

Experiences of miscarriage: the voice of parents and health professionals

OMEGA—Journal of Death and Dying
2024, Vol. 89(2) 777–794

© The Author(s) 2022

Article reuse guidelines:

sagepub.com/journals-permissions

DOI: 10.1177/00302228221085188

journals.sagepub.com/home/ome



Natalie Figueredo-Borda¹ , Mirliana Ramírez-Pereira² ,
Pedro Gaudiano³ , Cecilia Cracco⁴ , and Beatriz Ramos⁵

Abstract

The death of a child in the intrauterine stage has legal, psychological, spiritual, and health-related connotations that condition the woman's experience. To understand better the processes set in motion around early pregnancy loss, this ethnographic study explores the experiences of miscarriage in a group of 15 women. The following themes are analyzed: Experience of losing the child, spirituality, health care, and the need to physically recognize the child. The study shows that the need women have to honor the child who did not live may be conditioned by the perception of an uncertain loss and by the absence of a place to honor him/her. Attitudes among professionals are revealed that could be perceived as gender-related abuse. The care of women places emphasis on physical aspects, underlining the lack of comprehensive care during the grieving process.

Keywords

miscarriage, grief, gender, health service, pregnancy loss

¹Departamento de Bienestar y Salud, Universidad Católica del Uruguay, Montevideo, Uruguay

²Departamento de Enfermería, Universidad de Chile, Santiago, Chile

³Departamento de Humanidades y Comunicación, Universidad Católica del Uruguay, Montevideo, Uruguay

⁴Departamento de Psicología, Universidad Católica del Uruguay, Montevideo, Uruguay

⁵Departamento de Derecho, Universidad Católica del Uruguay, Montevideo, Uruguay

Corresponding Author:

Natalie Figueredo-Borda, Departamento de Bienestar y Salud, Universidad Católica del Uruguay, Av. 8 de octubre 2738, Montevideo 11600, Uruguay.

Email: nafiguer@ucu.edu.uy

Introduction

There are legal, social, psychological, spiritual, and health-related connotations attached to the loss of a pregnancy that have an impact on the experience of those who go through it.

Conceptual Details of Early Pregnancy Loss

Disparities exist regarding definitions of stillbirth and miscarriage. There are different concepts around early pregnancy loss. Thus, miscarriage is defined as the spontaneous loss of a pregnancy during the first 24 weeks of gestation; in the case of Australia miscarriage is considered to be up to 20 weeks of pregnancy and in Britain up to 24 weeks (Lee & Rowlands, 2015). According to Hay (2004), early miscarriage is the loss of a pregnancy during the first trimester, that is, less than 12 weeks of gestation, which occurs in up to one in every five pregnancies. Late miscarriage, in contrast, is less common, occurs during the second trimester between 12 and 24 weeks of gestation and affects 1 to 2% of pregnancies.

Social Silence

Early pregnancy loss or miscarriage is a phenomenon which receives scant public recognition, despite the frequency with which it occurs. Women who have suffered have identified positive and negative support-related experiences among those close to them. They also point out that close family and friends try to be supportive but are unsure about how to behave or what to say. Many women attribute this to the great silence surrounding miscarriage (Bellhouse et al., 2018).

This loss has considerable consequences for the mental health of the women, such that the symptoms of depressive and perinatal pain persist long after the loss (de Montigny et al., 2017). The manner in which health personnel communicate the loss to the parents can also affect their experience and psychological well-being (Murphy & Cacciatore, 2017). Disrespectful, cold, forceful, or inconsiderate communication further distresses parents. Moreover, medical terms and ambiguous descriptions may not be understood and this can generate more distress. Empathic health support gives parents a chance to be heard. The parents see the health team as a source of support and practical assistance that can help them to cope with their loss in the best way (Louw & Sturrock, 2013).

The consequences of pain due to perinatal loss can include important difficulties in the relationship with one's partner, depression, anxiety, and posttraumatic stress (Mills, 2015). Similarly, it leads to psychological, social and economic impacts on the whole family system (Murphy & Cacciatore, 2017). It is an unexpected loss receiving little attention at the social level and is of an ambiguous nature (Golan & Leichtentritt, 2016; Shannon & Wilkinson, 2020).

Both parents can present psychopathological symptoms immediately following the loss, or in the long-term. The woman may present immediate symptoms such as sadness, irritability, and appetite and sleep disturbances (Badenhorst & Hughes, 2007). They may also present symptoms in the long-term including anxiety about death, obsessive compulsive behaviors, suicidal ideation, guilt, shame, and worry about future pregnancies (Shannon & Wilkinson, 2020).

Women experience a bodily emptiness, feelings of inadequacy, helplessness, and a feeling of inefficacy and failure. The loss impacts their self-esteem, femininity and maternal capacity. At the same time, it is difficult for others to comprehend and appreciate what they have lost (Costa et al., 2013; Marquina et al., 2009). The fathers, meanwhile, must align their expectations of paternity while struggling with the emotional pain felt by their wives (Obst et al., 2020).

Many bereaved people are encouraged to put their experience of grief aside early, leaving it to be endured alone or abandoned before the process is complete, which can affect the psyche of the person going through it (Costa et al., 2013).

