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EXPLORING THE RELATIONSHIP BETWEEN MISCARRIAGE AND PSYCHOLOGICAL DISTRESS: A CORRELATIONAL STUDY

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ABSTRACT

Miscarriage is known as spontaneous abortion; it is an end to pregnancy resulting in the loss and expulsion of an embryo or foetus from the uterus before it can survive independently. The present study aimed to examine the relationship between psychological distress and miscarriage. After detailed literature review it was hypothesized that (i) There is a significant Correlation between miscarriage and psychological distress (ii) There is a significant difference in psychological distress levels during different trimester of pregnancy among female who experience miscarriage. A sample of 150 women was collected from different hospitals of Rawalpindi and Islamabad. To explore the relationship between Miscarriage and Psychological Distress, Depression Anxiety Stress Scale- 21 (DASS-21, Lovibond 1995). Data was analyzed using IBM SPSS Version 22. Result from the analysis of data shows that miscarriage is significantly and positively associated with stress, also shows significant positive inter correlation between stress and anxiety (r=0.719, p<.01), between stress and depression (r=.615, p<.001) and moderately strong positive correlation was also observed between anxiety and depression (r=0.703, p<.01). An analysis of Variance (ANOVA) shows no significant difference in stress F (2, 147) =0.589, p=.551, anxiety F (2, 147) = 0.454, p = .636 and in depression F (2, 147) = 0.551, p =.601 across the trimester among the women who have experience miscarriage.

Keywords. *Miscarriage, psychological distress, Depression, Anxiety, Stress.*

INTRODUCTION

Nowadays many pregnancies end in miscarriage, in medical terms miscarriage is also known as spontaneous abortion. It is an end to pregnancy resulting in the loss and expulsion of an embryo or fetus from the uterus before it can survive independently. (*The Johns Hopkins Manual of Gynecology and Obstetrics*, n.d.). Effect of this traumatic event varies from female to female or person to person leading to grief, anxiety, depression and even symptoms of Post Traumatic Stress Disorder (PTSD). Globally about 12-15 % of recognized pregnancies end in miscarriage and above 30-50 % of women experience anxiety and 10 to 15% experience depression lasting up to 04 months. (*What Is the Psychological Impact of Miscarriage? | Figo*, 2018). In some cases, grief doesn't lessen with time. According to American Psychiatric Association estimated 7-10% of people struggle with Prolonged Grief Disorder (PGD), which is characterized by intense and persistent grief that causes problems and interferes with their daily life. According to researchers, grief has been identified as a characteristic of post miscarriage distress, but trauma related to miscarriage has been neglected. But sometimes people are dissatisfied with professional emotional care, because there is no routine follow up (Lee & Slade, 1996). The grief

/ loss following a miscarriage is often overlooked and rarely questioned by healthcare professionals, friends or family and at the extreme case it led to symptoms of trauma (Layne, 2003). For Parents who are coping with pregnancy loss, the sense of isolation can be acute and emotionally debilitating, unlike other types of loss, parents who experience miscarriage or stillbirth often lack formal rituals like funerals to help process their grief. Their emotions can range from guilt and shame over the loss to profound sadness for the future they expected with their child (Huff, n.d.). Facing this traumatic experience alone in relative isolation can lead to severe psychological consequences. Gerber-Epstein, Leichtentritt, and Benyamini emphasized the importance of acknowledged that the emotional impact of a miscarriage may be directly proportional to the level of desire for the pregnancy (Gerber-Epstein et al., 2009).

CAUSES OF MISCARRAIGE:

During pregnancy, human body supplies hormones and nutrients to developing fetus to help it grow when fetus are not grown normally most of the first trimester miscarriages happens. According to American College of Obstetricians and Gynecologist (ACOG), many women who experience miscarriage may believe it was caused by a recent fall, injury, shock or stress. However, this is not the cause, in several cases individuals may have a miscarriage before realizing they are pregnant. There are different factors that causes miscarriages such as; -

1. A Problem with the baby's gene or chromosomes.

Mostly early miscarriages (before 12 weeks) are caused due to chromosomal issues with the baby. Chromosomes are responsible for development, about half to two third of miscarriages in the first trimester and when chromosomes are developed abnormally, the baby may have extra or missing chromosomes, causing improper development and pregnancy to end. Recurrent miscarriages can sometimes be linked to genetic factors, where one partner may unknowingly have a chromosome abnormality that can be passed on to each pregnancy. This occurs in about 2–5 out of 100 pregnancies. Chromosome condition might lead to Anembryonic pregnancy, Intrauterine fetal demise, Molar pregnancy and partial molar pregnancy. (*Miscarriage - Symptoms and Causes*, n.d.).

