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When hope is broken: A qualitative study of women's quality of life after late miscarriage or foetal loss

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ABSTRACT

Background: Late miscarriage and foetal loss are global health issues with enduring biopsychosocial consequences. Despite growing recognition, the long-term impact on women's quality of life remains underexplored.
Objective: To explore how late miscarriage and foetal loss affect women's quality of life, focusing on psychological, physical, social, and existential consequences, and to evaluate whether current healthcare support meets women's needs.
Methods: A qualitative study was conducted using semi-structured interviews with six women who had experienced late miscarriage or foetal loss. Data were analysed using systematic text condensation within a hermeneutic phenomenological framework.
Findings: Five themes captured the women's experiences: (1) Mental and physical consequences, including PTSD, anxiety, fatigue, and sleep disruption; (2) Social relationships and isolation, with loss of friendships and experiences of stigma but also moments of profound support; (3) The healthcare system's role, where empathic midwives and peer groups were valued but care was often fragmented and distressing; (4) Existential reflections and rituals, which helped informants honour their children and integrate the loss; and (5) Everyday life under strain, with disrupted daily routines and activity balance, yet some women describing personal growth over time. Across themes, informants emphasised the enduring nature of grief and the insufficiency of current support.
Conclusion and implication for practice: Late miscarriage and foetal loss have far-reaching effects on women's mental health, social connections, daily functioning, and sense of identity. Findings highlight the need for holistic, sustained, and flexible bereavement support that extends beyond the immediate postpartum period, addresses psychological and practical needs, and incorporates rituals and meaning making. Such approaches may reduce isolation, strengthen belonging, and promote long-term recovery and wellbeing.

Introduction

Pregnancy loss, including late miscarriage and perinatal death, is a life-altering event that can trigger sustained psychological and emotional distress for women. Pregnancy and birth are typically anticipated as joyful milestones; however, when complications result in miscarriage or foetal loss, many parents experience profound grief. Studies consistently show that women who lose a baby during pregnancy or shortly after birth often suffer from depression, anxiety, and posttraumatic stress disorder (PTSD), which may significantly impair daily functioning (Gold et al., 2016; Vlachou et al., 2024). Recent qualitative research further illuminates these experiences. A study from Türkiye identified multiple emotional reactions and coping strategies following perinatal loss, highlighting both distress and resilience (Ucar et al., 2025). Other studies have documented a spectrum of psychological outcomes, ranging from long-term trauma to experiences of personal growth, particularly after recurrent losses (Shin et al., 2023).

Definitions of pregnancy loss vary, complicating cross-study comparisons. Herbert et al. (2022) define miscarriage as loss before 20–28 gestational weeks and stillbirth as loss thereafter. In this study, the term *late miscarriage* is used to describe pregnancy loss occurring later in gestation. Late miscarriage refers to losses after 20–40 weeks, including pregnancy termination for foetal anomaly, while foetal death is defined as death within the first 40 days of life.

Despite the high prevalence of pregnancy loss (UNICEF, 2025a, 2025b), grief associated with pregnancy loss remains under-recognised

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both socially and within health systems. Historically, pregnancy loss was not acknowledged as a distinct form of bereavement within healthcare before the 1970s (Kennell et al., 1970). Since then, research has identified numerous biopsychosocial consequences, including increased risk of hypertension and high blood pressure (Dunne et al., 2024; Nichols et al., 2025), diabetes (Dunne et al., 2024), cardiovascular disease (Yang et al., 2025), sleep disorders (Dubey et al., 2025), and mental health disorders such as anxiety (Fernandez-Pineda et al., 2024; Shen et al., 2024; Westby et al., 2021), stress (Shen et al., 2024), depression and post-traumatic stress disorder (PTSD) (Fernandez-Pineda et al., 2024; Westby et al., 2021). However, the reported prevalence and severity of these outcomes remain inconsistent across studies, underscoring the need for further investigation.

PTSD has been increasingly recognised as a particularly disabling consequence, with 20 – 60 % of women and men experiencing miscarriage or foetal loss showing PTSD symptoms (Díaz-Pérez et al., 2023; Westby et al., 2021), emphasising the importance of early identification and sustained psychological support (Fernandez-Pineda et al., 2024). Despite these risks, miscarriage and foetal loss remain surrounded by silence and taboo in public discourse and healthcare, leaving many parents with inadequate professional support and limited social understanding, which may exacerbate psychological distress (Burden et al., 2016).

