REVISTA DE ENFERMAGEM REFERÊNCIA
homepage: https://rr.esenfc.pt/rr/
ISSNe: 2182.2883

RESEARCH ARTICLE (ORIGINAL)

Mothers' experiences of fetal death

Vivências maternas em situação de morte fetal

Experiencias maternas en situación de muerte fetal

Ana Maria Casalta Miranda[1]
https://orcid.org/0000-0002-8898-0511

Maria Otília Brites Zangão[2]
https://orcid.org/0000-0003-2899-8768

[1] Barreiro/Montijo Hospital Center, Nossa Senhora do Rosário Hospital, Lisbon, Portugal

[2] Comprehensive Health Research Center. University of Évora, Évora, Portugal

Corresponding author:
Maria Otília Brites Zangão
E-mail: otiliaz@uevora.pt

Received: 19.03.20
Accepted: 04.06.20

Abstract

Background: In 2019, the perinatal mortality rate in Portugal was 3.5%, one of the lowest rates in the past 10 years. Fetal death is one of the most traumatic experiences that women can face.
Objective: To analyze women's feelings/experiences in situations of fetal death.
Methodology: Cross-sectional descriptive study with a qualitative approach. Non-probability convenience sampling. Ten semi-structured interviews with women who experienced fetal death. IRaMuTeQ software, version 0.7 alpha 2, was used.
Results: Women reported that fetal death was a painful experience and that the news of fetal death had been delivered to them in a cold and inhuman way. They were satisfied with the care provided by the nurses, and highlighted the relational component. They also pointed out the lack of information and the preparation for hospital discharge.
Conclusion: Training activities aimed at the development of evidence-based practices should be implemented for the nurses who contact with women who experience fetal death, particularly regarding communication and interpersonal relationships.

Keywords: nurse midwives; postpartum period; women; fetal death

Resumo

Enquadramento: Portugal regista uma taxa de mortalidade perinatal de 3,5% em 2019, verificando-se assim, um dos valores mais baixos nos últimos 10 anos. A morte fetal é uma das experiências mais traumáticas que a mulher pode experimentar.
Objetivo: Analisar os sentimentos/vivências das mulheres em situação de morte fetal.
Metodologia: Assenta num estudo transversal, descritivo com uma abordagem qualitativa. Amostragem não probabilística, de conveniência. Incluiu 10 entrevistas semiestruturadas a mulheres que vivenciaram morte fetal. Utilizado *software* IRaMuTeQ , versão 0.7 alpha 2.
Resultados: As mulheres encaram a morte fetal como uma experiência dolorosa, é evidenciada a transmissão da notícia da morte fetal, como fria e pouco humana. Demonstram satisfação nos cuidados prestados pelos enfermeiros EESMO ao salientarem a componente relacional. As mulheres ressaltaram a falta de informação e de preparação para a alta.
Conclusão: Desenvolvimento de atividades formativas direcionadas aos enfermeiros que contactam com situações de mulheres que vivenciam morte fetal, no sentido de realizarem uma prática baseada em evidências científicas, nomeadamente no que concerne à comunicação e relação interpessoal.

Palavras-chave: enfermeiras obstétricas; período pós-parto; mulheres; morte fetal

Resumen

Marco contextual: Portugal registró una tasa de mortalidad perinatal de 3,5% en 2019, una de las cifras más bajas de los últimos 10 años. La muerte fetal es una de las experiencias más traumáticas que una mujer puede experimentar.
Objetivo: Analizar los sentimientos/las experiencias de las mujeres en situación de muerte fetal.
Metodología: Se basa en un estudio transversal y descriptivo con un enfoque cualitativo. Muestreo no probabilístico y de conveniencia. Incluyó 10 entrevistas semiestructuradas a mujeres que experimentaron una muerte fetal. Se usó el programa IRaMuTeQ, versión 0.7 alfa 2.
Resultados: Las mujeres consideran la muerte fetal como una experiencia dolorosa, se evidencia una transmisión de la noticia de la muerte fetal como fría y poco humana. Muestran satisfacción en los cuidados prestados por los enfermeros EESMO al destacar el componente relacional. Las mujeres resaltaron la falta de información y de preparación para el alta.
Conclusión: Desarrollo de actividades formativas dirigidas a enfermeros que tienen contacto con mujeres que experimentan una muerte fetal, con el fin de realizar una práctica basada en pruebas científicas, concretamente en lo que respecta a la comunicación y la relación interpersonal.