Regarding farewell rituals, the literature is divided on whether it is beneficial or harmful for the parents to have direct contact with their deceased child (Jones, 2019). Some studies (Badenhorst & Hughes, 2007; Hughes, et al., 2002) show that birthing parents who had direct contact with their deceased child presented higher levels of anxiety and depression than those who did not. On the other hand, parents' need to perform funeral rituals and to honor the child who did not live may be conditioned by the perception of an uncertain loss, or a body to bury producing an ambiguous loss (Boss et al., 2016; Golan & Leichtentritt, 2016).

Health Team

When early pregnancy loss occurs, the feelings of the staff and the care of the grieving parents are often inadequately addressed (Puia et al., 2013). Within the health team, it is the nurses and midwives who form significant relationships with women during pregnancy, birth, and postpartum (Wallbank & Robertson, 2013).

Stillbirth represents one of the most difficult experiences for health professionals. They reveal an inability to answer the spiritual needs of bereaved parents, that is, they are unable to respond with their own beliefs and as such cannot help. The reasons are probably linked to a personal conflict of faith and the incongruence between their own faith and professional practice (Nuzum & Meaney, 2016). Faith provides relief and confidence in situations of loss. In a study including Jewish women, faith allowed them to reconstruct meaning in the face of loss and move on, preserving their beliefs (Hamama-Raz et al., 2014).

Legal Aspects

From the legal point of view, it is the duty of physicians to inform and the right of parents to receive information about the unborn child (Uruguay, 1992, Decreto 258/992).

Administrative regulations conceptualize stillbirth or intrauterine fetal death as the cessation of fetal life during gestation, where the fetus is retained in the uterine cavity for time periods that can vary (Lozano Méndez et al., 2007).

The study focused on the experience of women whose child had lost his/her life before 20 weeks gestation or who weighed less than 500 g at the time of death; as well as on the experience of health professionals. In the South American context, legislation regarding registry and the health action protocol when early loss of a pregnancy occurs has recently been discussed and the legislation is in the process of being modified (Montevideo Portal, 2019; La Diaria, 2021; Proyecto de Ley. 150970 Cámara de Senadores (2021).

Method

The research was carried out in accordance with the qualitative paradigmatic position as a way of producing information coming from women who suffered the loss of a child at an early stage of pregnancy, and from health professionals who participated in their care. The study was performed within the post positivist paradigm in which the researchers position themselves as relative, neutral observers of the phenomenon (Lincoln et al., 2017).

The qualitative study involved the collection of information on beliefs, coping strategies, attitudes, and participant content (Kuen et al., 2019).

The study follows a flexible, circular design from an ethnographic perspective which is mainly descriptive and which combines beliefs and cultural aspects to address the problem under study. In this respect, culture is shared among the members of a group, without implying that they are cohesive groups. Ethnography focused as a theoretical perspective is pertinent in this study as those participating have common behaviors due to the experience of loss and are treated by health professionals in accordance with the characteristics, beliefs, and values which qualify them (Bikker et al., 2017). The loss of a child from the parental perspective was addressed through the narratives of the women and key informants. According to Gadamer (1969), the experience is the content of permanent meaning that an experience has for the person who lived it.

Participants

Fifteen informants voluntarily took part in the study. The inclusion criteria were women who experienced a miscarriage after no more than 20 weeks pregnancy or the fetus died weighing no more than 500 g, and the professionals who cared for the women suffering this loss. The time between losing the child and the study interview ranged from 1 to 12 years. Women receiving either public or private care were included. According to Rizo García (2015) emotions are maintained over time in the experience of daily life, which is why participants who suffered the loss of pregnancy at different times were included.

The study was carried out in two stages. In the first stage, women were contacted by telephone to invite them to participate and to request the details of other women in the same situation. In this stage, the same modality was applied to participating health personnel.

In the second stage, participant interviews were conducted: 9 women who had suffered the loss of a child and 6 key informants. Sampling was done using the snowball strategy, in which existing participants recruit other participants among their contacts who meet inclusion criteria, until information saturation is reached (Naderifar et al., 2017). The number of patients was determined by theoretical saturation of the information (Ortega-Bastidas, 2020). Data were collected through repeated face-to-face interactions between the researcher and the interviewee in a planned manner. In this technique, interviewees give their opinions on issues that may be related to their life, experiences or lived situations while the interviewer gathers and interprets this particular vision (Pessoa et al., 2019).

A guideline was designed for the interview which was validated by expert judgment and through pilot tests distributed according to the type of participant so that they could be checked and appropriate adjustments made. The interviews were performed by members of the research team with proven experience in this technique in a safe, private place selected in agreement with the participant. Confidentiality regarding participant identity and the information collected was ensured at all times.

Analysis

Analysis was carried out inductively through content analysis. This allowed the meaning of a message to be discovered, with the classification and/or coding of the elements into defined categories, with the aim of objectively and systematically identifying its meaning and achieving interpretation (Saldaña, 2021). ATLAS.ti 8[®] software was used to facilitate the ordering and coding of the information.

For the purposes of this research, the criteria of rigor of reflexivity, transferability and triangulation were used (Johnson & Rasulova, 2017). These criteria were met through coordination meetings, through the clarification of value and ideological positions prior to the interviews, triangulation of interviewers, use of field notes, and inclusion of information on all participants.