Recent studies highlight persistent shortcomings in healthcare provision, with women reporting limited continuity, emotional sensitivity, and tailored follow-up after loss (Freitas et al., 2025; Plagg et al., 2025). Although specialised support is increasingly offered through hospital-based bereavement teams, voluntary organisations, counselling services, and peer support groups, many women still experience unmet needs and fragmented care (Flach et al., 2022). These gaps highlight the importance of understanding women's subjective experiences of recovery, coping, and quality of life.

This study explores women's lived experiences of quality of life following late miscarriage or foetal loss, focusing on psychological, emotional, and physical changes over time and perceptions of existing support services, to inform improvements in healthcare delivery, bereavement support, and psychosocial interventions for families affected by pregnancy loss.

Methods

We conducted a qualitative study with a hermeneutic phenomenological orientation to explore women's experiences of changes in quality of life following late miscarriage or foetal loss. This approach was chosen to describe lived experience while interpreting the meanings informants ascribe to their loss (Birkler, 2021). Reporting followed the COREQ checklist for qualitative research, which is provided as supplementary material.

Informants and recruitment

Six women who had experienced late miscarriage or foetal loss were recruited in September 2023 via a Danish Facebook support group for bereaved mothers. Sample adequacy was assessed using the concept of *information power* (Malterud et al., 2016). Given the study's narrow aim, relatively homogeneous sample, rich interview data, and in-depth analysis using Systematic Text Condensation, six participants were considered sufficient. During analysis, no new themes relevant to the research question emerged, indicating adequate analytic saturation. Inclusion criteria specified miscarriage or foetal loss, including neonatal death within the first 40 days, reflecting the study's focus on pregnancy and the immediate postnatal period, which differ from the experience of losing an older child. Deaths up to 40 days postpartum were included to reflect an experiential understanding of perinatal loss. While timing and type of loss may shape experiences, the analysis focused on shared meanings rather than comparative differences. Participants were interviewed at varying times following the loss; however, time since loss was not systematically recorded, as the study focused on shared lived experiences of perinatal loss rather than temporal variation in women's experiences. We acknowledge the self-selection bias of online recruitment and the likelihood that participants may hold strong views about their experiences, which was considered in interpretation (Kvale and Brinkmann, 2015). Because recruitment occurred about a year after the acute COVID-19 pandemic, service availability, social support, and coping contexts during that period may have influenced participants' narratives (Seeberg et al., 2022).

Data collection

Interviews were conducted online and lasted approximately 105 min. Only the interviewer and participant were present at the interview. Interviews were scheduled at informants' preferred times and modalities to reduce burden and enhance comfort, audio-recorded with permission, and transcribed verbatim. Individual semi-structured interviews were conducted to enable in-depth narration while allowing flexibility to probe emergent topics (Kvale and Brinkmann, 2015). The interview guide was not pilot tested for ethical reasons; instead, it was informed by relevant literature, validated questionnaires, and the interviewer's prior experience. The interview guide was informed by domains from the World Health Organization Quality of Life assessment (e.g., psychological, physical, social relationships, environment), activity balance from activity science, and theories of belonging, social connection, and relatedness (Baumeister and Leary, 1995; Kristensen et al., 2022; Lambert et al., 2013; Skevington et al., 2004). Questions addressed emotional reactions, bodily changes, daily routines, relationships, and experiences with healthcare or community support after the loss (see Supplementary material).

Data analysis

Analysis was conducted by the first author and followed systematic text condensation to ensure a transparent, stepwise procedure from raw text to synthesised descriptions (Malterud, 2024). First, transcripts were red repeatedly to gain an overall impression and to bracket preliminary preconceptions while reflexive memos, analytic notes and tentative themes related to life quality after loss were noted. Second, meaning units were identified and coded across the material, segments that spoke to emotional, physical, relational, and existential changes, as well as encounters with support services. Third, coded meaning units were condensed into artificial quotations and code groups that captured recurrent patterns (e.g., disruptions to daily activity balance; forms of belonging and social support; embodied grief; perceived adequacy of care) were constructed. Finally, the condensates were synthesised into analytically grounded descriptions and categories that address the research questions. Throughout, treated systematic text condensation was not as theory generation but as an empirically anchored pragmatic method suited to health-research interviews (Malterud, 2024). Analytic saturation was assessed during the iterative process of Systematic Text Condensation. Themes were continuously compared and refined across interviews, and no new themes relevant to the research question emerged in the final interviews.