Palabras clave: enfermeras obstetrices; periodo posparto; mujeres; muerte fetal

How to cite this article: Miranda, A. M., & Zangão, M. O. (2020). Mothers' experiences of fetal death. *Revista de Enfermagem Referência*, *5*(3), e20037. doi:10.12707/RV20037

Introduction

The death of a baby is one of the most traumatic experiences parents and families can go through, and it often brings severe changes to family life (Binnie, 2020). The expectations developed during pregnancy concern the continuity of life and never death. When faced with fetal death, the couple feels betrayed and deceived, and that they have failed. They are prevented from experiencing the dreams, the fantasies, and the plans associated with parenthood, as well as from enjoying this powerful life event, so full of affection, that is the birth of a child (Ferreira, 2019; Quintans, 2018).

In recent years, particularly since 1980, available data shows a decrease in fetal and neonatal mortality in Portugal. In 2019, the perinatal mortality rate was 3.5% and the neonatal mortality rate was 1.9% (Pordata, 2020). This decrease is mainly due to technological advances which enabled close monitoring and early screening of complications during pregnancy. However, pregnancy losses continue to occur, accompanied by pain and drama.

Maternal and Obstetric Nursing has an essential role in fetal death experiences, even though the nurses specialized in Maternal and Obstetric Nursing (*Enfermeiros Especialistas em Enfermagem de Saúde Materna e Obstétrica*, EESMO) have some difficulty in coping with death in an environment where new lives are born every day. The moment when the woman/family is informed of the diagnosis of pregnancy loss is very delicate because it causes the EESMO to feel anxious and insecure whenever he/she is present at the time of communicating the bad news (Alves, 2018; Binnie, 2020).

The impact of fetal death goes far beyond the parents, extending to the family, friends, and EESMO, with the latter finding it difficult to approach, and even to provide care to, the woman who has experienced a fetal death (Binnie, 2020). Therefore, it is important to identify the feelings of women who experience fetal death with a view to helping EESMO provide appropriate care to these women.

The objective outlined for this study was to analyze the feelings/experiences of women who experienced fetal death.

Background

The human life cycle covers several stages, from embryonic development, birth, childhood, adulthood, to death and dying. These stages are universal, personal, and unique phenomena. Life and death are part of human existence. In some situations, death reverses the logical sequence of the life cycle, leading to early losses, such as those that occur during pregnancy (Quintans, 2018; Rocha, 2016).

According to the World Health Organization (WHO), fetal death is death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy (World Health Organization [WHO], 2016).

Perinatal deaths can be classified into three groups (WHO, 2016), according to timing - whether the death occurred in the antepartum period (prior to the onset of labor), in the intrapartum period or in the neonatal period (early neonatal - up to day 7 of postnatal life; or late neonatal - days 8-28 of postnatal life); the cause of perinatal death; and the maternal condition. Serrano, Centeno, and Ramalho (2018) also associate fetal deaths with three main factors: maternal, fetal, and placental conditions.

Many of these losses occur in uneventful pregnancies, without any previous signs of concern, increasing the shock felt by parents when faced with the news of their baby's death and making it harder to accept the loss. This unexpected or unexplained death is a complex and multifactorial situation (Serrano et al., 2018). Many aspects of the couple's reproductive history influence the way in which they cope with this loss (Pontes, 2016). Fetal death can have devastating effects on the couple's mental health, not only when the loss occurs, but also in future pregnancies, in which the risks of fetal complications and fetal death are higher (Pontes, 2016; Serrano et al., 2018).

Professionals should pay special attention to how they convey the news of fetal death to a woman, which they should do in a clear and effective way while respecting the woman's feelings. They should pay attention to the communication techniques, choosing a soft but firm tone of voice and adapting the vocabulary to the woman's cognitive skills and socio-economic status. On the other hand, it is very important for them to verbalize that they are available to care for these women (Quintans, 2018). All these aspects are important to help these women overcome the process of loss in an effective way.