The ethical criteria used were those defined by Ezekiel (2008) which state that research must comply with aspects of social value, scientific validity, equitable participant selection, favorable risk–benefit ratio, independent assessment, informed consent, and respect for registered participants. Identities were coded as follows: women who suffered miscarriage (WM) and professional women informants (PW).

Results

12 subcategories were identified which were classified into 4 main categories (See Table 1).

Table I. Emergent Categories and Subcategories.

Experience of the Loss of the Child: Me and my Pain.	Silenced Grief The Family Environment before the Loss Survival
Spirituality	Religion Search for comfort Resignation
Health care	Violence-abuse in care relationships and care of women. Good practices Consequences for mental health Restrictions on the right to decide on the fate of remains of the child: Biological waste.
Need to recognize and keep the child that did not live	Recognize their child: see the body Honor the child's passing

Category I—Experience of the Loss of the Child: Me and My Pain

This category was constructed with the emerging codes of silenced grief, family environment and survival. The participants refer to the moment they were told of the fetal infeasibility as one of the most difficult of their lives. They also expressed a feeling of emptiness, of a truncated life project, and frustration over the loss.

The *silenced grief* code emerged from the accounts given by the women who lost their pregnancy and from professionals who were close to the experience, who agreed that it was a silenced process; a phenomenon that cannot be discussed. In some cases, this silence is linked to feeling responsible or to blame for the failure. In other cases, there is talk of an intra-couple dynamic and, at other times, this includes the family who do not know how to provide comfort when faced with this loss. This also causes unelaborated grief as the women do not express their emotions or feelings and prefer to grieve without speaking, without externalizing the loss.

“the pain would not let me see, the pain is like a black tube, I couldn't see (...) and well, if someone came close, with clearer things, that some type of support they could give... without doubt it would have been different (...) I think I was very lonely (...) at that time I was like wrapped in pain and everything is a bomb... I didn't think clearly, no, you can't think, at one moment the pain overwhelms you and more if you can't share it, if you can't say anything” (WM 8)

“I lost it at 14 weeks, the loss was very traumatic because after the curretage, at home, I couldn't talk about the subject, my husband took it as relief, as though, that's it!.. it was very difficult for me” (WM 12)

“I remember that that day I walked and I came back walking because I had to let off steam in some way, but I had nobody to talk to... nor had I told my family that I was pregnant, it

was very recent, my husband and I knew about it. He was sad, but, the truth is we never spoke about it again” (WM 9)

The *family environment before the loss* gives an account of the response of the woman’s close circle to the miscarriage. In the case of the extended family, some relatives were unaware of the pregnancy so the women made the decision to keep it secret and thus excluded their support and emotional backing. Regarding the perspective of the professionals interviewed, they stated that within the families, depending on the gestational age at the time of the loss, the experience could be more intense if the embryo had lived more weeks.

“And later, we felt very alone, me and my husband because nobody spoke about the subject in the family environment, they didn’t speak to me about it to avoid stirring the pain, but later I understood that, because talking about the death of a child is not... it’s not an easy thing and even less so when it’s a baby” (WM 10)

“(…) sometimes the family experiences it in another way, like not communicating until three months of pregnancy, because it’s like it can be lost. For the family it’s only that the pregnancy is lost and that’s it and, for her, the woman experiences it as something horrible” (PW 3)

“It has some truth, because in reality pregnancies under 12 weeks that are lost, most of the time it’s because they are incompatible with life...to lose a pregnancy of more than 14 weeks has a different impact, perhaps because they already see the fetus, it’s fully formed. Do you understand? It has another emotional impact” (PW 2)

The *survival* subcategory emerges from the need to continue living, to remain functioning to the husband, other children and the family. The women try to understand, explain and give new meaning to the lived experience. Despite this, they say that it is impossible to forget the pain that the loss causes them. Also present is the support that the woman understands as family pressure to overcome the grief quickly.

“... they tell me you are young, you’re going to have more children, let’s move on... and no, it’s not like that, it’s not that I lost a pregnancy, I lost one of my children” (WM 7)

Category 2-Spirituality

In this category emerge the subcategories of religion, search for comfort, and resignation. Behaviors that the women engaged in after the perinatal loss are included, such as actions aimed at self-preservation. Among these are elements of faith and learning from people who had suffered the same. The chance to talk about the child that did not live, put the experience into words, share and integrate it, helps them to preserve their integrity. It also includes being a part of everything in harmony with oneself, with others, with God and with nature.

The *religion* subcategory shows the closeness and the refuge that religion represents and how, through rites, it can alleviate the anguish. The prayers and going to church to hear mass comforts the women. There is also the hope of seeing the child again in heaven or feeling the child's presence as though they were an angel who cares for them and accompanies them at all times, and this allows them to find some comfort among so much pain.

"I am certain that he is accompanied and cared for by God and if I have this, I don't need anything else; God was taking him for a reason. This certainty was very strong" (WM 15)

"I put the rosary on my belly and said: please God, give me strength" (WM 12)

The *search for comfort* through spirituality is an important support for the women since it points to an understanding of the meaning and purpose for life. This includes belonging to a particular religion, belief in a superior being and the presence of energies that move the world. The women and the health personnel with a high level of spirituality help the other women to focus on themselves and cope with the loss.

