

Psychological Impact of Recurrent Pregnancy Loss and the Effectiveness of a Nurse-Led Grief and Coping Intervention Among Affected Women: A Narrative Review

Tanuja Semwal¹

Associate Professor, Sai Nursing College, Dehradun, Uttarakhand

Nitesh Kumar²

Nursing Tutor, Government College of Nursing, Almora, Uttarakhand

Neelam Joshi³

Assistant Professor, Motherhood University, Roorkee, Haridwar, Uttarakhand

Akansha Adhikari⁴

P.G. Tutor, Swami Vivekanand Institute of Nursing, Jaspur, Uttarakhand

Deeksha Yadav⁵

P.G. Tutor, Teerthanker Parshvnath College of Nursing, TMU, Uttar Pradesh

Abstract

Recurrent pregnancy loss (RPL), generally defined as two or more failed pregnancies, affects an estimated 1%–5% of couples attempting to conceive and carries a psychological burden that is distinct from, and often more severe than, that of a single miscarriage. Women who experience RPL report elevated rates of depression, anxiety, post-traumatic stress symptoms, complicated grief, guilt, and self-blame, with distress frequently persisting into and complicating subsequent pregnancies. Because RPL is a socially disenfranchised form of loss that receives comparatively little formal bereavement support, nurses are often the first and most consistent point of contact for affected women across diagnostic work-up, pregnancy loss management, and antenatal surveillance in a subsequent pregnancy. This narrative review synthesizes the current evidence on (a) the psychological and emotional impact of RPL on women, (b) the theoretical basis for nurse-led grief and coping support, and (c) the effectiveness of nurse-led grief and coping interventions in reducing depression, anxiety, stress, and grief and in improving coping and quality of life. Evidence from randomized controlled trials, quasi-experimental studies, and systematic reviews indicates that structured nurse-led counseling — including individual counseling sessions, Swanson's Theory of Caring-based programs, and hybrid interventions combining hospital counseling with telephone or mobile-application follow-up — produces clinically meaningful reductions in grief, depression, anxiety, and stress relative to routine care alone, and improves coping and adjustment scores. However, the evidence base remains limited by small sample sizes, heterogeneous outcome measures, short follow-up periods, and inconsistent intervention protocols. The review concludes with implications for nursing practice, including routine psychological screening, structured grief-

and-coping counseling protocols, couple-inclusive approaches, and staff training and support, along with recommendations for larger, standardized trials of nurse-led interventions specific to RPL.

Keywords: recurrent pregnancy loss; miscarriage; perinatal grief; depression; anxiety; nurse-led intervention; coping; psychological support; bereavement counselling

1. Introduction

Pregnancy loss is one of the most common adverse outcomes of reproduction, and for a substantial minority of women it recurs. Recurrent pregnancy loss (RPL) has traditionally been defined by the World Health Organization and the Royal College of Obstetricians and Gynaecologists as three or more consecutive pregnancy losses before 24 weeks of gestation, but the American Society for Reproductive Medicine (ASRM) and the European Society of Human Reproduction and Embryology (ESHRE) have moved toward a broader definition of two or more clinical pregnancy losses, not necessarily consecutive, on the grounds that patient distress and diagnostic yield do not differ meaningfully between two and three losses. Depending on the definition applied, prevalence estimates range from roughly 1%–2% up to 5% of couples attempting pregnancy, with some population-based studies reporting even higher figures when the two-loss ASRM/ESHRE criterion is used.

Despite decades of research into the biomedical causes of RPL — endocrine, anatomical, immunological, genetic, and thrombophilic factors chief among them — a definitive cause remains unidentified in roughly half of couples even after a full diagnostic work-up. This diagnostic uncertainty compounds an already profound emotional burden: each loss re-opens grief for the pregnancies that came before it, while the search for an explanation, and the prospect of trying again, keep the experience psychologically unresolved in a way that a single, explained miscarriage often is not.

