistance. Most women described positive support experiences from their partners. Knowing that their husbands acknowledged their emotional state and offered unwavering support was instrumental in accepting their situation. Beyond emotional support, the women felt satisfied and grateful to receive physical support from their family members, which included childcare, household chores, and post-discharge care. These supports were valuable and comforting to them during the recovery period. A woman said:

"My husband was my main support. He constantly reassured me, saying, 'I know you're going through a very hard time, but I'm always here for you. He also took care of the house and our child so that I could rest. His presence and help made me feel safe and understood." (W10)

Another woman described:

"My mother brought me food every day and cleaned the house. She never let me lift a finger and would say, 'Just rest; I'll do everything.'" (W6)

1.b. Gaps in Emotional Support from Medical Staff

The participating women reported significant experiences regarding emotional support from healthcare providers. They frequently expressed dissatisfaction with feeling ignored and absence of adequate attention from medical staff, which can lead to feelings of hopelessness and distrust in the healthcare system. This highlights just how important effective communication and empathy are in healthcare. A woman mentioned:

"During my hospital stay, I felt completely ignored by the medical staff. Beyond the routine checks for vital signs a few times a day, no one ever came to see me. If I ever miscarry again, I will not return to any hospital for treatment, no matter what." (W9)

On the other hand, healthcare professionals acknowledged that they did not have enough time for in-depth discussions with each patient because of high patient numbers and heavy workloads; one of the midwives mentioned:

"This hospital is crowded, and most of the staff don't interact much with the patients. I can confidently say that the staff, due to their workload, don't have time to interact and prefer to spend most of their time performing treatments and writing records. We need to be able to connect with these women and comfort them." (HP2)

Families were dissatisfied with the limited information provided about the mother's condition during hospitalization and their inability to meet the healthcare staff. This lack of communication is not just frustrating

for families; it also adds to the mother's stress and potentially hinders the effectiveness of her care. The mother of a woman with a history of RM shared:

"No matter how many times I asked about my daughter, they never gave me a straight answer. Even if we can't go into the ward, they could at least tell us how she's doing. Just let us know." (FM3)

1.c. Peer Support and Shared Experience

Several women interviewed in this study reported that talking to other women with similar experiences provided them with emotional and psychological relief and made them feel validated and understood. One of the women stated:

"After my third miscarriage, I felt like the world had come to an end. But when I spoke with a woman who had the same experience as me, it felt like a weight had been lifted off my shoulders. I realized I'm not alone, and it's possible to be hopeful again." (W10)

The women showed a clear inclination towards seeking guidance and leveraging the successful experiences of others to overcome challenges. A woman shared:

"In one of my appointments with my doctor, I saw a woman who had become pregnant again after several miscarriages. I wanted to get her phone number, talk to her, and get advice from her." (W1)

2. Structural Support for Psychological Well-being

Women in the study frequently highlighted a need for better access to infrastructure facilities and equipment. Although the psychological consequences of miscarriage are well-recognized, the dissatisfaction women experience with healthcare services in this regard has been largely overlooked.

2.a. Supportive and Compassionate Care in Health Centers

The presence of dedicated facilities and equipment for psychological support of women with a history of RM plays a significant role in improving their experience during this time. A major infrastructural barrier identified by participants was the lack of adequate space in maternity wards. They emphasized the importance of calm and private environments, explaining that crowded wards intensified stress and impaired coping. For example, a woman said:

"I really wish the room wasn't so packed. You can always hear babies' heartbeats here, and I just can't stand it." (W11)

Some women emphasized the importance of immediate diagnostic action by the hospital following a miscarriage. They believed that sending the fetus or pregnancy tissue to a pathology laboratory could play a vital role in identifying the underlying causes of RM and preventing future losses. A woman explained:

"I think it's good if the hospital itself sends the baby to the laboratory after a miscarriage to check what has been wrong." (W7)