The mourning for the loss of a child is characterized by a lot of guilt and anger. Several authors, from Freud to the present day, have analyzed the grieving process and the responses of bereaved people. In these situations of loss, the mourning process can be divided into two aspects: one associated with the pain and suffering after the loss, and another one associated with the psychological process of elaboration of loss (Pontes, 2016). This mourning process is defined as the "process of resolving grief, emotional reaction to assist in overcoming great personal loss, feelings of extreme sorrow or loss processed through mourning and bereavement, consciously working with grief reactions and emotions." (International Council of Nurses, 2019).

The EESMO's intervention is reflected in the care provided to the woman at her admission to the unit with the diagnosis of fetal death, or when faced with the diagnosis during hospitalization, during labor, and, later on, in her confrontation with the death of her baby. This confrontation is perhaps the most complicated stage of the whole process because the woman always hopes that her baby will be born alive (Quintans, 2018).

The EESMO's interventions during the adaptation process should contribute to improve the women's physical, psychological, and social well-being because this

complex and demanding phenomenon of fetal death requires increasingly differentiated professionals to support them (Xavier, Nunes, & Basto, 2014).

Research questions

What are the feelings/experiences of women in situations of fetal death?
What are the women's feelings regarding the care provided by the EESMO before, during, and after the experience of fetal death?

Methodology

A cross-sectional descriptive study was conducted with a qualitative approach. The study was carried out in a Portuguese Hospital Center, in 2016, using a semi-structured interview, which included questions about socio-demographic data and the experiences of women when faced with fetal death, particularly about the feelings experienced when faced with the news of fetal death; who convey the news and how; how she felt with the care provided by the EESMO; the behaviors/attitudes that should be improved.
The Ethics Committee for Research in the Area of Human Health and Well-being of the University of Évora gave a positive opinion (No. 15008), and the Hospital Center authorized the study. Anonymity and confidentiality of the answers were ensured. Participants received information about the study, specifically concerning its objective and contributions, and signed the informed consent form for data collection and interview recording.
The sample was selected using the non-probability convenience sampling method (Marôco, 2018). The inclusion criteria were being a woman who experienced fetal death, with at least 13 weeks of pregnancy, and had given birth at the Hospital Center within five years prior to the study. Participants who did not meet these inclusion criteria were excluded from the study. All participants were identified based on the delivery rooms' records of the Hospital Center and invited via phone. All of them accepted to participate. The interviews took place in a room of the Hospital Center's training department and lasted approximately 30 minutes. They were recorded and later transcribed. During the interviews, the researcher was concerned with creating a calm environment away from the delivery/hospitalization rooms for the women who experienced the phenomenon to express themselves spontaneously. The period between the phenomenon and the interview ranged from 2 months to 5 years.
To ensure credibility and reliability, after transcription of the interviews each of the women were asked to read the transcript, thus validating the transcriptions and the interview. The corpus was organized using the analysis protocol of IRaMuTeQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires) software, version 0.7 alpha 2. The interviewed women were encoded (entre_01 to entre_10), as well as the variables (age, marital status, education level, and previous fetal death experience). The corpus consisted of 10 Initial Context Units (ICUs), with each interview being considered an ICU. Each ICU started with a command line:
**** *entre_01 *id_3 *estcivil_4 *hl_6 *exp_2

Results

The sample consisted of 10 participants, of Portuguese nationality, aged 26 to 55 years, with the majority (80%) of them being in the 30-39 age group. Concerning their marital status, the majority (80%) of them were married. With regard to having other children, only one (10%) woman mentioned having other children. As regards their education level, the majority (80%) of them had a 3- or 4-year undergraduate degree. Half of the sample reported having previously experienced pregnancy loss, while the other half reported that this was their first experience. Most fetal deaths (90%) occurred spontaneously, and only one (10%) fetal death resulted from a medical termination of pregnancy.
The interviews consisted of 103 Elementary Context Units (ECUs). Of these 103 ECUs, the software classified 89 text segments, capturing 86.41% of vocabulary richness, from which seven classes emerged via Descending Hierarchical Classification (Figure 1).
Figure 1 shows that classes 1 and 2 were created first. Later, the division of classes 3, 4, and 7 emerged, with classes 5 and 6 emerging from the latter. The intersection of classes 3, 4, and 5 represents well the connection between the meaning of fetal death for these women and their reaction to the news of fetal death, although the intersection with the need for support when faced with the news of fetal death is subtler. In addition, the classes concerning the feelings experienced by the women when faced with the loss and the need for support when confronted with the news of fetal death also emerged.
Regarding the percentages obtained for each class, the results show that class 5 covers 16 ECUs, with a percentage of 18% according to the total number of ECUs; class 1 consists of 15 ECUs, representing 16.85%; class 4 with 14 ECUs, representing 15.73%; class 2 with 12 ECUs, representing 13.48%; classes 6 and 7 with 11 ECUs, each representing 12.36%, and, finally, class 3 with 10 ECUs, representing 11.24%.
Data processing allowed for the organization of the corpus from the interviews into the following seven classes, which were designated according to content representation and the most frequent words: Class 1 – Integrating fetal death; Class 2 –Perception of women who experience a fetal death about the professionals' attitudes while delivering care; Class 3 – Mother's reactions to the news of fetal death; Class 4 - Meaning attributed to fetal death by the woman; Class 5 - Need for support when confronted with the news; Class 6 - Overcoming fetal death; Class 7 - Feelings experienced in a situation of fetal death.

