



# Between Pain and Hope: Parent's Grief at the Diagnosis of Fetal Malformation

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## Abstract

*Objectives:* to understand how parents experience grief after being diagnosed with fetal malformation during the prenatal period.

*Methods:* this was a qualitative, exploratory, and descriptive study conducted in the fetal medicine outpatient clinic of a tertiary public hospital in Fortaleza, Ceará. Data were collected between May and July 2019 using semi-structured interviews. Eight subjects participated, six pregnant women and two parents. The material was subjected to categorical content analysis in light of the theoretical model of psychosocial transitions of bereavement in dialogue with perinatal psychology.

*Results:* after the diagnosis was confirmed, the participants went through different stages of bereavement for the loss of their imaginary baby, which were not shown as linear, but with alternating feelings. Even with the diagnosis of fetal malformation, the parents' emotional attachment to the baby remains present. The main coping strategies reported were religiosity, social and family networks, communication, and mutual support between the couple.

*Conclusion:* the grief at the diagnosis of fetal malformation extends beyond physical loss, encompassing the loss of expectations and the need to redefine the parent's role amidst uncertainties regarding the baby's future. This underscores the importance of incorporating psychological services as an integral part of prenatal care.

**Key words** Bereavement, Parents, Congenital abnormalities, Prenatal diagnosis



## Introduction

The process of pregnancy and the result involving parents to prepare for the arrival of the newborn, without any delay, the idealization of a healthy child and a birth without complications. Intrinsic to this period, various feelings are mobilized, such as joy, insecurity and fear of the unknown. In the midst of this, a set of conceptions wrapped in dreams, plans and expectations about the baby is formed in the parents' psyche. Thus, the discovery of a fetal malformation symbolizes, for the parents, the loss of their idealized child.<sup>1</sup>

Fetal congenital malformations are structural or functional defects of organs, cells or cellular components that arise during the development of the fetus and manifest themselves before birth.<sup>2,3</sup> Any alteration during embryonic development can lead to malformations that vary in their level of impairment, which can have medical, social or aesthetic consequences for the person affected.<sup>3</sup>

The confirmation of a diagnosis of fetal malformation can trigger thoughts of helplessness and feelings of guilt, anger, frustration, revolta, sadness and anguish, as well as social isolation and negative impacts on self-esteem.<sup>4,5</sup> These reactions can be considered common to any bereavement process, an event which involves a range of biopsychosocial responses expected in a significant loss and which includes, in its elaboration process, the transformation and resignification of the relationship with what was lost.<sup>6</sup> In this sense, the period of adaptation to the diagnosis of fetal malformation reveals itself to the parents as a moment marked by unique and demanding challenges, with diverse repercussions in the emotional, conjugal and family spheres.<sup>7,8</sup>

It was because the authors of this study worked in a neonatal intensive care unit and were close to the parents' intense experience with their children being hospitalized so early due to prematurity, malformation and the necessity for surgery, that the topic presented here caught their attention. So, in order to improve our understanding of the emotional repercussions caused by the news of a malformation and to broaden our sensitivity to care for these families, we aimed to understand how parents experience grief after being diagnosed with a fetal malformation in the prenatal period.

## Methods

This is a qualitative, exploratory and descriptive study carried out at the fetal medicine outpatient clinic of a tertiary public hospital located in Fortaleza, Ceará, which is a reference in monitoring pregnancies of fetuses diagnosed with congenital anomalies. It should be noted that, although there is a distinction between the terms

fetal malformation, congenital anomaly and syndrome in the medical literature, these distinctions were not used in this study.

The data was collected between May and July, 2019, through semi-structured interviews which, in addition to surveying the participants' sociodemographic data, covered topics such as pregnancy planning, the initial reaction to the diagnosis, understanding and feelings about the child's condition, and the parents' feelings for the baby. The interviews were conducted individually in a private room at the clinic and recorded for later transcription.

Participants were recruited by convenience, when pregnant women and their parents were approached while they were waiting for their prenatal appointment and invited to take part in the study according to the following inclusion criteria: having been diagnosed with a fetal malformation during prenatal care for the current pregnancy; being over eighteen years old; allowing the interview to be recorded; having the cognitive ability to answer the proposed instrument. The number of participants was limited by the criterion of theoretical saturation, i.e. when it was found that the information provided was no longer contributed significantly to improve theoretical reflection, the inclusion of new participants was suspended.<sup>9</sup>

During the collection, although ten interviews were carried out, two pregnant women asked for the recording to be suspended during the procedure. These interviews were then excluded, since the interruption made it impossible to transcribe them in full, compromising the accuracy of the analysis. In the end, only eight participants were considered, six of whom were pregnant women and two fathers, who were partners of the two pregnant women interviewed.