2. Problems with the placenta.

The placenta is an organ attached to the womb and connected to the baby via umbilical cord, it supports baby's growth and development. Placental issues can occur at any point during pregnancy and may result in miscarriage or stillbirth. (Website, 2022b)

3. Weak cervix (cervical insufficiency)

The cervix is the gateway to the womb, during childbirth it opens to allow the baby to pass through. Weak cervix, may open prematurely, leading to a late miscarriage or preterm birth.

4. Problem with the womb lining (endometrium).

For pregnancy to occur, an embryo must implant in the lining of the womb, which needs to be prepared at the same time. After implantation, the lining must change again to support proper placenta development. These changes rely on a balanced interplay of hormones and cells in the womb lining at specific points in the cycle, and this balance can vary. Disruptions in this timing or balance can lead to fertility issues or miscarriage. (*What Causes a Miscarriage?* 2024)

5. Blood clotting problems

Antiphospholipid syndrome (APS) is a rare condition that raises the risk of blood clots, potentially leading to recurrent or late miscarriages. Thrombophilia, an inherited disorder, also makes the blood more prone to clotting, which can result in late miscarriages.

Types Of Miscarriages:

There are many types of miscarriages such as inevitable, threatened, missed or incomplete, complete and there are also other types of pregnancy loss like molar pregnancy, ectopic and blighted ovum (Nikcevic, 1999). In a single pregnancy, a person may experience two or more types of miscarriages. (Perry, 2024a).

Chemical Pregnancy:

A chemical pregnancy, or "pre-clinical" miscarriage, happens when a fertilized egg triggers the production of human chronic gonadotropin (hCG) but fails to implant. Some people

experience positive pregnancy test which turns negative, mild spotting or cramping and low hCG levels while other don't have any symptoms. Chemical pregnancies are common, with 45% of all conceptions failing and 80% of those are pre-clinical miscarriages. (Perry, 2024b).

Threatened Miscarriage.
It refers to vaginal bleeding during the first 20 weeks of pregnancy but pregnancy may continue with no further issues. In threatened miscarriage a women may experience light vaginal bleeding, mild abdominal pain, pelvic cramping, but cervix stays closed or it may open and leads to miscarriage.

Inevitable Miscarriage It refers to heavy vaginal bleeding in contrast to threatened miscarriage with strong lower stomach cramp, cervix started to open (dilate) and amino fluid start leaking.

Complete Miscarriage It is also called a complete abortion; bleeding occurs for several days as all the pregnancy tissue leaves uterus; Cramping pain similar to strong period pain is common as the uterus contracts to empty its content.

Incomplete Miscarriage An incomplete miscarriage occurs when some pregnancy tissues remain in the uterus after part of it has been passed. It can cause ongoing bleeding and cramping, though symptoms may subside in some cases. Retained tissue increases the risk of infection.

Missed Miscarriage A missed miscarriage occurs when the pregnancy ends without symptoms until a routine ultrasound reveals that fetus has no heartbeat. Symptoms like nausea ad fatigue may have decreased.

Recurrent Miscarriage Three or more consecutive miscarriages are known as Recurrent Miscarriage. It effects about 01% of the couple.

Primary Miscarriage If a Miscarriage occurs during first pregnancy, it's referred as primary Miscarriage.