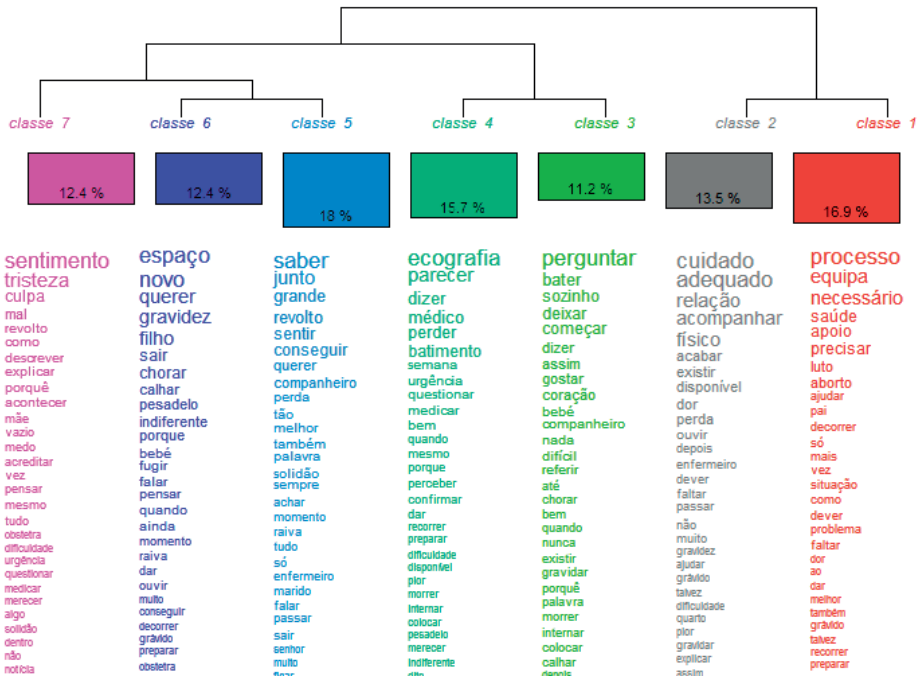

Figure 1. Dendrogram of Descending Hierarchical Classification.

Discussion

Based on the objective and the phenomenon (fetal death), seven classes were identified, and central themes emerged, which were compared with the literature, while highlighting the most frequent words within each class.

Class 1 – Integrating fetal death

More and more, the decision to have a child is taken under circumstances that are considered ideal, which leads to the development of high expectations during pregnancy. Once pregnant, the woman prepares herself for 9 months to receive the baby, in a mix of anxiety and fantasy, as this is the most important project in the couple's life (Ferreira, 2019). While preparing for motherhood, the situation of loss is not anticipated, and, after the acceptance of pregnancy, there is usually only room for happiness and lots of dreams and expectations to welcome the new family member, who is idealized throughout pregnancy. Contrasting with these experiences, a fetal death brings about anguish, sadness, and sorrow, shattering the possibility of experiencing motherhood and leading to a feeling of failure (Camarneiro, Maciel, & Silveira, 2015). Therefore, it is difficult to explain the uncertainties, often displayed in questions such as how, when, why,

> that I desired this pregnancy and this child, we planned everything, it was not fair, I thought that my body was not good to conceive a child, I didn't understand if I was still young why my baby had died, I got pregnant. (entre_10; July 2016)

"What had I done wrong so that everything would repeat itself, why me, it was hard for me to believe that" (entre_02; July 2016).