"I am a very spiritual person; I always try to explain things that happen from this perspective. I have also tried to look in (beyond) the empty spaces of classical medicine in search of another response in biodecoding, bioneuroemotion, family constelations and this, this has given me the peace to find an answer" (WM 9)

Regarding the *resignation* category, the participants state that after experiencing grief, they become resigned to the loss but without putting aside the sadness that the memory of the dead child causes. The modification of the life project due to miscarriage generates uncertainty and distress. They refer to asking themselves on occasion why this happened to them and try to find some sense in the lived experience and give it a new meaning. They also think that if they have a new pregnancy, they will be able to overcome the pain of the loss.

"Nature is wise...it happened for a reason, he didn't stay for a reason, I think it has a reason, there's something to learn... I remember the moment, it was a heartbreaking time ...and then the fear of not getting pregnant again... Then the little girl arrived to give me back my happiness" (WM 14)

Category 3—Health Care

This category integrates the subcategories violence/abuse in care relationships, good practices, consequences for mental health, and restricting decisions. In the care of women with perinatal loss by the professionals and health team personnel, experiences perceived as violence/abuse in care relationships and lack of empathy are collected. This inadequate care translated into abuse includes behaviors such as doubting that the

woman is suffering a miscarriage and making value judgments regarding the origin of the loss and issues related to gender equality can also be considered. In addition, there may be the intention to persuade the pregnant person to terminate the pregnancy.

“The sonographer told me to talk to my gynecologist because of my age. Why would I get complications with my fifth child!? ...he clearly told me that I should take advantage of the fact I was only a few weeks pregnant to have an abortion, but it happened spontaneously soon after...” (WM 11)

“I went to the emergency room with the loss, the doctor who saw me assumed that I had wanted to provoke the loss and she asked me, ‘what did you take? That was horrible for me’ (WM 7)

Nevertheless, *good practices* were identified, some participants reported feeling accompanied, supported and understood by the health care team.

“The nurses were very loving, they saw that I was very alone ...I really received affection there while they transferred me... they were kind to me by putting me in a single room, because hospitalization was on the maternity ward” (WM 13)

“After seeing the ecograph, the gynecologist told me ‘If you want, take some days to process it and perhaps there it will come out naturally’, I was 13 weeks pregnant. Then I went home calmly to wait for something natural” (WM 11)

“There are differences in the quality of care because of the human factor, not the profession, although the professionals who are closest are the nurses” (PW 6)

Inadequate care has *consequences for mental health* revealed as depression, mood swings and feelings of emptiness. As a result, the professionals refer to a truncated project.

“These things weigh heavily in the lives of the women, the post-event is a question of gender and it’s a question of mental health which is not considered in health systems... I don’t think that any woman can carry all this lightly” (PW 5)

“There is a project in this woman that was cut short we have to offer her that space and there is a small committee for that. Accompany the woman for as long as it takes to improve her quality of life after that pain” (PW 4)

“I had a discharge from my breasts...that reminded me every day of what happened, beyond the severe anemia... as a woman there is much more than physical consequences to remember: those of the spirit and the feeling of loss” (WM 14)

“I have been dragging this pain for eight years and each time the date passes it is a significant low-point, but in my experience, I wasn’t accompanied. I got depressed.... it hit us hard... much more than we imagined” (WM 13).

In the *restricting decisions* category health professionals' denial of the right of the pregnant person or the parents to decide on the fate of the child's remains is identified. It is the health professionals who elect not to explain the whole truth. In the effort to avoid more pain for the family, a fetus weighing more than 500 g is registered with a lower weight. Consequently, there is no certificate or funeral paperwork. Apparently, it is a common practice.

"The doctors say 'Poor people. Don't make life any harder for them!' and nursing too 'How can we do this to the parents!?' Well they had to do the registration process, find a funeral home to deposit it and take it to the cemetery... In some cases, if it had breathed although it was more than 22 weeks and more than 500 g, it is said, it was stillborn" (PW 1)

"When it is a pregnancy of more than 20 weeks or at the limit, we ourselves decide, that's enough, it stops here. To avoid pain for the mother or something worse... I do not remember that we were going to ask the mother what she wanted to do... The woman is going to be with the recent loss of her pregnancy and she's going to have to go out and bury it and go through the cemetery with a little box... well, it's horrible and frightening... (PW 3)

"You don't bury it, so there is no obligation to give it... there's no burial so there's no death certificate and, later, what to do if it's given? Where do you put it? Where do you take it? You're not going to bring it home... this is also another whole issue, he could have a full pathology" (PW 2)

"I expelled a mass of tissue and blood and put it in a small flask... when it was all finished I asked the doctor and he told me IT'S DONE... but I always think it ended up in the trash or they burnt it... I think they refused to give it to me, but I wasn't strong, I didn't claim it" (WM 12)

Category 4—Need to Recognize and Keep the Child Who Did Not Live

This category deals with the emerging codes *honor and recognize your child: see the body*. This makes it possible to grieve; seeing the body of the child who did not live implies recognizing it as your child and acknowledging her death. The idea is that the health care team should offer this alternative, making the body available and presenting it in the best way possible so that the parents can remember it.