The material obtained from the interviews was examined using content analysis, which is a set of techniques for analyzing communications which, based on systematic and objective methods for describing the content of reports, allows for the inference of knowledge regarding the conditions of production and reception of these messages.<sup>10</sup> The type of content analysis used was categorical. The corpus research was subjected to the three stages proposed by the method (pre-analysis, exploration of the material and analysis of the data acquired) and discussed in the light of the theoretical model of the psychosocial transitions of bereavement<sup>6,11</sup> in the dialogue with the concepts from perinatal psychology.<sup>4,12,13</sup>

The psychosocial transitions model of bereavement, proposed by Parkes,<sup>6,11</sup> offers a robust framework for understanding bereavement as a dynamic process, characterized by emotional reactions and psychosocial adjustments of the loss. Although initially proposed for the death of a loved one, this model is widely applicable

for other forms of losses, such as symbolic or potential loss, represented in this study by the diagnosis of fetal malformation. Parental grief, in this context, can be seen as a response to the loss of expectations and dreams about the child's future.

Parkes<sup>6,11</sup> states that the experience of loss challenges the assumed world, i.e. the individual's internal construction of what we expect from life, from ourselves and from others. In the case of fetal malformation, bereavement involves both the loss of the idealized baby and the necessity to reorganize these personal perspectives in order to incorporate the new reality. In this way, bereavement is not just about the absence of what was lost, but about the reconstruction of a new view of the world.<sup>14</sup>

In turn, perinatal psychology offers a fundamental approach to understand the emotional bond that parents begin to form with their baby during pregnancy and how this bond is confronted by the diagnosis.<sup>4,12,13</sup> This situation can trigger a significant emotional crisis, affecting parents during pregnancy and possibly in postnatal life, depending on the severity of the malformation.

In this article, excerpts from speeches have been presented to illustrate the findings. In order to maintain anonymity, the participants were identified by letters and numbers in the sequence in which the interviews took place, with the pregnant mothers being identified by the letter "M" and the fathers by the letter "F". It should be emphasized that the parents interviewed were referred to the psychologist linked to the fetal medicine service whenever emotional needs were identified, guaranteeing access to the psychological support.

The study was approved by the Research Ethics Committee at the hospital under CAAE 11654919.7.0000.5041.

## Results and Discussion

Regarding the profile of the interviewees, all lived in the cities in the Metropolitan Region of Fortaleza and were aged between 21 and 41. They were all literate, with high school being the highest level of education. The pregnant women had gestational ages between 23 and 36 weeks. The total number of pregnancies, considering the current one, ranged from one to four. Only one woman had a history of miscarriage and another reported a previous history of stillbirth related to the fetal anomaly. Table 1 shows the sociodemographic and biological characteristics of each participant in order to provide a more detailed overview of the people interviewed.

Based on the analysis carried out, three main thematic categories were identified: 1) Imaginary baby and parent-child bond; 2) Grieving process following the diagnosis of fetal malformation; and 3) Coping strategies used by

parents. These categories, initially guided by the research's theoretical framework, were refined and enriched by the data emerging from the interviews. Table 2 shows a synoptic table summarizing the thematic categories and the clippings of the most significant statements that represent them, which underpin the subsequent discussions.

### Imaginary baby and parent-child bond

The participants' accounts revealed different stories regarding the presence or absence of pregnancy planning and the desire to have a child. Of the eight interviewees, only one said she had planned her pregnancy. Despite this common lack of planning, all of them showed a desire to continue with the pregnancy once they became aware of it. Furthermore, it was possible to identify some of the expectations placed on the figure of the baby and the projects of motherhood and fatherhood, as well as the preparation for the arrival of the child, expressed by planning the trousseau and arranging the child's room.