The analytic stance was hermeneutic phenomenological. Phenomenology guided close attention to how experiences appeared in informants' life worlds, while hermeneutics- oriented interpretation toward situated meaning, acknowledging the researcher's historically informed preunderstanding (Kvale and Brinkmann, 2015). This dual stance supported both careful description and interpretive clarification of what changes in quality of life meant to women after late miscarriage or foetal loss.

Reflexivity

The first author's experience of late miscarriage informed the research question and heightened sensitivity to participants' narratives. Acknowledging that no analysis is free from preunderstanding, we applied disciplined reflexivity to examine how perspectives shaped decisions and interpretations (Collin et al., 1995). Strategies included post-interview journaling, coding memos, and iterative team discussions that challenged assumptions about grief, quality of life, and belonging. Guided by a hermeneutic perspective, analysis moved between parts and whole in a "hermeneutic spiral," allowing interpretations to be refined by the data (Collin et al., 1995; Kvale and Brinkmann, 2015). Consistent with phenomenology, women's descriptions were foreground before interpretation, with theory bracketed where possible (LeVasseur, 2003).

To support ethical and relational reflexivity, the interviewer disclosed her experiential proximity in recruitment materials and interview openings to reduce power differentials and acknowledge sensitivity (Kvale and Brinkmann, 2015). Empathy was balanced with analytical distance by using the semi-structured guide to ensure coverage of core domains while allowing informants to emphasise what mattered most (Baumeister and Leary, 1995; Kristensen et al., 2022; Lambert et al., 2013; Skevington et al., 2004).

Theoretical framework

Quality of life was understood through the WHOQOL framework, which defines it as individuals' perceptions of their position in life in relation to cultural context, goals, and concerns, incorporating objective and subjective dimensions (The World Health Organization Quality of Life Assessment (WHOQOL), 1995). WHOQOL assesses physical health, psychological wellbeing, social relationships, and environmental conditions (The Whoqol Group, 1998), making it well suited for exploring parental experiences following late miscarriage or foetal loss. Its emphasis on emotional wellbeing and social connectedness is particularly relevant given reports of grief, depression, and feelings of isolation among bereaved parents (Berry, 2022; Gold et al., 2016). Activity balance was included as a complementary perspective, addressing how time and energy are distributed across daily activities (Kristensen et al., 2022), as disruption to routines can reduce wellbeing while re-establishing balance may support recovery. Finally, the concept of belonging highlights the importance of acceptance and support within social networks in mitigating isolation and fostering resilience after pregnancy loss (Baumeister and Leary, 1995; Lambert et al., 2013).

Ethical considerations

This study adhered to the Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2013), with data anonymized and stored in accordance with GDPR. Under Danish law (Danish National Center for Ethics, 2025; The Danish Parliament, 2020), interview- and questionnaire-based studies without biomedical intervention or use of human biological material are exempt from ethics committee approval; therefore, ethical approval was not required. Informants received study information, provided written informed consent, and were informed of their right to withdraw at any time. Interviews followed a trauma-sensitive approach with opportunities for breaks and reflection, and the interviewer disclosed personal experience of pregnancy loss to foster trust while prioritizing participants' narratives (Kvale and Brinkmann, 2015). Reflexive practice was applied throughout recruitment, data collection, and analysis to minimize bias (Collin et al., 1995). Informants could contact the researcher after the interview for follow-up or clarifications, maintaining control over their contribution.

Results and analytic interpretation

Using systematic text condensation (Malterud, 2024), five themes captured women's experiences after late miscarriage or foetal loss: Mental and physical consequences of the loss, social relationships and isolation, the healthcare system's role, existential reflections and rituals, and everyday life under strain and traces of growth.

Informants overview

Table 1 summarizes demographic information, type and timing of perinatal loss, diagnoses, and number of living children for the six informants. Losses include early and late miscarriages, intrauterine foetal deaths, intrapartum deaths, and neonatal deaths up to 40 days postpartum.