"If the health team which attends a vulnerable mother or family, who is in shock, recommends that she does not see the body as it may be upsetting, she certainly won't see it. But in the grief, which is the part the professionals don't see, this appears and perhaps the woman/family will ask themselves later, why didn't they give us more time?" (PW 4)

"the health personnel wanted to see who the crazy woman was who wanted the embryo to be given back (...) I stayed calm and went to look for her in the laboratory, they gave her to

me in a sample bottle, then I went to the church and we buried her there, with a beautiful prayer and great peace” (WM 15)

Discussion

There is a seemingly widespread convention to keep the pregnancy secret during the first trimester. The silence is prolonged in the women as they do not feel empowered to reveal the pain of the loss. Thus, Bellhouse et al. (2018) found that the women felt alone and isolated with their feelings of pain and loss as friends and family were not aware that they were pregnant and did not know how to show their support. Other studies show that women who had an abortion where family support was inadequate, had the perception that there was an imposition to get pregnant to supplant the lost child. In contrast, in some cultures, family support for the woman following perinatal loss has been satisfactory (Kharb & Sheoran, 2018).

With the loss of a pregnancy, women report feelings of isolation and exclusion. They also refer to having been put under pressure by their families and friends to get back to their normal lives and “move on” without social validation of their loss. As a result, they decide not to talk about their experience of grief, which also allows them to avoid making those close to them uncomfortable. Despite the trauma of the experience, the women continue struggling to get on with their lives and survive the loss, although this means pretending to be calm and resigned when this is not yet the case (Garrod & Pascal, 2019).

In the study by Kalu (2019), religious beliefs allow the women to overcome the loss, remain emotionally strong, and hope for a better future and a successful pregnancy. They also state that the prayers of family members help them to accept and adapt to the loss. Spirituality and religious beliefs were the most common source of psychological support reported by women in the study.

Results from the study by Wright (2020) indicate that faith plays a key role in the process of perinatal mourning. Women turn to their faith and religious beliefs in search of comfort following their loss, also attributing their healing to the Love of God. The belief that God is actively involved with them in their suffering is translated into movement towards greater spirituality.

On the other hand, there is implicit criticism of the health care system. The loss of a child in the early stages of pregnancy leaves its mark on the women, which could be less deep or better tolerated with the appropriate professional accompaniment. The accounts of most participants show disagreement with the care received in emergency, ultrasound and during admission. In line with other authors, it is considered necessary to implement education programs in health institutions focused on sensitive, empathic care in situations of miscarriage (Cullen et al., 2017). Along the same lines but in a very different context, the women reflect on the right to receive comprehensive care, not solely addressing the cause of the loss (Kharb & Sheoran, 2018). Inappropriate treatment on the part of distinct health professionals and in different services is perceived as abuse. These would include cases such as the medical consultation with

the intention of incriminating the women having a miscarriage to the attempt to persuade a woman who had recently received bad news to terminate the pregnancy. Further, parents have heard insensitive comments from personnel regarding the period of expulsion of the fetus (Cullen et al., 2017).

In agreement with other studies, this study reveals situations of depression linked to the loss and the lack of professional support and guidance in this regard. In the study by Bellhouse et al. (2018), the women made a series of recommendations to improve care following SA. Some of the demands echo those of participants in this study, including the call for follow-up care after miscarriage and referrals to support services. Similarly, effective screening instruments and treatment options for the consequences of miscarriage on mental health have recently been recommended (Quenby et al., 2021).

Although this study did not find psychological or emotional support for women as follow-up, some participants felt the empathy of other health professionals through closeness, understanding, and affection. Care oriented to the support of the women has a positive effect in helping them to complete a normal grieving process after a miscarriage (Palas Karaca & Oskay, 2021). The treatment options for miscarriage require decisions that are sensitive to the woman's preferences and imply greater satisfaction with the care services provided. A good practice in this respect was the chance to choose the treatment for early pregnancy loss. This reassured the women, who were able to choose between conservative, medical or surgical management. Such a decision could lead to complex emotions including deep grief, denial, guilt, disappointment, pain, or comfort (Pinnaduwege et al., 2018).

One of the issues that emerges strongly and demands greater attention is the decision regarding the child's remains; to give them a place. According to the law in effect in Uruguay, those miscarriages after 20 weeks or where the fetus weighs more than 500 g are registered with names and buried. Remains not meeting these criteria are treated as biological waste after being studied anatomopathologically. Our study found that some health professionals decided on the fate of the remains without consulting the woman. In England, pregnancy losses before 24 weeks are considered miscarriages and the remains are legally deemed to be the woman's tissue (Human Tissue Act 2004). A miscarriage is not recorded, although many hospitals provide the woman with an unofficial certificate and crematoria frequently maintain non-mandatory records (Kuberska et al., 2020).

It was observed that most participants recognize this need after emerging from the shock of the recent loss, with the exception of one woman who was able to decide beforehand. Time is probably a key factor in the decision made by women who experienced the loss. When a miscarriage occurs, both the women's bodies and the fetuses have a somewhat uncertain nature. The women have begun the development of an identity as a parent although they cannot establish the identity with this child in the way they expected. Similarly, they feel the loss as something inherent to their physical dimensions. However, this part of themselves was on the way to becoming a person in his/her own right. As such, the fetus occupies a liminal space as it is already a baby in some sense and is also human tissue (Kuberska et al., 2020).

The possibility of seeing the remains of the loss for some women means coming into contact with the death of the child. Some women cannot make this contact, which in all likelihood makes the grieving process more difficult, although other women are comforted by being able to preserve the child's remains in a vessel.