During the pregnancy period, three gestations co-exist in the parents' psyche: the phantasmatic baby, the imaginary baby and the real baby. The phantasmatic baby is the one present from the beginning of the parents' existence, arising from the primitive experiences of each parent. The imaginary baby represents the set of constructions formed during the mental gestation of the conceptus, and is the result of dreams and desires for motherhood/paternity.<sup>1,15</sup> The formation of the real baby intensifies during the third trimester of pregnancy, as the movement of the fetus increases, signaling its real existence, as well as the use of technologies that allow it to be visualized.<sup>4</sup>

In this sense, the child begins to exist in the parents' minds long before birth, as long as the parents are able to imagine it. This movement helps form early and fundamental bonds that enable parents to invest in the care and affection of their child from the outset. The desire to know the baby's sex, the choice of name and the physical and behavioral characteristics idealized by the parents are part of the formation of the imaginary baby.

The construction of the imaginary child prepares the parents for the arrival of the real baby.<sup>16</sup> It is through prenatal consultations, heartbeat auscultations and various tests that the information about the development of the fetus is provided to the parents, helping them in the transition to the real baby. The use of imaging technology also makes it possible to make increasingly accurate diagnoses about the existence of any abnormalities during pregnancy, which can lead to a confrontation between the constructed figure of the imaginary baby and the real baby, who is different from the parents' representations.

Each pregnancy has a unique meaning related to the personal history of the pregnant mother and father, the

Table 1

Sociodemographic and biological characteristics of the participants. Fortaleza, Ceará, Brazil, 2019.

ID	Age (Years)	Marital status	Schooling	City of residence	Occupation	Gestational age (weeks)	Obstetric history
M1	40	Married	Elementary Incomplete	Fortaleza	Housewife	36	04 pregnancies, 01 stillbirth
M2	21	Married	High school Completed	Pacajus	Housewife	30	02 pregnancies
M3	22	Married	Elementary Incomplete	Caucaia	Informal work	26	03 pregnancies
M4	24	Married	High school Completed	Fortaleza	Housewife	26	01 pregnancy
M5	35	Consensual union	High school Incomplete	Paraipaba	Housewife	23	02 pregnancies
M6	36	Married	High school Completed	Fortaleza	Housewife	27	04 pregnancies, 01 abortion
F1	28	Consensual union al	Elementary Incomplete	Caucaia	Pastry chef	26	N/A
F2	41	Married	High school Completed	Paraipaba	Technical assistant	23	N/A

Table 2

Synopsis of the categorical analysis and significant cut-outs. Fortaleza, Ceará, Brazil, 2019.

Thematic Categories	Subcategories with Significant Cut-outs
1. Imaginary baby and parent-child bond	1.1 Pregnancy context (planning or surprise)
	<i>I was very happy, because we'd been planning it for a long time, and now it worked out. It's been two years, since the beginning of the marriage. (M4)</i>
	<i>It was a surprise, right, but as I said, I was happy. I've always wanted to be a mother, I already have two girls, so it would be another joy for me. (M6)</i>
	<i>The pregnancy was unexpected. It happened suddenly, nobody planned it. She got pregnant and we decided to have the baby [...]. (F2)</i>
	1.2 Idealized child
	<i>[...] last month, when I had the morphological [ultrasound], I found out it was a boy. That was another joy! First child. The father almost 'freaks out' again. (M4)</i>
	<i>For me, I thought that when the baby was born, [...] the baby would be born normally, the baby would be generate normally, but I don't know, it's the first time this has happened to me, so I don't understand much about it, I can't explain it properly. [...] When I thought of his name, I was thinking of the angel Rafael [fictitious name], so I named him Rafael. (F1)</i>
	1.3 Expressions of affection for the baby
	<i>Too much love. I can't wait to see it. (M3)</i>
	<i>Just happiness. Just feeling the baby move is a joy for me. (M4)</i>
	<i>I keep stroking her belly until I feel him kick. Then I keep kissing the belly. (F1)</i>
	1.4 Parental expectations
	<i>The only certainty he has is this: that he'll look after her, that he'll grow up together. (M3).</i>
	<i>I've always wanted to be a mother (M6).</i>
	<i>We've already bought everything. (F2)</i>

2. Grieving process following the diagnosis of fetal malformation

2.1 Shock and denial

*I was really overwhelmed, because I'd seen so many cases of mothers having children with problems, and I thought I'd never go through it. It was such a shock, at the time I thought... I didn't know what to do... there... there... at the same time I was happy, and at the same time I was sad, because it's hard to have a child with a problem, sick. (M2)*

*I was very sad. I cried, I cried a lot. And at the time I told him [my husband], I thought he'd fainted on the spot, because I was still here in hospital, and he was at work, so he was quiet for half an hour, not answering anything, and I cried a lot. (M3)*