Unlike stillbirth or neonatal death, miscarriage and recurrent miscarriage are frequently treated by the wider society, and sometimes by health systems themselves, as minor or private medical events rather than as bereavements. This has been described as a form of disenfranchised grief — loss that is not openly acknowledged, socially validated, or publicly mourned — which can intensify feelings of isolation, stigma, and self-blame among affected women. Nurses and midwives, who typically provide the most sustained direct contact with women across diagnostic visits, pregnancy loss management, and surveillance of subsequent pregnancies, are uniquely positioned to identify psychological distress early and to deliver structured emotional support as part of routine care. This has given rise to a distinct body of research on nurse-led grief and coping interventions for RPL, ranging from brief bereavement counseling delivered immediately after a loss to multi-session, theory-based counseling programs delivered across a pregnancy or diagnostic work-up.

This review addresses two linked questions. First, what is the nature and magnitude of the psychological impact of RPL on affected women, including depression, anxiety, stress, grief, post-traumatic stress symptoms, and impaired quality of life? Second, what evidence exists for the effectiveness of nurse-led grief and coping interventions in reducing this burden and improving women's coping and psychological wellbeing? The review closes by drawing out implications for nursing practice and directions for future research.

2. Review Approach

This is a narrative review rather than a systematic review or meta-analysis; no formal protocol was registered and no independent risk-of-bias assessment or quantitative pooling of effect sizes was undertaken. Literature was identified through targeted searches of biomedical and nursing databases (including PubMed/MEDLINE, ScienceDirect, Wiley Online Library, and Frontiers) using combinations of the terms recurrent pregnancy loss, recurrent miscarriage, habitual abortion, perinatal loss, grief, depression, anxiety, post-traumatic stress, coping, nursing counseling, nurse-led intervention, and bereavement care. Priority was given to systematic reviews and meta-analyses, randomized controlled trials, and quasi-experimental intervention studies published within roughly the past decade, supplemented by earlier foundational studies on perinatal bereavement counseling and by guideline documents from ASRM, ESHRE, and RCOG on the definition and epidemiology of RPL. Findings are synthesized descriptively, and reported effect sizes and statistics are cited as presented in the original studies.

3. Psychological Impact of Recurrent Pregnancy Loss

3.1 Depression, Anxiety, and Stress

A consistent finding across cross-sectional studies, cohort studies, and meta-analyses is that women with RPL show substantially higher rates of depression, anxiety, and stress than women without a history of pregnancy loss. A systematic review and meta-analysis focused specifically on RPL found that women who had experienced RPL had roughly a fourfold to fivefold higher likelihood of moderate-to-severe depression than comparison groups, alongside elevated anxiety and stress; pooled estimates from that review placed moderate-to-severe depression at approximately 19.5% among women with RPL, compared with about 7% among their male partners who had undergone the same losses, indicating a marked gender difference in psychological burden. Other reviews describe depressive symptoms occurring in roughly 20%–55% of affected women and anxiety symptoms in roughly 20%–40%, with moderate-to-severe depression diagnosed in 8%–20% and post-traumatic stress disorder identified in as many as 25%–39% of affected women in some samples; some studies additionally report a higher risk of obsessive-compulsive symptoms after early pregnancy loss. Women with RPL have also been shown to report lower quality of life and greater psychological distress than women without such a history, and, compared with women who have had only a single miscarriage, those with recurrent losses tend to show more severe and more prolonged depressive and stress symptoms, with a greater negative impact on mental health carried forward into later pregnancies.

3.2 Grief, Guilt, Stigma, and Disenfranchised Loss

Because miscarriage and stillbirth are often not recognized by society as equivalent to other bereavements, they have been characterized as socially disenfranchised losses that can give rise to complicated grief and profound isolation. Population surveys have documented biased or dismissive public attitudes toward miscarriage, which appear to reinforce affected women's self-blame and sense of stigma. Feelings of grief following RPL have been described as comparable in intensity to grief following a major bereavement more broadly, typically easing over roughly six to twelve months for many women, although a subset continues to experience clinically significant grief, guilt, anger, and preoccupation with the loss well beyond this period.

3.3 Anxiety in Subsequent Pregnancy and Anticipatory Grief

A distinctive psychological feature of RPL is that grief over past losses becomes intertwined with acute anxiety and hypervigilance about a future or current pregnancy. Qualitative accounts describe women experiencing persistent apprehension that resurfaces at times of stress even years after their losses, particularly during a subsequent pregnancy, alongside anticipatory grief for a pregnancy that has not yet been lost but is feared to be at risk. This chronic uncertainty — sometimes summarized by women as not knowing whether the pregnancy will again end in loss — has been shown to affect maternal-fetal attachment and to prolong psychological strain well into a successful pregnancy, rather than resolving once a live birth becomes more likely.