Mental and physical consequences of the loss

The women described intense emotional reactions including sadness, shock, anger, and a deep sense of meaninglessness. Several recalled screaming when they realised their child had died:

> *"I was in the deepest grief. For instance, there was that scream that came out of me when they took my girls. I had no control over it, and it still echoes in my head."* (Nina)

Others spoke of losing all hope and optimism for the future:

> *"I think a sense of meaninglessness will always weigh on me. I cannot imagine becoming happy… […] …I no longer have hopes and dreams for the future as I once did. I am not as optimistic. I find it difficult to imagine what a good life would look like."* (Anna)

These accounts illustrate a profound reduction in psychological wellbeing, a core WHOQOL domain (Skevington et al., 2004). The women's narratives show that the loss was not merely a single traumatic event but a rupture that continued to shape emotional life and sense of purpose.

Lasting clinician-diagnosed psychological consequences were common, including intrusive fears of death, hypervigilance, and anxiety:

> *"I developed complex PTSD and severe anxiety, and now it is moderate anxiety. My baseline stress level in the body is constantly elevated."* (Nina)

Memory lapses and concentration difficulties were widespread:

> *"I could not see the point of eating. I could not take in very much. I became tired quickly and lost focus just as quickly."* (Anna)

These symptoms disrupted participation in work and home life, reflecting both WHOQOL's psychological and physical health domains (The World Health Organization Quality of Life Assessment (WHOQOL), 1995).

Grief also manifested somatically:

> *"I have compression fractures in my back. I am tired and drained of energy but unable to sleep."* (Nina)

This combination of exhaustion, pain, and hyperarousal limited engagement in restorative and productive activities, creating a collapse in activity balance (Kristensen et al., 2022) and further eroding quality of life.

Social relationships and isolation

Loss of social bonds and lack of understanding from others emerged as a major theme. Women described friends and colleagues withdrawing. Anna reflected on how socialising had changed:

> *"Before, being with my friends recharged me, but now it takes more of my energy… […] … Now I do not have the same energy for it."*

These experiences show a breakdown in WHOQOL's social relationships domain and demonstrate the centrality of belonging to

Table 1
Characteristics of the informants and circumstances of perinatal loss.

Name	Age	Region	Type of Perinatal Loss	Time of Loss	Child's Diagnosis	Living Children
Anna	32	Southern Denmark	Late neonatal death	10 days after birth	Hypoplastic left heart syndrome	One
Leah	30	Funen	Early miscarriage/ intrauterine foetal death	Twin loss: early miscarriage and intrauterine foetal death at 16 weeks (delivered at 22 weeks)	Unexplained cause	Three
Julie	40	Funen	Intrapartum death	Same day as birth	Unexplained cause	Four
Nina	33	Southern Denmark	Intrapartum death/ neonatal death	Twin loss: Same day as birth and 10 min postpartum (22 weeks' gestation)	Twin-to-Twin Transfusion Syndrome	One
Sofie	48	Zealand	Intrauterine foetal death	29 weeks' gestation	No autopsy performed	None
Klara	32	Southern Denmark	Post neonatal death	40 days after birth	Sudden infant death syndrome	Four

psychological wellbeing (Baumeister and Leary, 1995). When belonging was disrupted, women described feeling stigmatised and unsupported, experiences known to exacerbate grief and depression (Lambert et al., 2013).

This social withdrawal left many feeling isolated, stigmatised, and unsupported. Yet there were also examples of profound care and solidarity.

Julie recalled how her neighbour recognised what she needed even when she couldn't articulate it:

> *"One day my neighbour knocked on the door and said, "I just have to give you a hug because this is just terrible"….[…]…The next day she came with freshly baked rolls and food that could be heated, and she made sure there was lunch for the children…[…]…I have thanked her a thousand times."*

Together, these accounts reveal that social relations were both a potential source of pain and of healing, when supportive, they offered validation and belonging, but when absent, they amplified loneliness and made coping far harder.