*[...] he [the doctor] just asked me to do it again, another morphological [ultrasound], because he couldn't find the baby's nasal bone. Then I freaked out! I went again, then I had another [exam] to see if it was really true, and then it was. I did another [morphological] test, and it was just one thing. (M5)*

*[...] I even told her [wife] not to think too much about these things, I'm not much of a thinker. I'm more focused on work, on my other children, on her children, who are the youngest and oldest. (F1)*

*It was the first morphology exam I've ever done, [...] he [the doctor] said it, but I didn't really believe him, so I had another exam done. (F2)*

2.2 Longing and searching

*Very sad [crying, pause]. Very sad, because we also search on Google. And many cases are good, but others are not. [So it's up to God [crying]]. (M4)*

*That my son comes healthy. That's what I want most. (M5)*

2.3 Disorganization and despair

*We're afraid, because the child, as soon as the baby is born, the baby is going to have surgery. You have to know if the child is going to be able to withstand this surgery. Then we're afraid, I don't know, I've never lost a child, I already have my first daughter, who is one year and eight months old, and now I'm going to have my second, but so far I don't know what it's like to lose a child. It must be an immense pain, but I don't really like to talk about it, no. (M2)*

*I talk to the baby [the fetus], I feel fine, but then I start thinking about the kidneys, I get sad. Then, when I get nervous, he moves, but then he stops, he stays still. [...] Then I think in the same way: I don't know if God will give the baby to me, or not, or if the baby will survive or not. (M3)*

2.4 Reorganization and adaptation

*[...] then he said that I had to do a treatment, that it was for the child, when the baby is born, the baby will not be born with a problem. So we ran, we went after and today we're here [the fetal medicine clinic], having treatment. We have to hope that the child is born well, and that the baby survives." (M2)*

*I've managed to calm down, when I 'talk' about the subject with someone, then I'm calmer, I'm not ready to explode [...]. Things don't always necessarily go according to plan, you know? And it's not like you're going to suffer in anticipation, it's not like that, but it's a way of taking care of the feelings you have for [the baby]. (M3)*

*It's because you can often accept it and not accept it, right? But I want myself to accept it. I know it's going to be difficult, but he's my son. He came from my womb, and I'm going to love him the same way. [...] If God gave me him with a problem, it's because he thinks I deserve it, he thinks I'll be able to look after him." (M5)*

*If he comes, he'll be treated well. If he doesn't, there's nothing I can do. (F1)  
When God gives us a special child to look after, it's because we are special parents to be able to look after them. (F2)*

	<p>3.1 Religiosity</p> <p><i>Asking God for strength, that God will work a miracle. (M1)</i></p> <p><i>It's hard to have a child with problems, sick, but God finds a way [...] so I took God by the hand, and God knows what he's doing. (M2)</i></p> <p><i>So, I also ask God not to suffer so much, because I don't know yet the pain of losing someone so close, and, I mean, it's a piece of me [...] I ask God that if he has to take it, he will, and I won't suffer, and that if God has to give it to me, I'll be very grateful. (M3)</i></p>
<p>3. Coping strategies used by parents</p>	<p>3.2 Social and family network</p> <p><i>[...] sometimes I feel ashamed, and sometimes I don't like it, because there are a lot of people where I live. We say something, then the next day everyone knows. Then I don't tell everyone. I say it's fine, and that's it. And the people I tell are close, friends of my family, friends I've had for a long time, but other people I don't tell. (M3)</i></p> <p><i>[...] my mother is very Catholic. We went to her house, we started to go to mass to ask for strength. The Family also got United to give advice to him (husband). Then we accepted more, and that helped us to take care of her. (F2)</i></p>
	<p>3.3 Mutual support for the couple</p> <p><i>Sometimes he [husband] doesn't like to talk much, neither with his mother nor with his daughter, he keeps to himself. Even with me he doesn't talk much, because he says I'm too uptight, I only think silly things, so he keeps quiet. (M3)</i></p> <p><i>He shows in being strong, he's strong. [...] So, if he sees me in any distress, he always gives me strength. That's why he doesn't leave me alone, he's always with me." (M5)</i></p>

circumstances surrounding this period and the present support network. These and other factors influence the process of forming the bond, understood as the bond that unites parents and children and can be identified from behavioral, cognitive and affective aspects that indicate attachment, concern and interaction with the fetus, as well as care for the pregnant woman's health.<sup>12,17</sup>

All the reports collected in this study pointed to the presence of an emotional bond with the baby, with expressions of contentment at the arrival of the new child, even though there was a fetal malformation. These data are in line with the study carried out by Borges and Petean,<sup>17</sup> who identified the persistence of the maternal-fetal bond, even after the diagnosis of congenital malformation. These authors also emphasize the importance of this emotional bond as a facilitator for pregnant women to express better emotional responses to prenatal diagnosis and to cope with the pregnancy.