The way of keeping the child in the memory implies the possibility of honoring her and to do this the women need to preserve something of the child. Here the importance arises of professionals' orientation toward the woman who feels too vulnerable and labile to make decisions or choices. The memory often requires a place to honor the child but if there is no place, no physical space, this spiritual need is not satisfied. At present in Uruguay, burials of remains with the characteristics mentioned above are not carried out. The ceremony is important to the grieving process. In contrast, in England, sensitive burial or cremation of remains from before 24 weeks are permitted (Human Tissue Authority, 2015). In other studies, it can be observed that the women accept the unofficial certificate of pregnancy loss offered to them in the hospital. However, other women preferred to have the chance to formally register the death in recognition of their child (Fuller et al., 2018).

In the study, the ritual to honor the dead child is linked to a religion, which offers symbols to help connect the memories and the identity of the child. The evidence shows that in the choice of objects that represent the loved one, the emotions of bereavement are channeled through the form of the ritual (Wojtkowiak et al., 2021).

Final Considerations

An important strength of this research is the opportunity to be able to fully understand the experiences of miscarriage from both the point of view of the women who had the loss and the various health professionals. The focus on the woman reveals an experience of great suffering with unmet and inadequately resolved needs. These needs include the right to grieve, to make a decision on the remains of the child who did not live and the right to comprehensive care that preserves their health in all respects. Furthermore, it is possible to warn of the perception of abuse in health care during early loss linked to stereotyped gender roles.

Focused ethnography was a suitable approach to achieve the aims. A study limitation is related to the snowball recruitment method, an aspect that could skew the sample and include women from similar backgrounds. In future research, it would be important to use other means of recruitment and data collection. This would allow the inclusion of other participants so that cultural differences in needs can be explored.

Acknowledgments

The authors would like to thank the participants who generously provided their time and insight into this important research. The authors also acknowledge the contributions of Dr. Mabel Rivero in the review of legal aspects. They also thank the Omar Ibarгойen Paiva Foundation for its financial support in translating the article.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical Approval

The study was approved by the research ethics committee at the Faculty of Nursing and Technology, Universidad Católica del Uruguay, reference number: 004-2018.

ORCID iDs

Natalie Figueredo-Borda  <https://orcid.org/0000-0002-1508-7837>

Mirliana Ramírez-Pereira  <https://orcid.org/0000-0003-1439-4162>

Pedro Gaudiano  <https://orcid.org/0000-0002-2330-1944>

Cecilia Cracco  <https://orcid.org/0000-0003-3953-001X>

References

- Badenhorst, W., & Hughes, P. (2007). Psychological aspects of perinatal loss. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 21(2), 249–259. <https://doi.org/10.1016/j.bpobgyn.2006.11.004>
- Bellhouse, C., Temple-Smith, M. J., & Bilardi, J. E. (2018). “It’s just one of those things people don’t seem to talk about...” women’s experiences of social support following miscarriage: A qualitative study. *BMC Women’s Health*, 18(1), 176. <https://doi.org/10.1186/s12905-018-0672-3>
- Bikker, A., Atherton, H., Brant, H., Porqueddu, T., Campbell, J., Gibson, A., McKinstry, C., Salisbury, S., & Ziebland, S. (2017). Conducting a team-based multi-sited focused ethnography in primary care. *BMC Medical Research Methodology* 17(1), 139. <https://doi.org/10.1186/s12874-017-0422-5>
- Boss, P., Bryant, Ch., & Mancini, J. (2016). *Family stress management: A contextual approach* (3er ed.). Sage Publications.
- Cámara de Senadores. (2021), *Morinatos. Se reconocen derechos de sus progenitores*. Comisión de Salud Pública, 28 de junio de 2021. Uruguay. <https://parlamento.gub.uy/documentosyleyes/ficha-asunto/150970>
- Costa, J., Da Rocha, A., Iaconelli, V., & Nascimento, E. (2013). Quando a morte visita a maternidade: atenção psicológica durante a perda perinatal. *Teoria Y Prática*, 15(3), 34-48. <https://www.redalyc.org/articulo.oa?id=193829739003>.
- Cullen, S., Coughlan, B., Casey, B., Power, S., & Brosnan, M. (2017). Exploring parents’ experiences of care in an Irish hospital following second-trimester miscarriage. *British Journal of Midwifery*, 25(2), 110–115. <https://doi.org/10.12968/bjom.2017.25.2.110>