3.4 The Couple Dimension

Most RPL research has historically focused on women, but a smaller body of couple-oriented research indicates that male partners also experience grief, helplessness, anxiety, depression, anger, guilt, and loneliness after pregnancy loss, generally with lower intensity and shorter duration than their female partners. Men have also reported external pressure to remain outwardly composed in order to support their partners, which may suppress or delay their own grief responses. Because psychological burden differs by sex and because partners influence one another's coping, several reviews argue that support should, where feasible, address both members of the couple rather than the woman alone, since couple-focused interventions have been shown to strengthen partners' capacity to support one another.

4. Theoretical Basis for Nurse-Led Grief and Coping Support

Two theoretical frameworks recur across the nurse-led intervention literature. The first is Lazarus and Folkman's transactional model of stress and coping, which frames RPL as a chronic, recurring stressor that women appraise and respond to through problem-focused and emotion-focused coping strategies; nursing counseling interventions informed by this model typically aim to strengthen adaptive coping (for example, cognitive reappraisal and forward planning) while reducing maladaptive patterns such as avoidance and self-blame. The second is Swanson's Theory of Caring, which conceptualizes nursing support around five caring processes — knowing the patient's experience, being with her emotionally, doing for her practically, enabling her to problem-solve and access resources, and maintaining belief in her capacity to cope — and has been used explicitly as the structuring framework for at least one randomized nursing-care program for women undergoing pregnancy loss. Interventions built on these frameworks share a common structure: they combine an empathic, relationship-based counseling component with concrete informational and coping-skills content, delivered by a nurse who maintains continuity of contact with the woman across a period of heightened vulnerability such as diagnostic testing or a subsequent pregnancy.

5. Evidence on Nurse-Led Grief and Coping Interventions

5.1 Individual and Group Nursing Counseling

Several randomized controlled trials have tested brief, nurse-delivered counseling protocols for women with recurrent miscarriage. In a randomized controlled trial conducted in Taiwan, 62 women with at least two consecutive miscarriages were assigned to either routine care or routine care plus three sessions of nursing counseling delivered during the 12-week prenatal genetic testing period; the counseling was designed to promote self-awareness, reduce self-blame, clarify medical doubts, and encourage forward-looking life

planning. The intervention group showed significant paired pre-post reductions in stress and depression, whereas the control group did not, indicating that even a brief, structured counseling protocol delivered at a key clinical decision point can measurably improve psychological outcomes.

Earlier controlled trials of individual counseling delivered by nurses to women bereaved by spontaneous abortion have produced more mixed results: one trial of 280 women receiving two individual nursing counseling sessions did not find a statistically significant difference in depression or general health questionnaire scores between intervention and control groups, suggesting that intervention timing, dose, and content matter and that a small number of unstructured counseling sessions may be insufficient on their own to shift standardized depression scores.

5.2 Bereavement Interventions Delivered Immediately After Loss

A classic randomized trial of a secondary bereavement intervention, grounded in professional grief-care guidelines and delivered to women shortly after a miscarriage at 12–20 weeks' gestation, found that the intervention group reported significantly lower levels of despair on the Perinatal Grief Scale than the usual-care control group at a two-week follow-up, although active grieving remained high in both groups and coping difficulty did not differ significantly between groups. This pattern — reduced despair without a corresponding reduction in active grieving in the short term — illustrates that early bereavement counseling may attenuate the most distressing dimension of grief without eliminating the grieving process itself, which is expected and appropriate in the immediate aftermath of a loss.

5.3 Theory-Based, Multi-Modal Nursing Care Programs

More recent trials have tested multi-component nursing programs explicitly grounded in Swanson's Theory of Caring and combining hospital-based counseling with mobile-application support and telephone follow-up after discharge. In a prospective randomized controlled trial conducted in a Turkish tertiary hospital among 50 women whose pregnancies were terminated in the second trimester, the intervention group showed significantly lower perinatal grief, depression, anxiety, and stress scores, together with significantly higher coping and adjustment scores, than the control group at follow-up assessments extending to 12 weeks after discharge; the intervention group also reported lower perceived labor pain, shorter time to discharge, and greater readiness for a subsequent pregnancy. This program illustrates the potential of layering brief in-hospital counseling with structured post-discharge follow-up (via mobile application and telephone) to sustain psychological benefit beyond the acute hospital stay.