Compassionate and empathetic care from healthcare staff is another vital element of infrastructural support. A key aspect of this is patient-centered care, which focuses on the unique needs and experiences of everyone. Healthcare providers participating in this study emphasized the critical importance of addressing women's emotional and psychological needs during childbirth. Furthermore, they believed that restricting physical activities and requiring permission for even simple tasks undermines women's independence and autonomy, potentially escalating anxiety and reducing their tolerance for difficult conditions. A midwife reported:

"Unfortunately, in our hospitals, the patient is confined to the bed and is not allowed to perform even the simplest tasks without our permission. These restrictions create a sense of dependence and limit the patient's autonomy, increasing feelings of hopelessness and anxiety; consequently, they make it difficult for the patient to tolerate the conditions." (HP5)

A key concept emerging from the interviews was the current lack of specific, standardized guidelines in healthcare settings

for supporting women have experienced RM. The healthcare workers believed this significantly limits the ability to provide consistent and effective care. One of the midwives stated:

"*We don't have specific protocols for people who are admitted with this history; as a result, health care providers act based on their experiences." (HP1)*

This comment clearly highlights a structural gap within the care system. Conversely, establishing legal and supportive frameworks could significantly improve this situation. As the obstetrician pointed out:

"If this is like a law or even a support package, it would definitely be better to maneuver the method, and this would make it mandatory for both doctors and staff to implement it." (HP11)

2.b. The Role of Organizations in Providing Financial and Counseling Support

Participants, especially women, frequently described financial barriers and the need for support from related organizations as important concerns. These challenges mainly involved limited financial and counseling assistance. Women reported high medical and counseling costs associated with pregnancy and RM, urging cost reduction. Healthcare providers emphasized the critical role of insurance coverage in reducing expenses and improving access to care. A mother noted:

"The doctor always orders tests before pregnancy, but the cost is too high for me. I wish they could reduce the costs a little for people like us who have fertility problems, so that we can do the tests." (W1)

A midwife noted:

"I really think insurance companies need to step in because if costs are too high, people just won't get treatment at all." (HP2)

Furthermore, healthcare providers reported that given the limited access to specialized psychological counseling in health centers and the financial barriers families encounter, the role of social workers in hospitals is also of significant importance. However, the findings indicate that this role is not currently being fully fulfilled. One of the midwives stated:

"Our hospital social worker has practically no role in providing psychological counseling to patients and does nothing for patients, but as far as I know, she can assess the patient's mental condition." (HP1)

3. Educational Support for Psychological Well-being

Interviews revealed a critical need for targeted training among women, their families, and medical staff to facilitate adaptation to the prevailing circumstances. This training was categorized into three subcategories:

3.a. Education for Mothers' Psychological Readiness

The healthcare providers believed that educating women about the causes of miscarriage, medical procedures, and treatment options could help them better understand their situation. They placed significant emphasis on providing information from the very beginning of admission to the women's ward. This signifies that information is a vital component of the treatment and support process and should not be postponed. This is supported by the following quotes, one healthcare provider asserted:

"As a midwife, I try to provide information to the mother from the very beginning of her admission, as this information can help her cope with the situation more easily." (HP2)

Targeted education in health centers is crucial for empowering women. Beyond medical information, women emphasized the need for training that supports psychological readiness, including skills such as stress management, emotion regulation, coping strategies, and effective communication. Many participants described entering a subsequent pregnancy with unresolved anxiety, intrusive thoughts, and uncertainty about how to manage their emotional reactions. This highlights the importance of structured psychoeducational support to strengthen mental preparedness and reduce psychological distress before

another pregnancy. A woman expressed:

" After my miscarriage, I didn't know how to calm myself or deal with my fears. I wish someone had taught me how to manage my emotions before trying again." (W6)