PSYCHLOGICAL IMPACT OF MISCARRIAGE

Miscarriage, or spontaneous abortion by affecting 10-20% of pregnancies, is the most common pregnancy complication and form of reproductive loss (Stratton & Lloyd, 2008), accompanied by both short- & long-term psychological effects, which are frequently underestimated by healthcare providers. (Quenby et al., 2021). The loss of pregnancy can be both physically and psychologically challenging to women. It disrupts women's reproductive plans and raise concerns about their ability to carry future pregnancies (Nansel, Doyle, Frederick, & Zhang, 2005). There are several etiological reasons that become cause of miscarriage including immunologic, anatomic and genetic abnormalities, endocrine disorder and heritable and/or acquired thrombophilia and environmental factors (Bicking Kinsey et al., 2015). Since there are no records of miscarriage of national level and that many women miscarry before their pregnancies are clinically confirmed or they even realize that they are pregnant, these figures are likely to be miscalculated. While miscarriage is common, but for some women it can be a traumatic experience, leading to considerable psychological distress (Lok & Neugebauer, 2007). Many women long after physical recovery may persist high level of anxiety, depression and grief (Nikcevic´, Kuczmierczyk, & Nicolaides, 2007). In a qualitative study it was suggested that a history of miscarriage have negative impact on women, leading to anxiety, psychological disorders and a compromised quality of life (Adolfsson, Johansson, & Nilsson, 2012). In another study it was suggested that women with recurrent miscarriage are at a greater risk for psychological issues including pregnancy related anxiety, irritability, fear, fatigue, sleep disturbance, difficulty concentrating and often experience heightened depressive symptoms. (Gong et al., 2013). Walker and Davidson in their study suggested that 45% of women experience clinically significant anxiety symptoms 03 months after a miscarriage. (Walker & Davidson, 2001). In an article it was reviewed that women having history of miscarriage, experience higher levels of anxiety during their subsequent pregnancy compared to those without a prior loss (Geller, Kerns, & Klier, 2004). Miscarriage can also involve significant

physical discomfort, especially if medical procedures for fetal evacuation are performed and heavy bleeding persist. There is no evidence that different methods used to remove the fetus cause different psychological reactions. For example, Nielsen et al. reported similar grief reaction in female undergoing dilation and curettage versus expectant management (Nielsen, S., Hahlin, M., Moller, A., & Granberg, S., 1996). Researches have demonstrated that due to stress, probability of conception may decrease and risk of miscarriage is likely to increase. (Andalib et al., 2006; Louis et al., 2011; Ebbesen et al., 2009; Maconochie et al., 2007; Sugiura-Ogasawara et al., 2002). Elevation in level of stress hormones particularly cortisol, have been liked to stress and women with higher level of cortisol may have higher risk of experiencing miscarriage (Nephomancy et al., 2006; Vidovic et al., 2011; Wadhwa et al., 1996). There is ongoing debate that whether the emotional response is more intense right after the loss, compared to weeks, months or even years later and whether a miscarriage on later stage felt more strongly than an early one. Because reconciling a miscarriage at 10 weeks of gestation can be more difficult compared to a loss at 25 weeks. At 10 weeks, there are no visible signs of pregnancy, and the mother has not yet felt her baby's movement, making the loss less apparent. On contrary, a loss at 25 weeks usually involves a visibly pregnant mother who has felt fetal movement, and the loss is noticeable to those around her. A miscarriage at 10 weeks may not be recognized by the social or workplace environment, and as a result, the women may not receive the same level of social, emotional and healthcare support that a later pregnancy loss would garner. As a result, reaction can vary from person to person, influenced by individual differences and personal significance of the loss to those who are involved. Further, the risk of miscarriage is not same among women of different ages, estimated ranging from 09% to 75% (Nybo Andersen et al., 2000). Factors such as paternal and maternal age, termination, infertility, previous miscarriages, assisted conception, low pre pregnancy BMI, stress and changing partners are independent risk factors for miscarriage (Maconochie et al., 2007). Although age and number of previous miscarriages are independent risk factors for miscarriage, but they are interlinked for e.g. older women and those with a history of multiple miscarriages are more likely to miscarry than younger women. Numerous, other factor including infections, endocrine and immune disorders, thrombophilia and unknown causes may also play a role but evidence is equivocal (RCOG, 2013). In Finland a study on suicide identifies a significantly higher mean annual suicide rate in women who had miscarried in the year prior to their suicide (18.1 out of 100,000) compared with women who had delivered a baby (5.9 out of 100,000) these reactions tend to be extreme (Gissler, Hemminki, & Lönnqvist, 1996).

Age is also an important factor that influences the likelihood of miscarriage. It was found consistently in studies that maternal age is related to increased risk of miscarriage (Nybo Andersen et al., 2000). Due to global trend of delaying childbirth, it is crucial to explore how age affects reproductive potential of women, however, the full extent of this impact is not completely understood yet. It is well established that woman's fertility starts to decline gradually after the age of 20, and around 35 it decreases more rapidly. (te Velde & Pearson, 2002). Women over age of 35 years have higher risk of miscarriage and it further increase after 40 (RCOG, 2013). Due to age related factors such as declining egg quality, hormonal imbalances, or underlying medical conditions that become predominant with age (Maconochie et al.,2007). In addition to the physiological effects, older women may experience higher levels of psychological distress following a miscarriage. In a study it was found that women aged 35 and above have high anxiety and depressive symptoms after miscarriage as compared to younger women. This response could be due to fear of future pregnancy and concerned about fertility. They also feel societal pressure to conceive before their biological clock runs out, which amplifies their feelings of grief and distress after a miscarriage (Elliott et al., 2014). The number of children a woman has also plays a significant role in shaping her emotional response to miscarriage. Studies shows that women with children may experience complex feelings of miscarriage, not only for the child they were expecting but also for the ideal family structure they had planned. Harris and Williams (2005) suggest that women with children experience guilt and failure due to inability to