Whatever remains in the realm of the unknown and the obscure weakens the psychic world, therefore, the woman needs to know and understand the causes for her fetal loss even to the point of questioning herself about whom to blame, "anger sadness guilt powerlessness blame, what did I do wrong not to be a mother for the third time, is it punishment, I feel incomplete as a woman" (entre_02; July 2016).

It becomes difficult to accept the loss when everything went well during pregnancy, so the expected outcome would be the birth of a healthy child, "the pregnancy went smoothly, we were so happy, we had everything prepared at home, we wanted this child so much, it was not fair" (entre _09; July 2016).

Her failed pregnancy makes her feel an enormous sense of injustice and coping difficulties, expressing anger against herself and those closest to her, particularly her parents and husband (Alves, 2018). This anger was reflected in the interviewed women's account "I thought that I hadn't done nothing to deserve this, I or any other woman, I cried a lot, I'm angry at everything and everyone right now, I'm angry at everyone, me, God, my husband, my parents" (entre _10; July 2016).

Class 2 – Perception of women who experience a fetal death about the professionals' attitudes while delivering care;

The nurse should put aside his/her own set of values and beliefs to provide, together with the other team members, quality care to these women; provide a safe

and adaptive environment through empathetic and active listening; respect their culture, race, religion, values, and beliefs; inform the couple about the issues regarding the situation; identify parents and families at risk of triggering non-adaptive responses to loss; and help the couple/family to adjust to the new situation, promoting the acceptance of loss (Alves, 2018; Pontes, 2016; Lei nº 156/2015 de 16 de setembro).

Participants felt that they had received an ongoing and appropriate support from the nurses, and that they were very sensitive to their verbal and non-verbal expression of pain. It is clear that emotional care is the ability to understand the invisible aspects in care delivery (Sequeira, 2016; Xavier et al., 2014), "they were very sensible and humane, I felt that the human and relational component overlapped the technical part of care, I felt that I wasn't alone, but nothing could fill the void that I felt, the pain you feel is indescribable" (entre _04; July 2016).

The opportunity to have the partner and the family's assistance and emotional support was also highlighted. The support of family and friends is essential for women, especially during the mourning process (Rios, Silveira dos Santos, & Dell'Aglio, 2016). The father is highlighted as the key figure, and it is important for the couple to stay united in supporting each other and finding the strength to cope with the loss, "they were present, they didn't leave me alone, they allowed my partner to be there and a friend to visit me, they were very humane when my baby was born, they asked us if we wanted to see the baby, I felt a lot of support" (entre _03; July 2016).

The women reported that another positive attitude from the nurses was providing for a safe environment to keep them from hearing other newborns crying and being around other women in labor (Serrano et al., 2018),

> the team that assisted me was very sensible and put me in the last room where I wouldn't be disturbed by the coming and going of other pregnant and puerperal women, they were always there, they gave me space to cry and unburden myself and they respected me whenever I wasn't in a mood to talk. (entre _06; July 2016)

However, some women were not offered this type of environment, suggesting a difference in care, and, even, insensitivity, dehumanization, and bad practices in care delivery. The nurse is responsible for providing these conditions or to adapt them if they do not exist so that women can enjoy privacy while going through this situation,

> I heard my partner say thank you and I only cried about the environment . . . the place for birth, I heard the moaning of some pregnant women and even the crying of a baby, I remember that very well, hearing that cry was difficult. (entre _07; July 2016)

In addition to emotional pain, physical pain, triggered by labor induction, should also be considered in women's assistance. Physical pain should be avoided because it is considered extremely aggressive, and emotional pain is not possible to avoid (Alves, 2018; Catlin, 2017). The women also highlighted the nurses' words of positive reinforcement in the valorization of their emotional pain. In approaching these women, nurses should use expressions such as "I feel sad for you", "What can I do for you?", "This must be hard for you" to confirm women's overwhelming pain over their loss (Jansson & Adolfsson, 2011), "how hard it must be for you to hear the baby that has just been born crying in the next room, I felt that the nurse understood my pain regarding the physical environment, I think it was not the right one for me, I wanted to get away from there" (entre_01; July 2016).