3.b. Family Education for Women's Support

Healthcare staff emphasized the importance of training husbands so they could better support their wives after a miscarriage. When a husband has more information on how to behave with his wife, he can better understand her needs and provide stronger support. This principle also extends to the wider family. Reproductive health specialist stated:

"It is good to teach the husband and the family how to treat the woman because the woman is now extremely sensitive to all behaviors and this can cause her distress, which in itself can be one of the reasons for RM." (HP10)

They also consistently highlighted the need for partners and families to be fully informed about the treatment process. They believe that this awareness helps families better understand the woman's physical condition and provide more effective support. A midwife remarked:

"In my opinion, suitable training for the mother and her husband can be very helpful. If the training is not effective, the husband may become restless and make wrong interpretations of the treatment process." (HP3)

Referring to the significant role of a husband's awareness in the experience of miscarriage, one healthcare provider mentioned: *'I think all the education given to the woman should be given to her husband as well… Sometimes the reason for the woman's anxiety in the ward is her husband, and he's saying to his wife, why does a miscarriage have to take so long? (HP4)*

3.c. Educating Staff in Compassionate Care

According to the psychologist interviewed in this study, healthcare providers lack sufficient training in how to approach women experiencing RM; as a result, they are uncertain about the appropriate course of action. This lack of training leads to confusion among them regarding proper reactions and suitable interventions. She advocated for enhancing healthcare providers' knowledge in this area, as well as the necessity of targeted referrals of these women to psychological specialists for more comprehensive support. This is reinforced by her statement:

"Healthcare providers haven't been trained on how to deal with mothers in these situations, so they just don't know what to do. Basic training is enough; they should definitely be referring these women to a psychologist." (HP8)

A significant gap has been observed in the communication skills of healthcare providers when they interact with women, especially during sensitive times like after a challenging experience. This communication problem reflects a broader lack of education in compassionate care, as most providers have not been trained to respond empathetically to mothers' emotional needs. This educational gap not only impacts the quality of the patient's experience but also directly affects women's physical and psychological health outcomes. A psychologist noted:

"There is a critical need for enhanced training for healthcare providers in establishing empathetic and supportive communication with mothers, as this directly influences their physical and mental well-being." (HP6)

Discussion

This study explored the psychosocial experiences surrounding RM through the combined perspectives of women, their family members, and healthcare providers. The findings of this study demonstrated that women's psychosocial experiences after RM were shaped through three interrelated domains of support: interpersonal support in building resilience, structural support for psychological well-being, and educational support aiming at enhancing emotional

recovery. Together, these categories reflect the multilevel nature of women's needs and illustrate how individual relationships, health-system structures, and knowledge-based resources collectively influence their adjustment process.

Within the category of interpersonal support in building resilience, one subcategory examined husband and family emotional companionship. Participants described their husbands as their main source of psychological support after RM, appreciating their emotional understanding, reassurance, and practical help. These findings align with recent studies that indicate strong marital support is associated with fewer symptoms of depression and anxiety.[8, 13] Participants also received practical support from family members, such as help with childcare and household tasks, which mirrors evidence that extended family assistance can buffer psychological distress during perinatal crises.[14, 28] However, some family behaviors, though well-intentioned, can reinforce feelings of inadequacy or blame.[12, 29] In cultural settings, societal narratives may attribute responsibility for reproductive loss to women.[30] Such ambivalence suggests that sociocultural norms mediate how support is perceived and delivered. Addressing these complexities through culturally grounded psycho-educational interventions could strengthen partners' empathy, reduce stigma, and transform familial care into a more empowering resource.[8, 29-31]

A further component of the main category of interpersonal support in building resilience is related to the gaps in emotional support from medical staff. In our study, poor communication often blamed on limited time, heavy workloads, and inadequate staffing left some women feeling ignored, rushed, or treated as just a clinical case. These experiences corroborate research from Australia, which found that time and resource limitations were the major obstacles, often causing physical health to be prioritized over emotional well-being.[20] In contrast, some studies have reported more satisfactory emotional communication, which has been attributed to structured perinatal bereavement training and improved staffing conditions.[32] This divergence likely reflects system-level differences; in many developing settings, miscarriage is clinically categorized as a routine event rather than an emotional crisis, and the staff often lack formal preparation in counseling or empathic communication. As a result, this marginalizes emotional care.