expand their family further. Having other children may give a sense of emotional continuity, as they can offer support throughout the grieving process (Foster & McKernon, 2012). Contrary to women without children, they may experience the loss more intensely, as it may represent their opportunity to become mother. The grief of a miscarriage can be particularly profound for women who are childless, leading to feelings of isolation, despair and heightened psychological distress (Linton et at., 2010). This can also impact marital satisfaction negatively, as partners struggle to manage the grief and emotional fallout of the miscarriage. Furthermore, women having recurrent miscarriages has shown increase in psychological distress, higher levels of anxiety and relationship strain (Gong et al., 2013). Recurrent miscarriages often lead to a sense of hopelessness and failure, for both parents. This shared grief creates significant strain on the relationship, as couples may struggle to cope with the physical and emotional toll of repeated loss. Recurrent miscarriage increases conflict and emotional intimacy, further aggravating relational difficulties. The inability to conceive or maintain pregnancy can crate feelings of frustration, disappointment, and alienation within the relationship, leading to a decline in marital satisfaction. (Swingle et al., 2007). The ability to share grief, express emotions, and support each other through the healing process can make marital bond strong, reducing the strain caused by the miscarriage. In contrast, couples who struggle to communicate or cope in isolation may experience decrease in marital satisfaction, as emotional distance develops between the partners. In terms of marital satisfaction researched suggests that couple's way of coping with miscarriage have significant effects on long term marital relationship. Couples who provide emotional support to each other and are engage in open communication tend to experience better marital satisfaction after miscarriage (Barrera et al., 2002). It was suggested by Geller et al. (2004), that women often experience more intense emotional responses, and men may be more likely to suppress their emotions, leading to misunderstandings and emotional disconnect. Therefore, the psychological and emotional response to miscarriage, influenced by factors such as age, number of children and previous pregnancy losses has a profound impact of marital satisfaction, with effective communication and mutual support being key to maintaining relational harmony during such difficult time (Geller et al. 2004).

According to the literature it is hypothesized:

1. There is a significant Correlation between miscarriage and psychological distress.
2. There is a significant difference in psychological distress levels during different trimester of pregnancy among female who experience miscarriage.

Method

Participants:

The target population was women's having experience of miscarriages taken from different hospitals of Islamabad and Rawalpindi. Participant's includes women's having experience of miscarriage ranging from 19-40 years. Size of the sample was 150.

Instruments:

Informed Consent:

Participant's consent was taken. It was also stated that every information provided will be kept confidential and will only be used for research purpose. Participants are requested to read attentively and mark according to their suggestions. It was also stated that their participation is voluntary and they can withdraw anytime.

Demographic Sheet:

Demographic sheet was used to take all the relevant information of the participant's regarding the research. Information includes age, education, number of children, number of miscarriages, duration of marriage, and miscarriage of the baby before, mid or after the children, and trimester of miscarriage.

MEASURE:

The DASS-42 is commonly used in both clinical and non-clinical settings to identify levels of depression, anxiety and stress making it useful for screening mental health concerned and tracking changes over time during therapy. DASS-21 is a shorter version of the original tool, other variation of tool includes a youth version (DASS-Y) and (DASS-10).

DASS takes a dimensional approach focusing on the severity of symptoms rather than labeling someone with a disorder. The overall score reflects general psychological distress (Henry & Crawford, 2005). The three subscales depression, anxiety and stress are reliable and sensitive enough to detect changes making it a reliable for both research and treatment monitoring.

DASS-21 was initially developed using sample of university students, with the items subsequently checked for validity against outpatient including patients suffering from anxiety, depression and other mental disorders (Lovibond & Lovibond, 1995). The internal reliability of the total scale is .93. For the depression scale, reliability is .88, .82 for the anxiety subscale, and .90 for the stress subscale (Henry & Crawford, 2005). Confirmatory factor analysis has validated a 04 factors model for DASS-21, comprising the three individual subscales along with a general psychological distress factor reflected in the total score. This model showed the best fit among those tested, with statistical indicators (χ^2 = 893.7, df = 162, CFI = 0.94, SRMR = 0.03, RMSEA = 0.05).