5.4 Self-Administered and Digitally Delivered Coping Interventions

Recognizing that formal nurse contact time is limited, researchers have also developed nurse-designed, self-administered coping tools intended to extend support between clinical visits. The Positive Reappraisal Coping Intervention (PRCI), originally validated among fertility patients awaiting IVF outcomes, was adapted and tested in a feasibility randomized controlled trial for women with RPL during the anxious early-pregnancy waiting period; it consists of a brief explanatory leaflet and a short set of positive reappraisal statements that women read at least twice daily, and feasibility data suggested it is an acceptable, low-cost option with no evident downside, worthy of a larger definitive trial. More recent digital approaches have moved toward guided, internet-delivered psychological programs — for example, a protocol for an internet-delivered compassion-focused therapy program for women with RPL, incorporating psychoeducation and experiential

exercises with psychiatric-nursing-guided support via weekly messages — reflecting a broader shift toward scalable, technology-supported extensions of nurse- and clinician-led psychological care.

5.5 Synthesis Across Meta-Analytic Evidence

A systematic review and meta-analysis of nonpharmacological interventions for parents experiencing perinatal loss, which included several nurse-delivered counseling trials, concluded that such interventions reduce grief, stress, depression, and anxiety among parents with miscarriage, and are similarly effective in reducing stress specifically among parents with recurrent miscarriage; couple-focused formats were identified as particularly beneficial because they addressed the psychological needs of both partners simultaneously. Within that meta-analysis, a four-arm randomized trial of brief nurse counseling was highlighted as producing the largest treatment effects on resolving grief and depression among the interventions reviewed, for both women and their male partners, relative to a no-treatment control condition. A separate systematic review of nursing interventions to facilitate grieving after perinatal death likewise concluded, based on four rigorously appraised studies, that nursing interventions delivered before and after a perinatal loss can improve psychological self-concept, role functioning, couple relationship quality, depression, post-traumatic stress, and grief symptoms.

6. Discussion

Taken together, the evidence indicates two clear conclusions. First, RPL carries a substantial and well-documented psychological burden for women — encompassing depression, anxiety, stress, complicated and disenfranchised grief, guilt, and anticipatory anxiety in subsequent pregnancies — that is generally more severe and more persistent than the psychological impact of a single, isolated miscarriage. Second, nurse-led grief and coping interventions, particularly those that are structured, theory-informed, and delivered across more than a single encounter, are associated with meaningful reductions in depression, anxiety, stress, and grief, and with improvements in coping and readiness for a subsequent pregnancy, when compared with routine care alone.

Several patterns are worth highlighting for practice. Interventions that combine an empathic, relationship-based counseling component (consistent with Swanson's Theory of Caring) with concrete coping-skills content and continuity of contact — for example, hospital counseling reinforced by telephone or mobile-application follow-up — appear to produce broader and more durable benefit than a small number of unstructured counseling sessions alone. Interventions timed to coincide with a period of heightened uncertainty, such as diagnostic work-up or the early weeks of a subsequent pregnancy, appear well matched to when women's distress and need for support are greatest. Finally, several reviews converge on the observation that couple-inclusive approaches, which acknowledge and address the male partner's grief alongside the woman's, may enhance outcomes for women by strengthening the support available to them within the relationship.

The evidence base nonetheless has important limitations. Many trials have small sample sizes, are conducted at a single center, and use heterogeneous outcome measures (grief scales, depression inventories, and stress or coping scales differ across studies), which complicates direct comparison and precludes confident pooled effect estimates. Follow-up periods are frequently short, often limited to a matter of weeks, so the durability of benefit beyond three to twelve months is not well established. Some studies of brief individual counseling have failed to show significant benefit on standardized depression measures, indicating that dose, timing, and structure of counseling matter and that not all nurse-delivered support produces measurable psychological benefit. Very few trials have been conducted specifically in populations meeting the current ASRM/ESHRE two-loss definition of

RPL, with many drawing instead on broader miscarriage or perinatal-loss samples that include women with a single loss.