Another subcategory within the overarching theme of interpersonal support in building resilience involved peer support and shared emotional experiences. In our study, peer support helped women with recurrent pregnancy loss feel less lonely and better understood. Sharing experiences with others who had similar losses provided comfort and reduced distress. Earlier evidence also showed that supportive peer connections might improve emotional coping and well-being.[18] Recent qualitative evidence from one study indicated that support from someone who had experienced early pregnancy loss felt uniquely comforting and offered understanding beyond what professionals or family could provide.[33] Although peer connections are valuable, formal and supervised, peer-support programs remain limited, and developing structured models may better promote emotional recovery after miscarriage. Healthcare providers were a critical but inconsistent source of support.

Within the main category of structural support for psychological well-being, one subcategory focused on supportive and compassionate care in health centers. Interviewees consistently highlighted the pressing need for improved access to specialized facilities and infrastructure. Women who have experienced RM require distinct and empathetic care throughout diagnosis, hospitalization, and post-discharge follow-up. One of the key aspects of care that was repeatedly mentioned in the interviews was patient-centered care. Adopting a patient-centered approach, where the patient's needs and desires are prioritized, is essential for improving mental health experiences and outcomes.[34] However, participants'

experiences contrasted with those from well-resourced health systems, where specialized miscarriage clinics and formal bereavement guidelines ensure more consistent and empathetic care.[29, 35] In these settings, structured organizational support including training, patient to staff balance, and defined care protocols helps normalize emotional support as a professional responsibility rather than an optional extra. A major source of distress for participants was being accommodated in maternity wards alongside expectant mothers, which compounded their grief and anxiety. Limited space and inconsistent care further undermined their sense of privacy and dignity issues also observed in similar reports.[21, 36] Conversely, in health systems with patient-centered frameworks, emotional privacy is regarded as an essential component of quality maternity care.[34] Hence, women's dissatisfaction stems less from individual neglect than from systemic and environmental barriers that constrain compassionate and dignified support.

Another finding was the absence of standardized protocols for the management of RM. In Iran, absence of clear legal and clinical frameworks has led to inconsistent and often emotionally insufficient care after pregnancy loss.[25] Healthcare workers act based on personal experience, while there are no national protocols to guide communication, follow-up, or referral to counseling. By contrast, Kazakhstan's adoption of national digital systems and unified reporting standards has improved the organization and equity of miscarriage care.[37] Similarly, evidence indicates that the absence of clear structures and guidelines may diminish healthcare providers' ability to establish effective communication, understand patients' perspectives, and offer appropriate emotional support.[25] Only through enforceable national guidelines and institutional accountability can bereavement support shift from individual discretion to an equitable component of professional care.[25]

The subcategory, situated within the main category of structural support for psychological well-being, addresses the participants' experiences and perceptions regarding the organizational role to provide financial and counseling support. Women in the present study emphasized the substantial financial pressures associated with RM care, including the high cost of diagnostic tests, follow-up visits, and psychological services. Healthcare providers also noted that although hospital social workers are trained and capable of offering counseling support to women, this capacity is not effectively utilized within the current system. Results from the qualitative study indicated that the high costs of psychological and genetic services were a major barrier to timely access within the public system, alongside limited availability of support from psychology and social work units in hospitals.[21] In line with these findings, another qualitative study conducted in Iran reported that women experienced substantial financial strain and felt that some providers did not fully take families' economic circumstances into account, underscoring the need for more accessible financial and psychosocial support.[25]