The construct validity of the tool is moderate to strong correlations with well established measures of depression, anxiety and stress (Brown et al., 1997). Test retest reliability over a 02 weeks interval has demonstrated consistency with coefficients ranging from 0.71 to 0.81 for Depression, 0.74 to 0.81 for Anxiety and 0.81 to 0.89 for stress (Antony et at., 1998).

The DASS-21 has been extensively normed, with data used for interpretive purposes based on a sample of 1,794 (815 male, 979 female) non-clinical adults (18 – 91 years of age; Henry & Crawford, 2005). The percentile for general psychological distress (the overall score) is based upon Henry & Crawford's data (mean = 9.43, sd = 9.66). The subscale percentiles were based upon Lovibond & Lovibond's (1995) original data (n = 1,044 males, 1,870 females; 17 – 69 years of age) where a percentile table could be inferred for enhanced accuracy (see Table 9 and Figure 3 of the DASS manual). The severity levels are determined from the DASS manual (Table 9; Lovibond & Lovibond, 1995),

Procedure:

The present research objectives, procedure and materials used were first reviewed and approved by higher education research committee. After formal approval of research, different hospitals were approached for the data collection of women's having the experience of miscarriage. Snowball sampling technique was also used to approach the participants. They were explained the purpose of research and were asked to voluntarily participate in the research. On their verbal and written consent, they were briefed about the procedure of the research and their queries regarding research procedure were entertained. They were also informed about their rights as research participants. The participants then filled the research scales, which were demographic sheet, Depression, Anxiety, and Stress Scales by Lovibond and Lovibond (1995). During the administration of self-reported inventories, they were allowed to ask any questions regarding scales if they need clarity or were not able to understand the items in the questionnaires. In the end, they were thanked for their cooperation and participation in the research.

Results

Table 01

Psychometric Properties of Depression anxiety stress scale (N=150).

Variables	No. of items	α	M	SD	Range		Skewness	Kurtosis
					Minimum	Maximum		
DASS	21	.898	30.31	10.836	10	54	.336	-.552
Stress	7	.758	12.42	4.617	3	22	.457	-.781
Anxiety	7	.761	10.90	4.749	2	23	.625	.153
Depression	7	.774	10.99	4.900	0	22	-.030	-.405

Table 1 show the reliability statistics of psychological distress (stress, anxiety, and depression).

Table 2
Pearson product moment Correlation coefficient between miscarriage and psychological distress. (N=150).

Study variable	1	2	3	4	
Stress	1	.719**	.615**	.176*	.880**
		.000	.000	.031	.000
Anxiety		1	.703**	.143	.907**
			.000	.080	.000
Depression			1	.160	.860**
				.050	.000
DASS					1

Note. The Pearson product moment Correlation shows that miscarriage is significantly and positively associated with stress, also significant positive inter correlation between stress and anxiety *(r=0.719, p<.01),* as well as between stress and depression *(r=.615, p<.001)* and moderately strong positive correlation was also observed between anxiety and depression *(r=0.703, p<.01).*

Table 3
Analysis of variance for psychological distress on the trimester of miscarriages groups (N =150).

	First trimester (n=105)		Second trimester (n=41)		Third trimester (n=4)		F	P
	M	SD	M	SD	M	SD		
Stress	12.16	4.423	12.95	5.181	13.75	3.775	.598	.551
Anxiety	10.71	4.358	11.51	5.827	10.25	1.500	.454	.636
Depression	10.72	4.923	11.63	5.014	11.25	2.986	.551	.601

Note. An analysis of Variance (ANOVA) shows no significant difference in stress F (2, 147) =0.589, p=.551, anxiety F (2, 147) = 0.454, p = .636 and for depression F (2, 147) = 0.551, p =.601 across the trimester.