The healthcare system's role

Women's experiences with the healthcare system varied widely. Positive encounters included midwives who offered compassionate guidance: *"My midwife was exceptional, and I would not have managed without her."* (Sofie). Support groups were described as therapeutic:

> *"Coming into the group was simply like pure therapy. It was honestly one of the best things we had done for ourselves."* (Sofie)

Access to chaplains was also meaningful: *"The hospital chaplain at the hospital was a great help."* (Anna). These examples illustrate how compassionate care bolstered WHOQOL's environmental domain, offering safety and practical as well as emotional support.

However, many experiences were distressing. Several women spoke of the pain of being placed on maternity wards with healthy babies:

> *"With a dead baby in my belly, I have to look at lots of beautiful pregnant women who have just given birth to their babies, and I am placed in the maternity unit about to give birth to this dead baby. And I have to hear one baby after another cry for their mother… […] …that was very hard."* (Leah)

Others described being examined in inappropriate spaces due to lack of rooms: *"I was seen in a laundry room because there was no space at the hospital."* (Nina). Bureaucratic processes added further hurt, as when Anna received a letter referring to her 'maternity leave' despite her child's death: *"That hurts. You feel alone."* Julie expressed intense anger following the loss, which she linked to her experience of care during birth: *"It still feels like my midwife made such a serious mistake that she actually killed my child."* These examples show how failures of sensitivity disrupted both environmental and social domains, threatening women's sense of institutional belonging.

Women also highlighted gaps in support. Group sessions ended abruptly, and waiting times for therapy were long:

> *"You have to find a psychologist yourself, and there is a six-month waiting period… […] …The grief group was really good, but it ended after seven sessions, and then you are left on your own."* (Anna)

Another reflected on the difficulty of seeking help: *"I needed much more support, but I was not able to seek help on my own."* (Nina). Practical needs were also significant, like when Nina's mother had to buy doll clothes to dress her twins who died at birth:

> *"I had no clothes for them. The clothes I had bought, which I had bought really small, were not nearly small enough when they arrived… […] …It touched something in me that there were no clothes for them. It is an enormously significant thing."*

These experiences underline that continuity and sensitivity in health and social services are crucial. When present, they provided safety and support; when absent, they compounded grief and made adjustment harder. A supportive care environment is not just logistical but existential. Validating parents' grief and offering them a place of belonging in the aftermath of loss.

Existential reflections and rituals

Many women turned to rituals and symbolic acts to honour their children and integrate the loss into their lives. They described planting trees, celebrating birthdays, making jewellery or photo albums:

> *"I have planted two trees for them and had pictures made. I celebrate the children's birthday every year."* (Nina).

Sofie recalled:

> *"A friend brought out the pictures of my daughter and acknowledged her as a child. That felt so good"*.

Anna shared:

> *"I want to remember the children we have lost by talking about it and I have had jewellery made with the children."*

These practices can be seen as activities that restore meaning within WHOQOL's psychological wellbeing domain and contribute to a renewed activity balance, providing rhythm and symbolic continuity in daily life.

Spirituality and faith played a complex role. For some, contact with a priest was deeply supportive:

> *"The hospital chaplain helped me find calm and gave me space to be angry and sad and to cry and scream."* (Sofie)

Others experienced a crisis of faith:

> *"My view of religion has completely changed. I have very little faith in God and Christianity, especially after this. I am angry. I used to believe in*

> *karma. That has caused problems now. How did I deserve this? How did my girls deserve this?"* (Nina).

Several found comfort in believing they would one day be reunited: *"I believe in life after death. That is where I will meet my children again." (Anna)*. Sofie noted:

> *"I still believe that there is something between heaven and earth. But religion does not give me the answers."*

These accounts demonstrate that the spirituality-, religion-, personal beliefs facet of WHOQOL can be both a source of resilience and of distress when belief systems are challenged.

Everyday life under strain and traces of growth

Daily life was often profoundly disrupted. Women struggled with basic tasks such as bathing, eating, or leaving the house:

> *"Even having the strength to take a shower was a challenge. Making food was a challenge, and simply getting out the door was a challenge."* (Sofie)

Work became difficult or impossible:

> *"I have worked since I was a teenager, but now I do not work at all. I no longer contribute to society, and I wonder if I even have a voice."* (Nina)

Julie noted cognitive strain:

> *"I cannot keep up with fast conversations. I cannot participate in work meetings. I am partially on sick leave. I lived on coffee and liquorice."*

Others described hypervigilance toward surviving children:

> *"If I left the room she was in to get a glass of water, I would hold my breath until I came back, because I already imagined finding her lying in a huge pool of blood when I returned. That pervasive fear of losing her has stayed with me."* (Nina)

These disruptions affected multiple WHOQOL domains, physical health, psychological wellbeing, and environment, and created a state of occupational imbalance.