Within this study, one of the subcategories of educational support closely linked to psychological well-being was education aiming at enhancing women's psychological readiness. The findings highlight the importance of providing accessible and structured educational resources from the earliest stages of care. Consistent with previous research, access to accurate and timely information can reduce anxiety, lessen feelings of helplessness, and support more effective coping with the experience of miscarriage.[28, 38] Beyond medical information, the results of this study also indicate the value of educating women about practical coping skills, including stress management, self-care strategies, and communication skills for expressing the needs and seeking support from healthcare providers or social networks. Existing evidence suggests that structured psycho-educational interventions

can improve women's self-efficacy, resilience, and psychological adjustment following miscarriage.[16, 19] However, unlike some well-resourced healthcare systems where educational programs are systematically integrated into care, such support in many contexts including Iran often remains inconsistent and insufficiently structured.[39] This underscores the need for more coherent educational approaches in the care of RM, which could enhance psychological outcomes and improve the overall quality of support provided to affected women.[40]

A further dimension of educational support for psychological well-being involved family education for women's support. Involvement and awareness of husbands and family members play a crucial role in women's emotional recovery after RM. Partners who understand both physical and psychological aspects can offer more empathetic and sustained support. Similar findings from a study showed that providing emotional and educational guidance for relatives improves adjustment and overall care experience.[38] This alignment likely reflects shared family-centered values emphasizing collective coping after loss. In contrast, the lack of structured education for families in Iran limits their ability to provide informed support. This difference stems from the absence of formal psycho-educational initiatives within maternity care systems.[29] Integrating family-oriented training into reproductive health programs may, therefore, enhance emotional recovery and patient satisfaction.

Within the educational support category, another subcategory pertained to educating staff in compassionate care. Women emphasized that healthcare providers' communication style and demeanor strongly influenced women's psychological recovery and engagement with care after pregnancy loss. The findings underscore the need for comprehensive training in communication and counseling skills to foster more patient-centered and empathetic support.[12] Iranian qualitative evidence shows such training remains limited and lacks a formal psychosocial framework; professionals themselves report unmet educational needs in bereavement care, empathy, and supportive communication.[39] This gap suggests that training currently focuses more on clinical competence than on emotional care, reflecting systemic priorities that underplay psychosocial wellbeing. Integrating structured psycho-educational components into professional development could, therefore, bridge this divide and enhance holistic, compassionate miscarriage care.

A major strength of this study is its novelty to examine the experiences of psychosocial support from perspective of women with RM, alongside their families and healthcare providers. However, the study also has limitations. The sensitive nature of loss and grief may have led some women who had experienced miscarriage to decline participation. Therefore, the purposive sampling of volunteers may not fully reflect the experiences of women who did not participate.

Conclusion

This study identified three key categories of psychosocial support for women who have experienced RM: interpersonal support in building resilience, structural support for psychological well-being, and educational support for psychological well-being. Understanding these needs is crucial for designing, planning, and handling anxiety and worries in women with RM. Therefore, we recommend further research to develop a psychosocial intervention program specifically tailored to the psychosocial experiences of these women. Furthermore, miscarriage, due to its numerous complications, is considered not only a health issue but also a social problem, as it ultimately jeopardizes the health of families and communities. Therefore, public education about miscarriage is crucial. This education can raise awareness of the profound psychological consequences of RM for both women and men.

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Authors' Contribution

A.T., Z.A., M.J., and B.Ch. made substantial contributions to the study design and project development. Data were gathered by A.T., and data coding was performed by A.T., Z.A., and M.J. Data analysis and interpretation were conducted by A.T. and Z.A. The initial manuscript draft was prepared by A.T. All authors contributed to critical revision of the manuscript for important intellectual content and approved the final version for publication, agreeing to be accountable for the accuracy and integrity of the work. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Conflict of Interest

None declared.

Declaration on the use of AI

The authors declare that no artificial intelligence tools were used in the preparation of this manuscript.

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