Class 3 - Mother's reactions to the news of fetal death

The moment when women receive the news of fetal death is always disturbing and, when confronted with the loss, they question if what is happening to them is even real, they do not seem to understand what is being told to them, and, sometimes, they do not even believe what they are hearing is true. The fact that fetal death occurs unexpectedly and unpredictably adds to the trauma felt when they are informed of their baby's death (Pontes, 2016). When the news is transmitted in a clear, direct way, it can reduce the trauma, allowing women to better understand what is being said and accept the phenomenon (Alves, 2018; Quintans, 2018), " was given by the doctor, he seemed quite distant, I wasn't sure if I was hearing the message correctly" (entre _04; July 2016).

Most women, when confronted with the news, trigger reactions of doubt, disbelief, and uncertainty, and they find it difficult to believe in what they are being told, even questioning if it is not a mistake or if what they are hearing is true. This is the shock phase when it is difficult to assimilate the information, and women should be given time to interiorize, and, if necessary, reformulate the information (Pontes, 2016; Jansson & Adolfsson, 2011), "my reaction was disbelief, I thought it was a diagnostic error, it wasn't likely to be happening to . . . I have difficulty in defining shock, anger, sadness, anguish, outrage, loss, loneliness, lack of interest, fear (entre _01; July 2016).

Some women are so eager to have a child that, even in the presence of clear signs of threat to the development of their pregnancy, they do not believe it will happen to them. Even when faced with real signs, they go into denial as a form of defense (Alves, 2018),

> the doctor confirmed the news when I arrived at the obstetrics emergency due to heavy bleeding in the second trimester, it was very bad because I got the confirmation of what I didn't want to hear when the doctor observed me and said that there was nothing he could do, that the baby wasn´t alive. (entre _04; July 2016)

Other women come to the point of not believing, questioning the diagnosis asking for a second opinion, as they want to hear something different that will satisfy them (Jansson & Adolfsson, 2011), "then what I'm hearing is not true, you got it wrong, if I'm not bleed-

ing, I'm not in pain, it can't be true, I'm going to ask for a second opinion" (entre _06; July 2016).

Some professionals, who deal with these situations on a daily basis, sometimes neglect the emotional component, communicating the news in an inappropriate way, viewing the woman as just another clinical case that needs to be treated,

> only said that the baby had stopped growing and had died, that we needed to induce labor and that there are usually no apparent reasons for these situations, that maybe it was nature taking care of these situations that something was not right. (entre _10; July 2016)

Class 4 - Meaning attributed to fetal death by the woman

This class reveals the break with the expectations created during the pregnancy, a meaningless experience, the transformation of the dream into a nightmare when the pregnancy does not continue to term (Pontes, 2016). In this regard, it is also mentioned that the woman sees fetal death as the rejection of her ability to perform her role as a woman and a mother, with the participants' accounts revealing that an interrupted pregnancy leads to an interrupted motherhood (Pontes, 2016) "because I felt that for them it was just an obstetric problem that had to be taken care of, nothing else, while for me it was losing a part of me" (entre _07; July 2016). The women's wishes and dreams regarding that child are frustrated, preventing her from using her maternal capacity and causing an unbearable pain (Quintans, 2018), "it was the greatest disappointment, it was like feeling that it was the end, the end of everything, of all the dreams, the loss of my baby, once again everything crumbled, a feeling of sadness and guilt took over me" (entre _03; July 2016).

Class 5 - Need for support when confronted with the news

In adverse situations, the human being needs support to deal with the difficulties satisfactorily. During antenatal and emergency department visits due to several situations, women are not always accompanied by their partners or relatives, and sometimes they have to deal with overwhelming news on their own. According to the participants, not having their partner with them to share the pain makes the situation even more difficult, even making them feel unprotected (Alves, 2018),

> at the 20-week check-up, the doctor who followed my pregnancy tried to listen to the baby's heart with the Doppler but he couldn't, he tried to reassure me but in vain, the anger was so big that nothing and no one could calm me down, I couldn't stop crying, it would have helped if my husband could have gone with me. (entre _03; July 2016)

This participant confirmed the importance of the partner's presence when the news is broken, considering it a facilitating factor. It also consolidated the importance of having someone to share the experience (Alves, 2018), "I was alone for a while with my partner, we cried in silence, we supported each other, we would only like them to tell us why our happiness ended like this" (entre _10; July 2016).