- deMontigny, F., Verdon, C., Meunier, S., & Dubeau, D. (2017). Women's persistent depressive and perinatal grief symptoms following a miscarriage: The role of childlessness and satisfaction with healthcare services. *Archives of Women's Mental Health, 20*(5), 655–662. <https://doi.org/10.1007/s00737-017-0742-9>
- Ezekiel, E., Wendler, D., & Grady, C. H. (2008). An ethical framework for biomedical research. In: E. Ezekiel, Ch Grady, R. Crouch, R. K. Lie, F. G. Miller, & D. Wendler (Eds.), *The oxford textbook of clinical research ethics* (pp. 123–135). Oxford University Press.
- Fuller, D., McGuinness, S., Littlemore, J., Kuberska, K., Turner, S., Austin, L., & Burgess, M. (2018). *Death before birth: Understanding, informing and supporting choices made by people who have experienced miscarriage, termination and still birth: Preliminary project findings for meeting with representatives of the department of health and social care*. UK Data Service. <https://testprojectwebsiteblog.files.wordpress.com/2019/03/summary-of-project-findings-report-for-dhsc.pdf>
- Gadamer, H. (1969). *Wahrheit und Methode*. Mohr.
- Garrod, T., & Pascal, J. (2019). Women's lived experience of embodied disenfranchised grief: loss, betrayal, and the double jeopardy. *Illness, Crisis & Loss, 27*(1), 6–18. <https://doi.org/10.1177/1054137318780582>
- Golan, A., & Leichtentritt, R. D. (2016). Meaning reconstruction among women following stillbirth: a loss fraught with ambiguity and doubt. *Health & Social Work, 41*(3), 147–154. <https://doi.org/10.1093/hsw/hlw007>
- Hamama-Raz, Y., Hartman, H., & Buchbinder, E. (2014). Coping with stillbirth among ultra-orthodox jewish women. *Qualitative Health Research, 24*(7), 923–932. <https://doi.org/10.1177/1049732314539568>
- Hay, P. E. (2004). Bacterial vaginosis and miscarriage. *Current Opinion in Infectious Diseases, 17*(1), 41–44. <https://doi.org/10.1097/00001432-200402000-00008>
- Hughes, P., Turton, P., Hopper, E., & Evans, C. (2002). Assessment of guidelines for good practice in psychosocial care of mothers after stillbirth: A cohort study. *The Lancet, 360*(9327), 114–118. [https://doi.org/10.1016/s0140-6736\(02\)09410-2](https://doi.org/10.1016/s0140-6736(02)09410-2)
- Human Tissue Authority. (2015). *Guidance on the disposal of pregnancy remains following pregnancy loss or termination*. Royal College of Nursing. http://www.rcn.org.uk/_data/assets/pdf_file/0020/78500/001248.pdf
- Johnson, S., & Rasulova, S. (2017). Qualitative research and the evaluation of development impact: incorporating authenticity into the assessment of rigour. *Journal of Development Effectiveness, 9*(2), 263–276. <https://doi.org/10.1080/19439342.2017.1306577>
- Jones, J. (2019). Support and follow up needs of parents after pregnancy loss, stillbirth and neonatal death: recommendations for practice. *International Journal of Birth & Parent Education, 6*(2), 20.
- Kalu, F. (2019). Women's experiences of utilizing religious and spiritual beliefs as coping resources after miscarriage. *Religions, 10*(3), 185. <https://doi.org/10.3390/rel10030185>
- Kharb, R., & Sheoran, P. (2018). A study to explore living in experiences of women with miscarriage at selected hospital, ambala, Haryana, India. *International Journal of Reproduction Contraception, Obstetrics and Gynecology, 7*(7), 2856–2861. <https://doi.org/10.18203/2320-1770.ijrcog20182895>

- Kuberska, K., Fuller, D., Littlemore, J., McGuinness, S., & Turner, S. (2020). Death before birth: liminal bodies and legal frameworks. In: C. Dietz, M. Travis, & M. Thomson (Eds.), *A jurisprudence of the body* (pp. 149–178). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-42200-4_7
- Kuen, K., Liu, D., & Hong, Y. (2019). Qualitative research methods in empirical social sciences studies - young scholars perspectives and experiences. In: K. Kuen, D. Liu, & Y. Hong (Eds.), *Challenges and opportunities in qualitative research* (pp. 1–6). Springer.
- La Diaria. *Proyecto sobre “hijos nacidos sin vida”: Diferencias entre blancos acerca de establecer o no un mínimo en la edad gestacional*. (2021). La Diaria. <https://ladiaria.com.uy/politica/articulo/2021/7/proyecto-sobre-hijos-nacidos-sin-vida-diferencias-entre-blancos-acerca-de-establecer-o-no-un-minimo-en-la-edad-gestacional/https://www.montevideo.com.uy/Salud/Chile-promulga-ley-que-permite-sepultar-con-nombre-a-bebes-muertos-antes-de-nacer-uc726912>
- Lee, C., & Rowlands, I. J. (2015). When mixed methods produce mixed results: integrating disparate findings about miscarriage and women’s wellbeing. *British Journal of Health Psychology*, 20(1), 36–44. <https://doi.org/10.1111/bjhp.12121>
- Lincoln, Y., Lynham, S., & Guba, E. (2017). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In: N. Denzin & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 213–316). Sage Publications.
- Louw, J., & Sturrock, C. (2013). Meaning-making after neonatal death: narratives of Xhosa-speaking women in South Africa. *Death Studies*, 37(6), 569–588. <https://doi.org/10.1080/07481187.2012.673534>
- Lozano Méndez, F., Rodríguez Estula, G., Curbelo Ferrari, C., Berro, G., & Rodríguez Almada, H. (2007). Óbito fetal guía de manejo para montevideo. http://www.medicinalegal.edu.uy/bibliografia/archivos/prot_derobitnacper.pdf
- Marquina, M., Oviedo, S., Parra, F., & Urdaneta, E. (2009). Duelo materno por muerte perinatal. *Revista Mexicana de Pediatría*, 76(5), 215–219.
- Mills, T.A. (2015). Improving support in pregnancy after stillbirth or neonatal death: IMPs study. *BMC Pregnancy Childbirth*, 15(suppl 1), A14. <https://doi.org/10.1186/1471-2393-15-s1-a14>
- Montevideo Portal. (2019). *Chile promulga ley que permite sepultar con nombre a bebés muertos antes de nacer*. <https://www.montevideo.com.uy/Salud/Chile-promulga-ley-que-permite-sepultar-con-nombre-a-bebes-muertos-antes-de-nacer-uc726912>
- Murphy, S., & Cacciatore, J. (2017). The psychological, social, and economic impact of stillbirth on families. *Seminars in Fetal and Neonatal Medicine*, 22(3), 129–134. <https://doi.org/10.1016/j.siny.2017.02.002>
- Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: a purposeful method of sampling in qualitative research. *Strides in Development of Medical Education*, 14(3), Article e67670. <https://doi.org/10.5812/sdme.67670>
- Nuzum, D., Meaney, S., & O’Donoghue, K. (2016). The place of faith for consultant obstetricians following stillbirth: a qualitative exploratory study. *Journal of Religion and Health*, 55(5), 1519–1528. <https://doi.org/10.1007/s10943-015-0077-7>