Despite this strain, some women described personal growth over time. Anna explained how her self-awareness and boundary setting had been affected:

> *"My whole idea of life with children, work, and friendships has been turned upside down. In other ways, I have become more in touch with myself, I have become better at sensing my own needs and at saying no".*

Others experienced to have become a better person:

> *"I believe that he (the child she lost) has given me something fundamental. I have put on the brakes to become a better version of myself."* (Leah)

> *"I actually like the new version of myself. I will never be the old Julie again, because completely different emotions are at play. But I do not think my new self is a bad thing, because I think I am beginning to appreciate life more. And I make bigger reflections than I used to and am better at sensing what I need. What I want."* (Julie)

This duality of vulnerability and growth shows how the loss became a turning point, painful, but also reshaping priorities and values. These reflections can be interpreted through the lens of post-traumatic growth (Tedeschi and Calhoun, 2004), suggesting that re-establishing balance and selectively re-engaging in meaningful activities supported a reoriented sense of identity and purpose, even as grief remained.

Discussion

This study explored women's experiences of late miscarriage and foetal loss and how these events shaped their mental health, social relations, and daily lives. While WHOQOL domains are used here as an interpretive framework to contextualize the findings, the analysis itself was guided by a hermeneutic phenomenological focus on women's lived experiences and meaning making following loss.

Women reported intense emotional pain, persistent anxiety, and physical exhaustion, consistent with studies showing high rates of depression and PTSD after perinatal loss (Gold et al., 2016; Herbert et al., 2022). Reported identity changes suggests that perinatal loss is not only acute grief but a transformative event affecting women's self-concept, aligning with research on prolonged grief disorder (Flach et al., 2022).

Social relationships were both a source of suffering and support. Consistent with Minton et al. (2023), women experienced stigma, withdrawal, isolation, and loss of belonging, while practical and emotional support were highly valued, underscoring the potential of peer networks and targeted psychoeducation to strengthen coping.

Healthcare encounters strongly shaped experiences of loss. Empathic midwives, hospital chaplains, and support groups were reported as transformative, whereas placement on wards with crying newborns or impersonal communication caused significant distress, underscoring the need for trauma-informed care, clear communication, and continuity of psychosocial support beyond the immediate postpartum period (Burden et al., 2016). Based on the findings, we recommend that midwifery-led care prioritise separating bereaved parents from maternity wards with healthy newborns and ensure continuity through a designated midwife after loss. In resource-constrained settings, this could be achieved through low-cost organisational measures such as flexible room allocation, clear communication protocols, and basic training in trauma-informed bereavement care.

Women engaged in rituals and existential reflection as part of meaning-making, aligning with Wojtkowiak et al. (2021), who show that rituals can reduce symptoms of complicated grief. For some, faith provided comfort; for others, the loss challenged or diminished religious beliefs. Addressing spiritual and existential needs may therefore be an important component of bereavement care (Eklund et al., 2022).

Finally, informants reported profound disruptions to daily functioning, including inability to work, difficulty maintaining routines, and social withdrawal. These findings suggest that interventions should not only focus on psychological support but also help women re-establish a balanced and meaningful everyday life (Kristensen et al., 2022). Some women also described personal growth and redefined priorities.

Taken together, these findings highlight the need for integrated bereavement care that addresses psychological, social, physical, and existential dimensions of loss, which in the discussion are interpreted in relation to WHOQOL domains to support implications for practice. Long-term, flexible support options, including peer groups, specialized psychological care, and workplace accommodations, may help women navigate the lasting impact of late miscarriage and foetal loss and support recovery of well-being and identity.

This study highlights priorities for advancing research and practice. Longitudinal studies should track the course of complex PTSD, prolonged grief, and anxiety after late loss, and test interventions for physical symptoms such as fatigue and musculoskeletal pain. Further work should evaluate sustained bereavement care models, including the timing and delivery of psychosocial support, and examine how meaning-making and rituals can be integrated. Intervention studies could explore whether structured occupational or lifestyle support helps restore routines and quality of life.