Class 6 - Overcoming fetal death

When experiencing fetal death, it is not only the child's death that needs to be overcome but also the loss of the hope and joy that being pregnant represented (Quintans, 2018). Thus, anxieties, sadness, the fantasies, and emotions need to be experienced and shared to create healthy mechanisms for the elaboration of loss and facilitate a readjustment of the psychological balance (Pontes, 2016),

> after the abortion, it becomes a taboo topic, not talking about it is the worst thing that people can do because that pregnancy existed and there are a lot of fantasies about what could have been, a lot of things are left unresolved. (entre _05; July 2016)

Apart from the idealizations that remain unfulfilled, other people's lack of acceptance of the loss is no less important, making it impossible for women to share their feelings, anguish, and fantasies with family/friends/society (Rios et al., 2016), "everyone knows that we were pregnant, but then it's extremely difficult for them to accept the mourning for the loss of a child, for other people these babies didn't exist, they didn't feel them, they have already forgotten them" (entre _05; July 2016).

The importance of family and social support to cope with the psychological stress associated with these losses is an extremely important factor in resolving the loss. In hospital settings, in addition to the importance of attitudes of support, availability, and empathy, the referral to emotional support systems after the loss is equally important (Alves, 2018; Rios et al., 2016). The participants mentioned that these attitudes were not reflected in care delivery "perhaps the health team is not concerned with referral during the experience of the mourning process" (entre _04; July 2016).

Class 7 - Feelings experienced in a situation of fetal death

These feelings cause many women to express anger and helplessness. The loss of a child is a devastating experience for the woman/family (Rios et al., 2016; Rocha, 2016). The participants experienced mixed negative feelings that are difficult to describe; it is as if life has played a trick on them, robbing them of so many dreams and hopes, betraying them, and they wonder why them? However, these reactions depend on the culture, values, experiences, and characteristics of each individual (Alves, 2018; Quintans, 2018; Rios et al., 2016), "my first feeling was one of despair and anger and, at the same time, of guilt, I wondered what I did wrong, why I don't deserve to be a mother" (entre _06; July 2016). In addition to these feelings, women also acknowledged that, even as time goes by, the memories remain alive in their daily lives and that they can accurately recall the event even after some months or years (Pontes, 2016), "a mixture of feelings,

helplessness, anger, sadness, guilt, and fear, even though more than a decade has passed, the memories remain as if it was today" (entre _04; July 2016).
The results also show that women who stop feeling their babies think, inevitably, of loss and experience feelings of anger and sadness, requiring individual support from the health team.
The limitations of this study are the sampling method and the cross-sectional design, which makes it impossible to extrapolate the results to the general population. Future studies should use random probability sampling.
The merit of this study lies in the fact that the research on this topic that is difficult for women to address is scarce. Therefore, this study paves the way for the development of more comprehensive research.

Conclusion

Pregnancy loss was the focus of this article. Pregnancy does not always have a *happy ending*, preventing women from experiencing the much-desired dream of motherhood. The unexpected loss of a child is an overwhelming experience. Many of these losses take place in an uneventful pregnancy, without any warning signs.
Despite the recognition of this problem, society in general and health professionals in particular are not truly aware of the consequences and the meaning of these losses for these women.
The results of this study show that women consider fetal death as a painful experience. On the one hand, the news of fetal death is broken to them by some health professionals in a cold and inhumane way, while, on the other hand, women were satisfied with the care provided by the EESMO, highlighting the relational component. However, these women stressed that the moment of hospital discharge is underestimated, particularly regarding the lack of information and preparation for hospital discharge.
Therefore, it is important to emphasize the nurses' intervention in this critical phenomenon from the perspective of those who experienced it. These actions include keeping in mind what each woman experienced, providing more attention, adopting an appropriate attitude at the moment when they are informed of the news, and being alert to the multiplicity of reactions to adapt their intervention to each woman's needs. It was also possible to better understand the issue of fetal death, what it involves, and how to help these parents overcome grief, and believe that it is possible to become pregnant and give birth to a healthy child.
Training activities aimed at the development of evidence-based practices should be implemented for the nurses in contact with women who experienced fetal death in order to carry out a practice based on scientific evidence, particularly regarding communication and interpersonal relationships. Further studies should be developed to allow for the generalization of results.

Manuscript extracted from the Report drawn up within the scope of the Master's in Maternal Health and Obstetric Nursing at the University of Évora, Portugal.