### The grieving process following the diagnosis of a fetal malformation

When analyzing the participants' statements, it was observed that the process of parental bereavement in the diagnosis of fetal malformation is permeated by complex emotional dynamics. These dynamics range from initial shock to gradual acceptance and the reorganization of expectations.

Parkes<sup>6</sup> states that bereavement cannot be considered as a state, but rather as a dynamic process, involving not only a set of symptoms that begin with the loss, but also a range of reactions that merge and replace each

other. Each stage has its own characteristics, and there are considerable differences in the expressions from one person to the next, both in terms of duration and the way each phase is presented. The author warns that in any grieving process, it is rarely clear exactly what has been lost.

The significant loss dealt with in this research is triggered by the discovery of a fetal malformation, i.e. the loss of the imaginary baby, idealized as healthy and without complications in its development and birth. The emotional, cognitive and behavioral reactions triggered by the diagnosis can be seen in the common phases of: shock and denial of the loss; longing and searching for what has been lost; disorganization and despair, with manifestations of sadness, anger and anxiety; reorganization and recovery, with acceptance of reality, adjustment of expectations and emotional balance, even if the suffering is not completely eliminated.<sup>6,12,14,18,19</sup> These phases can occur at different times during pregnancy and are not necessarily presented in this order.<sup>6,13,18,19</sup>

In the reports, the manifestation of shock, a phase marked by an abrupt disorder of emotions, accompanied by feelings of helplessness, crying or even the desire to flee,<sup>5,13</sup> emerged shortly after the diagnosis was announced. In this stage, denial can occur in a more subtle way, when parents or the pregnant woman look for other professionals or tests that might contradict the diagnosis, or in a more explicit way, when, despite all the evidence, there is a refusal to broach the subject or the existence of the malformation is ignored.<sup>13</sup>

In some of the participants' speeches, the presence of feelings of intense sadness, fear, anger and anxiety was noticeable. On the other hand, other accounts were marked by a search for explanations and solutions, as well as a strong desire for the baby's condition to change or improve, even if the diagnosis was irreversible. These expressions gave indications of how the parents were dealing with the diagnosis and going through the grieving process.

With the gradual reduction of anxiety and intense emotional reactions, acceptance and adaptation begin to set in, representing the phase of reorganization and balance.<sup>5,6,13</sup> The feelings of emotional confusion soften and, gradually, the parents feel more comfortable in the situation and begin to believe in their ability to care for the baby.<sup>5,12</sup> In some cases, even though the adaptation process is present, it can be observed in an incomplete way.

At this stage, the baby is seen as a special child. The perception of vulnerability previously experienced is modified by a feeling of growing capacity and coping with the situation.<sup>5</sup> A movement of positive acceptance begins.<sup>12,18</sup> Thus, the pregnant woman or couple begin to form new plans for a reality beyond the baby's malformation and express the experience of an emotional reorganization.<sup>5</sup>

Studies<sup>12,16</sup> consider that parents need to work through the grief of losing the imaginary baby in order to be able to fully connect with the real baby to come. If the grieving process is fixed in one of the phases, a complicated atmosphere will form within the family, where the ghost of the imaginary healthy baby will become present, tending to interfere with the process of bonding with the real baby. In addition, as a negative consequence, there may also be a deficiency in maternal-fetal health care, manifested through absences from medical appointments, failure to take tests and a lack of self-care on the part of the pregnant woman.

### Coping strategies used by parents

Faced with the diagnosis of a fetal malformation, there are elements that interfere with the modulation of the parents' coping and help them, or not, to get through the grieving process. In this study, religiosity, the social and family network, communication and mutual support between the couple were the main factors reported.