There are also workforce implications. Nurses delivering repeated, emotionally demanding grief counseling to women experiencing cyclical loss are themselves at risk of emotional labor and burnout, and qualitative research on gynecological nurses working in early pregnancy units has described the toll of this work alongside the protective role of organizational support, debriefing, and RPL-specific training. Sustainable implementation of nurse-led grief and coping programs therefore requires attention not only to patient-facing protocol design but also to staff training, caseload, and institutional support structures.

7. Implications for Nursing Practice

- Incorporate routine psychological screening (for depression, anxiety, and perinatal grief) into standard RPL diagnostic and follow-up visits, rather than relying on spontaneous disclosure of distress.
- Adopt structured, multi-session grief and coping counseling protocols — ideally theory-informed (e.g., Swanson's Theory of Caring or a stress-and-coping framework) — rather than a single, unstructured supportive conversation.
- Time key counseling contacts to coincide with periods of heightened vulnerability: at diagnosis, immediately after each loss, during diagnostic work-up, and during the early weeks of a subsequent pregnancy.
- Extend nurse contact beyond the hospital encounter using low-cost adjuncts such as telephone follow-up, mobile applications, or self-administered coping tools (e.g., positive reappraisal materials) to sustain support between visits.
- Where feasible, offer couple-inclusive counseling that acknowledges the male partner's grief and strengthens the couple's capacity to support one another, rather than addressing the woman in isolation.
- Provide nurses delivering this care with training in perinatal bereavement counseling and with organizational support (debriefing, peer support, manageable caseloads) to protect against emotional labor and burnout.
- Avoid assuming that pregnancy loss is a resolved, purely physical event; treat RPL as a bereavement requiring the same acknowledgment and follow-up afforded to other significant losses.

8. Limitations of This Review and Directions for Future Research

As a narrative rather than systematic review, this synthesis did not apply formal risk-of-bias appraisal or quantitative meta-analysis, and the selection of studies, while guided by targeted database searches, is not guaranteed to be exhaustive. Future work would benefit from a formal systematic review or meta-analysis restricted specifically to nurse-led interventions in populations meeting a consistent RPL definition (two or more losses, per ASRM/ESHRE), with harmonized outcome measures (for example, the Perinatal Grief Scale, a validated depression and anxiety measure, and a validated coping or adjustment scale) and longer follow-up extending across a subsequent pregnancy and postpartum period. Larger, multicenter randomized trials are needed to confirm the promising effect sizes reported in single-center studies, and further research should examine the comparative effectiveness of different delivery formats (in-person versus telephone versus digital), the optimal number and timing of sessions, the added value of couple-based versus individual formats, and the experiences and support needs of nurses delivering this care.

9. Conclusion

Recurrent pregnancy loss imposes a significant and often under-recognized psychological burden on women, encompassing depression, anxiety, stress, complicated grief, guilt, and persistent anxiety in subsequent pregnancies. Because RPL frequently receives less formal bereavement recognition than other reproductive losses, nurses occupy a pivotal position to identify distress and to deliver structured emotional and coping support across the diagnostic and treatment pathway. Current evidence, while still limited in scale and methodological uniformity, indicates that nurse-led grief and coping interventions — particularly structured, theory-informed, multi-session programs that extend support beyond the acute clinical encounter — can meaningfully reduce depression, anxiety, stress, and grief and improve coping among women affected by RPL. Embedding such interventions into routine reproductive and maternity care, supported by adequately trained and resourced nursing staff, represents a practical and evidence-aligned step toward addressing the psychological dimension of a condition that has long been treated primarily as a biomedical one.