Discussion

The present study aimed to examine the relationship between psychological distress and miscarriage. After detailed literature review it was hypothesized that (i) There is a significant Correlation between miscarriage and psychological distress (ii) There is a significant difference in psychological distress levels during different trimester of pregnancy among female who experience miscarriage. The Pearson product moment correlations in Table-02 shows significant positive correlation between miscarriage and psychological distress stress and anxiety *(r=0.719, p<.01),* as well as between stress and depression (r=.615, p<.001) and moderately strong positive correlation was also observed between anxiety and depression (r=0.703, p<.01), hence our 1st hypothesis which suggest that there is a significant Correlation between miscarriage and psychological distress is supported because miscarriage contributes to heightened psychological distress. It indicates that women who experience miscarriage reported increased stress levels. Recent studies corroborate these findings, A study by Farren et al. (2024) revealed that women with an experience of miscarriage are at increased risk of developing common mental health disorders at later stages in their life. After pregnancy loss, in first few months between 18% to 32 % of women experience anxiety disorders, 11-30% exhibits depressive symptoms. A mixed method study by Fernandez-Pineda et al. (2024) highlight that After 14 to 31 months of miscarriage 47.9% women reports moderate to severe anxiety and 38.0% of women reports depression emphasizing the need for targeted psychological support for women experiencing miscarriage. Quenby et al. (2024) highlights dual role of psychological distress in miscarriage and suggested that it can serve both as a contributing risk factor for and consequences of miscarriage. Following the loss, stress can both heighten the physiological risk of experiencing a miscarriage and intensify as emotional reaction. In this study relationship between stress, anxiety and depression were found to be quite strong showing

a common phenomenon that women experience more than one type of emotional struggle after a miscarriage. A Study by Li, Tan and Hou (2023) found that women who experience miscarriage more likely develop depression, anxiety and even post-traumatic stress disorder (PTSD). In another study Ferguson et al. (2024) highlighted that emotional impact of miscarriage often involves different feelings, not just one type of distress.

Although the Analysis of Variance (ANOVA) found no significant difference in levels of psychological distress (Stress, anxiety and depression) across the 03 trimesters in which miscarriage occurred. This finding suggests that psychological distress does not significantly vary by the gestational age of loss. Whereas, some studies suggest that pregnancy loss in second trimester leads to greater emotional distress due to more advances stage of fetal development (Sheldon et al., 2023). Yet, more recent studies have shown mixed results. For instance, Jones and Marelli (2024) reported no significant difference in anxiety, or depression, based on different trimester and attributed consistent distress across all trimesters regardless of gestational age. Another study indicates that repeated miscarriage may increase psychological distress due to compound grief, stress and anxiety (Erdem et al., 2020). The findings of this study imply that, aside from timing there are other factors that can be more influential in determining the level of psychological distress such as the quality of social support, individual coping mechanisms, and prior experience of loss might play a more central role in shaping emotional responses to miscarriages. Kousar, Khan and Alam (2024) in a study emphasized the importance of social support and coping strategies in mitigating psychological distress following miscarriage. It was perceived that social support and active coping strategies were positively correlated with better psychological outcomes, highlighting the need for comprehensive support systems for women experiencing miscarriage. Previous study by Suter et.al (2012) emphasized the importance of personalized care in managing emotional distress following miscarriage, highlighting the positive effect of support networks and individual coping mechanism on recovery. This highlights the importance of healthcare providers to take a holistic approach, considering both the social and psychological factors influencing women's responses to miscarriage. Additionally, language that is used to describe miscarriage can also impact women's emotional responses. Research indicates that women who have lost a baby prefer the term "pregnancy loss" over "miscarriage" as it carry connotations of blame and failure. A study by the Guardian (2024) found that 61% women felt "miscarriage" was unacceptable due to its implication, and only 22% find it acceptable. An overwhelming majority 82% preferred "pregnancy loss", suggesting that mores compassionate language may significantly affect the mental and physical well being of grieving parents, mitigating feelings of trauma and guilt.

Conclusion:

This study can be concluded that miscarriage is closely linked to psychological distress (stress, anxiety and depression), many women experience more than one type of emotional struggle after miscarriage. While the stage of pregnancy loss (trimester) don't make big difference in how women feel distressed, but other factors such as social support, previous experiences of loss and personal coping skills play a bigger role in shaping their emotional response.

Findings of this study also suggest that how we talk about miscarriage matters and preferred the term "pregnancy loss" over "miscarriage" because it feels less judgmental and caring.

Overall, this study highlights the need for compassionate and holistic care that supports social and emotional needs of women after miscarriage. Using suitable language and providing the right support can make real difference.

Limitation and Recommendation:

Following are the limitations and the recommendations

1. Due to the time constraints and limited resources sample was small.
2. Researchers can also do qualitative analysis and longitudinal study with women having the experience of miscarriage.
3. Effect of the current pregnancy on the previous miscarriage can also be studied in future.
4. Study can also include couple so that father's grief or distress can also be examined.

5. Study can also open new domains by conducting it on handicap women's during pregnancy or if had a miscarriage.

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