- Obst, K. L., Due, C., Oxlad, M., & Middleton, P. (2020). Men's grief following pregnancy loss and neonatal loss: a systematic review and emerging theoretical model. *BMC Pregnancy & Childbirth*, 20(1), 11–17. <https://doi.org/10.21203/rs.2.14041/v4>
- Ortega-Bastidas, J. (2020). ¿Cómo saturamos los datos? Una propuesta analítica “desde” Y “Para” la Investigación cualitativa. *Interciencia*, 45(6), 293–299.
- Palas Karaca, P., & Oskay, Ü. Y. (2021). Effect of supportive care on the psychosocial health status of women who had a miscarriage. *Perspectives in Psychiatric Care*, 57(1), 179–188. <https://doi.org/10.1111/ppc.12540>
- Pessoa, A. S. G., Harper, E., Santos, I. S., & Gracino, M. C. D. S. (2019). Using reflexive interviewing to foster deep understanding of research participants' perspectives. *International Journal of Qualitative Methods*, 18(1), 160940691882502. <https://doi.org/10.1177/1609406918825026>.
- Pinnaduwege, L., Honeyford, J., Lackie, E., & Tunde-Byass, M. (2018). A comparison of the number of patient visits required for different management options for early pregnancy loss at an early pregnancy assessment clinic. *Journal of Obstetrics and Gynaecology Canada*, 40(8), 1050–1053. <https://doi.org/10.1016/j.jogc.2017.10.034>
- Puia, D. M., Lewis, L., & Beck, C. T. (2013). Experiences of obstetric nurses who are present for a perinatal loss. *Journal Obstetric Gynecologic & Neonatal Nursing*, 42(3), 321–331. <https://doi.org/10.1111/1552-6909.12040>
- Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podeseck, 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. *Lancet (London, England)*, 397(10285), 1658–1667. [https://doi.org/10.1016/S0140-6736\(21\)00682-6](https://doi.org/10.1016/S0140-6736(21)00682-6)
- Rizo García, M. (2015). Interacción y emociones: La microsociología de Randall Collins y la dimensión emocional de la interacción social. *Psicoperspectivas*, 14(2), 51–61. <https://doi.org/10.5027/PSICOPERSPECTIVAS-VOL14-ISSUE2-FULLTEXT-439>
- Saldaña, J. (2021). *The coding manual for qualitative researchers*. Sage Publications.
- Shannon, E., & Wilkinson, B. D. (2020). The ambiguity of perinatal loss: A dual-process approach to grief counseling. *Journal of Mental Health Counseling*, 42(2), 140–154. <https://doi.org/10.17744/mehc.42.2.04>
- Uruguay (1992). Decreto 258/992 del Poder Ejecutivo del 9 de junio de 1992. SMU. In *Decreto 258/992 del Poder Ejecutivo del 9 de junio de, 1992*. SMU. <https://www.smu.org.uy/publicaciones/libros/laetica/ncmdydp.htm#decreto>.
- Wallbank, S., & Robertson, N. (2013). Predictors of staff distress in response to professionally experienced miscarriage, stillbirth and neonatal loss: A questionnaire survey. *International Journal of Nursing Studies*, 50(8), 1090–1097. <https://doi.org/10.1016/j.ijnurstu.2012.11.022>
- Wojtkowiak, J., Lind, J., & Smid, G. E. (2021). Ritual in therapy for prolonged grief: A scoping review of ritual elements in evidence-informed grief interventions. *Frontiers in Psychiatry*, 11(1), 623835. <https://doi.org/10.3389/fpsy.2020.623835>.
- Wright, P. M. (2020). Perinatal loss and spirituality: A metasynthesis of qualitative research. *Illness, Crisis & Loss*, 28(2), 99–118. <https://doi.org/10.1177/1054137317698660>

Author Biographies

Natalie Figueredo-Borda Doctor of Medicine from the University of Barcelona, Spain.

Mirliana Ramírez-Pereira Doctorate in Nursing from the Andrés Bello University; Chile.

Pedro Gaudio Doctor of Theology from the University of Navarra, Spain.

Cecilia Cracco Doctor in Psychology, University of Salvador, Argentina.

Beatriz Ramos Professor of Family, Conjugal Society and Inheritance.