In practice, maternity care teams should proactively screen for mental health difficulties, ensure clear referral pathways, and receive training and promote compassion, continuous care while avoiding distressing encounters. Partner and community education may reduce stigma and strengthen social networks, while integrating rituals into bereavement care could support adjustment. Holistic follow-up should address women's return to daily roles and occupational participation. At the policy level, improved access to psychological services and funding for long-term, family-oriented bereavement programs are needed to extend support beyond the immediate aftermath of loss.

Strengths and limitations

A strength of this study is the use of in-depth, semi-structured interviews allowed women to share nuanced experiences of late miscarriage and foetal loss in their own words, and the study was strengthened ethically and methodologically by its trauma-sensitive interviewing approach. Further, the study's focus on existential reflections and ritual practices adds an important contribution to the field, as such aspects are not commonly explored in perinatal loss research. Systematic text condensation provided a transparent and stepwise analytic process, enhancing dependability (Malterud, 2024). This, in combination with phenomenological hermeneutics, offers both interpretive depth and analytic clarity. Reflexive practice, including journaling and iterative discussion, helped ensure that interpretation was grounded in informants' accounts rather than researcher assumptions. Finally, a key strength of the study is its integrative conceptual framing, which uniquely brings together psychological, social, embodied, and existential dimensions of perinatal bereavement. In addition, the findings have clear practical relevance for midwifery-led bereavement care, highlighting the importance of continuity, relational support, and attention to everyday and existential needs beyond the immediate postpartum period.

Nevertheless, several limitations should be acknowledged. The small, self-selected sample limits transferability to broader populations, and women who volunteered may have been those most ready to share their experiences. Recruitment via an online peer-support group may also have overrepresented women with ongoing distress, and heterogeneous inclusion criteria may have encompassed qualitatively different loss experiences, yet no subgroup analyses were conducted. As with all interview studies, findings rely on self-report and may be shaped by recall or emotional state. Within a hermeneutic phenomenological approach, the use of predefined quality-of-life domains may have shaped participants' narratives. I addition, the absence of formal member checking or triangulation constrain transparency and dependability. The researcher's own experience of pregnancy loss may have influenced interpretation, although reflexive strategies were employed to minimize bias (Kvale and Brinkmann, 2015).

Conclusion

This study explored how late miscarriage and foetal loss affect women's quality of life, focusing on psychological, social, and existential consequences in both the short and long term. Using a qualitative design and systematic text condensation, we analysed in-depth interviews with six women and identified five overarching themes: mental and physical consequences, social relationships and isolation, the role of the healthcare system, existential reflections and rituals, and strain on everyday life.

Findings show that women face significant emotional and physical challenges after late loss, including symptoms consistent with prolonged grief, anxiety, and PTSD. They often experience a diminished sense of self, disrupted daily routines, and difficulty re-engaging in work and social roles. Social withdrawal and stigma intensified distress, though supportive relationships provided important buffers. The healthcare system was described as both a source of support and additional pain, with empathic midwives and support groups valued, but systemic gaps and abrupt discontinuities leaving many feeling abandoned.

Rituals and existential reflections played a crucial role in helping women integrate their loss, reconstruct meaning, and honour their children. Many also described a permanent shift in identity and priorities, underscoring the enduring nature of grief.

Taken together, these findings highlight the need for flexible, continuous, and specialised support extending beyond the immediate aftermath of loss. Interventions should address psychological wellbeing, activity balance, and social reintegration, while recognising that grief is evolving rather than linear. Incorporating rituals, meaning-making practices, and improving public understanding of perinatal loss may help reduce stigma and foster belonging.

This study contributes to public health by emphasising that supporting parents after late miscarriage and foetal loss requires a holistic approach that acknowledges the complexity and duration of grief, strengthens social networks, and ensures sustained access to compassionate, tailored care. By doing so, health systems can better protect women's mental health and promote long-term wellbeing.

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CRediT authorship contribution statement

Alexia Nicholine Juul Konstantinou: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Julie Dalgaard Guldager:** Writing – review & editing, Supervision, Methodology.

Declaration of competing interest

The authors have no competing interests to declare that are relevant to the content of this article.

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Supplementary materials

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