Authors contribution
Conceptualization: Miranda, A. M., Zangão, M. O.
Methodology: Miranda, A. M., Zangão, M. O.
Data processing: Miranda, A. M., Zangão, M. O.
Writing - preparation of the original draft: Miranda, A. M., Zangão, M. O.
Writing – review, and editing: Miranda, A. M., Zangão, M. O.

References

Alves, S. I. (2018). *Perda perinatal: Perspetiva da díade parental* (Master's dissertation). Retrieved from http://web.esenfc.pt/?url=Xn-W222o0

Binnie, C. (2020). Breaking the silence. *British Journal of Midwifery*, *28*(3), 144-145. doi: 10.12968/bjom.2020.28.3.144

Camarneiro, A. P., Maciel, J. C., & Silveira, R. M. (2015). Vivências da interrupção espontânea da gravidez em primigestas no primeiro trimestre gestacional: Um estudo fenomenológico. *Revista de Enfermagem Referência*, *4*(5), 109-117. doi: 10.12707/RIV14064

Catlin, A. (2017). Creation of interdisciplinary guidelines for care of women presenting to the emergency department with pregnancy loss. *Journal of Perinatology*, *37*, 757-761. doi: 10.1038/jp.2017.61

Ferreira, F. M. (2019). *Diferentes modelos de maternidade e suas implicações: Motivações, expectativas e realidades de mães portuguesas* (Doctoral thesis). Retrieved from: https://hdl.handle.net/10216/120929

International Council of Nurses. (2019). *ICNP Browser*. Retrieved from https://www.icn.ch/what-we-do/projects/ehealth/icnp-browser

Jansson, C., & Adolfsson, A. (2011). Application of Swanson's Middle Range Caring Theory in Sweden after miscarriage. *International Journal of Clinical Medicine*, *2*(2), 102-109. doi: 10.4236/ijcm.2011.22021

Lei nº 156/2015 de 16 de setembro. *Diário da República nº 181/2015 - 1.ª Série*. Assembleia da República. Lisbon, Portugal. Retrieved from https://dre.pt/application/conteudo/70309896

Marôco, J. (2018). *Análise estatística com o SPSS Statistics* (7ª ed.). Lisbon, Portugal: Gráfica Manuel Barbosa & Filho.

Pontes, V. V. (2016). *Trajetórias interrompidas: Perdas gestacionais, luto e reparação*. doi: 10.7476/9788523220099

Pordata. (2020). *Taxa de mortalidade perinatal e neonatal*. Retrieved from https://www.pordata.pt/Portugal/Taxa+de+mortalidade+perinatal+e+neonatal-529

Quintans, É. T. (2018). *Eu também perdi meu filho: Luto paterno na perda gestacional/neonatal* (Master's dissertation, Pontifical Catholic University of Rio de Janeiro, Psychology Department, Brazil). Retrieved from https://www.maxwell.vrac.puc-rio.br/34141/34141.PDF

Rios, T. S., Silveira dos Santos, C. S., & Dell'Aglio, D. D. (2016). Elaboração do processo de luto após uma perda fetal: Relato de experiência. *Revista de Psicologia da IMED*, *8*(1), 98-107. doi: 10.18256/2175-5027/psico-imed.v8n1p98-107

Rocha, L. (2016). *Cuidados à mulher que vivencia o óbito fetal: Um desafio para equipe de enfermagem* (Master's Thesis, Federal University of Santa Catarina, Brazil). Retrieved from http://www.scielo.mec.pt/pdf/aogp/v12n3/v12n3a15.pdf

Sequeira, C. (2016). *Comunicação clínica e relação de ajuda*. Lisboa, Portugal: Lidel.

Serrano, F., Centeno, M., & Ramalho, C. (2018). Estudo das situações de morte fetal após as 24 semanas. *Acta Obstétrica e Ginecológica Portuguesa*, *12*(3), 240-244. Retrieved from http://www.scielo.mec.pt/pdf/aogp/v12n3/v12n3a15.pdf

World Health Organization. (2016). *The WHO application of ICD-10 to deaths during the perinatal period: ICD-PM*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/249515/9789241549752-eng.pdf

Xavier, S., Nunes, L., & Basto, M. L. (2014). Competência emocional do enfermeiro: A significação do constructo. *Pensar Enfermagem*, *18*(2), 3-19. Retrieved from http://pensarenfermagem.esel.pt/files/Artigo1_3_19.pdf