References

- American Society for Reproductive Medicine (Practice Committee). (2012). Evaluation and treatment of recurrent pregnancy loss: A committee opinion. *Fertility and Sterility*.
- Bailey, S., Bailey, C., Boivin, J., Cheong, Y., Reading, I., & Macklon, N. (2015). A feasibility study for a randomised controlled trial of the Positive Reappraisal Coping Intervention, a novel supportive technique for recurrent miscarriage. *BMJ Open*, 5(4), e007322.
- Bailey, S., et al. (2020). Effective support following recurrent pregnancy loss: A randomized controlled feasibility and acceptability study. *Reproductive BioMedicine Online*.
- Bashiri, A., & Borick, J. L. (2016). Recurrent pregnancy loss: Definitions, epidemiology, and prognosis. In *Recurrent Pregnancy Loss* (Chapter). Springer.
- Eleje, G. U., Ugwu, E. O., Igbodike, E. P., Malachy, D. E., Nwankwo, E. U., Ugboaja, J. O., Ikechebelu, J. I., & Nwagha, U. I. (2023). Prevalence and associated factors of recurrent pregnancy loss in Nigeria according to different national and international criteria (ASRM/ESHRE vs. WHO/RCOG). *Frontiers in Reproductive Health*, 5, 1049711.
- Farren, J., Jalmbrant, M., Falconieri, N., Mitchell-Jones, N., Bobdiwala, S., Al-Memar, M., Tapp, S., Van Calster, B., Wynants, L., Timmerman, D., & Bourne, T. (2022). Pregnancy loss: Consequences for mental health. *Frontiers in Global Women's Health*, 3, 1032212.
- Johnson, O. P., & Langford, R. W. (2015). A randomized trial of a bereavement intervention for pregnancy loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 44(4), 492–499.
- Kavlak, O., Atan, Ş. Ü., et al. Individual counseling in mothers bereaved by pregnancy loss: A randomized clinical trial. (PMC9393948).
- Li, S. N., Xie, J., et al. (2024). Effectiveness of nonpharmacological interventions for improving the mental health and other psychosocial outcomes of parents with perinatal loss: A systematic review and meta-analysis. *Depression and Anxiety*, 2024, 2181544.
- Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podsek, M., Stephenson, M. D., Fisher, J., Brosens, J. J., Brewin, J., Ramhorst, R., Lucas, E. S., McCoy, R. C., Anderson, R., Daher, S., Regan, L., Al-Memar, M., Bourne, T., MacIntyre, D. A., Rai, R., Christiansen, O. B., ... Coomarasamy, A. (2021). Miscarriage matters: The epidemiological, physical, psychological, and economic costs of early pregnancy loss. *The Lancet*, 397(10285), 1658–1667.

- Royal College of Obstetricians and Gynaecologists (RCOG). (2011). The investigation and treatment of couples with recurrent first-trimester and second-trimester miscarriage (Green-top Guideline No. 17).
- European Society of Human Reproduction and Embryology (ESHRE) Early Pregnancy Guideline Development Group. (2017). Recurrent pregnancy loss guideline.
- Sun, C. C., et al. (2021). Effectiveness of empathic caring on stress and depression for women with recurrent miscarriage: A randomized controlled trial. *Applied Nursing Research*.
- Nursing Counseling on Stress and Depression for Women With Recurrent Miscarriage (Clinical Trial NCT04361747). *ClinicalTrials.gov*.
- Yesildere Saglam, H., & Kartal, Y. (2024/2025). The effect of nursing care during pregnancy termination on women's prenatal grief, depression, anxiety, stress and coping levels: A randomized controlled study, based on Swanson's Theory of Caring.
- Swanson, K. M. (1991). Empirical development of a middle range theory of caring. *Nursing Research*, 40(3), 161–166.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer Publishing Company.
- Recurrent pregnancy loss (2018). *Australian Journal of General Practice* — summary of RCOG, ASRM, and ESHRE guidelines.
- Couples Miscarriage Healing Project: Randomized Trial (NCT00194844). *ClinicalTrials.gov*.
- Nursing interventions to facilitate the grieving process after perinatal death: A systematic review. (2021). *International Journal of Environmental Research and Public Health* / related PMC article, PMC8197264.
- Guided internet-delivered compassion-focused therapy for women with recurrent pregnancy loss: A protocol of a randomized controlled trial. (2026). Department of Psychiatric Nursing, Graduate School of Medicine, University of Tokyo.
- Recurrent pregnancy loss, psychological distress and wellbeing support for women: A mixed-methods analysis. PMC12581269.
- Psychological support for recurrent pregnancy loss: A review of the current state and challenges. (2026). PMC13476463 / Cureus.
- Depression, stress and anxiety among women and men affected by recurrent pregnancy loss (RPL): A systematic review and meta-analysis. (2023). PMC10301891.
- Recurrent pregnancy loss: A shared stressor — couple-orientated psychological research findings. (2020). *Fertility and Sterility* (ScienceDirect).

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