For all those interviewed, religiosity was pointed out as an important source of help in the search for balance and in coping with the emotional repercussions of the diagnosis. This finding is in line with studies<sup>5,19,20,21</sup> which have shown that religious practices and spiritual support, because they are linked to feelings of hope and faith, in helping parents to find support in dealing with a situation that requires overcoming, acceptance and

decision-making. In addition, despite religiosity being considered a practice with high participation among women, the men in this study also relied on it as a resource of encouragement to cope with the experiences arising from their child's malformation, which is in line with the findings of other studies.<sup>21,22</sup>

In turn, the socio-family network, seen as those people or systems that are willing to support and reinforce the parents, was also identified as a factor that had an impact on coping with their child's diagnosis. This support can take the form of expressions of affection, encouragement or assistance, helping parents to cope with the situation.

However, sharing information about the fetal malformation is not always a strategy to guarantee support. The bereavement of the imaginary child brings with it a situation of ambiguous loss, the bereavement of the living child, leading to an experience that cannot be openly admitted and which is often not socially validated because it is not recognized.<sup>6,23</sup> In this situation, it is common for parents to encounter expressions of curiosity and uncaring approaches from other family members and acquaintances, which can lead some of them to choose silence as a form of protection.<sup>24</sup>

Although this choice of silence was present in several speeches during the interviews, it is considered that the search to maintain a social network, as opposed to isolation, can help parents not to remain focused on the diagnosis and to seek healthier ways of dealing with their child's malformation and its consequences. The support network can provide emotional, financial and/or instrumental support (help with housework, for example) which, in cases of high-risk pregnancies, acts as an important protective factor for the mental health of the pregnant woman and the father.<sup>5,20,25</sup>

In the same way, communication and mutual support between the couple also influenced their approach to coping with the diagnosis. The reports that emerged from the research point to a relationship of partnership and complicity between the couple, which strengthens them to face the situation. On the other hand, it was also observed that there are those who have opted for silence, which can promote distancing within the relationship.

The news of a malformation diagnosis is so traumatizing and destructive that it can have repercussions on the marital relationship, whether it is one of closeness with the establishment of mutual support, or one of distance with the experience of isolation. Klaus *et al.*<sup>12</sup> use the term asynchronous to describe parents who go through the stages of adaptation at different rates. These parents usually do not talk to each other much about their feelings and can therefore experience difficulties in their relationship. It is as if a temporary emotional separation develops between them, which in some cases can even lead to divorce.

The length of the process of parents adapting to the presence of a child with a malformation will vary from family to family.<sup>18,19</sup> However, in the vast majority of cases it will be a long and painful process, which usually leads to personal growth, changes in personal and spiritual beliefs, as well as parental self-confidence.<sup>12,19</sup>

Coming into contact with the diagnosis during prenatal care can help form coping strategies in the postpartum period. In this sense, it is recommended<sup>5,8,20</sup> that health professionals offer multidisciplinary support and psychological services as part of prenatal care to help parents cope with this challenging experience, process their emotions and make informed decisions about pregnancy and future care.

This present study provided access to the psychological repercussions caused to the parents by the diagnosis of a fetal malformation, and helped to understand the symbolic aspects brought up by them, thus making it possible to delve into the elements involved in the grieving process. The reflections prompted by the theoretical model<sup>4,6,11,12,13</sup> contributed to reading what was expressed by the parents after the loss of their imaginary baby following the confirmation of a fetal malformation.

One of the limitations of the study was the difficulty in locating other parents during prenatal consultations at the fetal medicine clinic. This resulted in a predominantly female data collection, which was not the initial desire of the research, which sought to include both parents in a more balanced way.

Despite this, by integrating the psychosocial transitions model with concepts from perinatal psychology, a broader understanding of the bereavement experience lived by parents after the diagnosis of a fetal malformation was obtained. This theoretical dialog highlighted the complexity of perinatal bereavement, which was not limited to physical loss, but also involved the loss of expectations and the need to redefine the parental role in the face of uncertainties about the baby's future.

In this way, the information gathered here may prove relevant to professional practice in the fields of fetal medicine, neonatology and perinatal psychology in outpatient and hospital settings. By making it possible to recognize the emotional manifestations that parents go through in this situation, they contribute to welcoming and assisting parents and their families, supporting them in dealing with the grieving process they experience.

### Authors' contribution

Conceição YZS: Conceptualization, methodology, research, data curation and analysis, writing of the original draft of the text and approval of the final version

of the article. Melo EP: Conceptualization, methodology, supervision, review and editing of the manuscript, and approval of the final version of the article. All the authors approved the final version of the article and declare no conflict of interest.

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