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Mother's experiences of perinatal grief: A qualitative study in Spain

María Consuelo Cruz-Ramos [a], Yolanda Hernández-Albújar [b,*], Davinia María Resurrección [a]

[a] Department of Psychology, Universidad Loyola Andalucía, 41704 Seville, Spain
[b] Department of Sociology, Universidad de Sevilla, 41013, Seville, Spain

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ABSTRACT

Background: Perinatal loss has a profound impact on the mother's mental health due to its unexpected nature, which disrupts the expectations and aspirations built during pregnancy. Although its impact is clinically documented, this grief remains silent and socially discredited, preventing mothers from receiving the recognition and support they need.

Aim: This study aims to delve into the lived experiences of mothers who have experienced perinatal loss, examining their grief coping mechanisms and the lasting impact of these experiences on their lives.

Methods: Thirteen mothers aged 31 to 49 who had experienced perinatal losses between gestational weeks 10 and 38 were interviewed using semistructured interviews. The resulting qualitative data were then examined using reflexive thematic analysis.

Findings: We grouped mothers' experiences into four themes: first news and medical procedure, farewell and mourning, making sense of the loss, and continuity. Our results show that each woman experiences this loss in her own unique way. Still, when addressed actively and consciously, the grieving process becomes integrated into each person's life story and can foster personal growth.

Conclusion: It is essential to continue working to raise awareness and visibility of perinatal loss. Furthermore, it is crucial to establish individualized care protocols to address the specific needs of each woman, with the support of a multidisciplinary team that includes psychological support throughout the postpartum period. Women can use their experiences, even the painful ones, to empower themselves, thus fostering personal growth and resilience.

Statement of Significance

Problem

The invisibility of perinatal loss continues to be present in our society, directly affecting women who experience it.

What is Already Known

It is well known that perinatal loss directly affects maternal mental health, increasing the risk of anxiety, depression, and post-traumatic stress disorder.

What this Paper Adds

This study offers first-person accounts of experiences of perinatal grief, highlighting the real needs of mothers. We identified the need for further research into healthcare protocols to facilitate the grieving process for women, including psychological follow-up after discharge from the healthcare center.

Introduction

The transition to motherhood is a complex process of development, during which women reevaluate and reconstruct their understanding of themselves and their personal and relational identities in order to develop their maternal identity (von Mohr et al., 2017). Consequently, when perinatal loss occurs, it affects women not only physically but also shatters their expectations and dreams of becoming a mother (Berry et al., 2021).

Perinatal loss refers to the experience of losing a baby at any point in the perinatal period, whether due to miscarriage, stillbirth, or neonatal death (Cuenca, 2023; Donegan et al., 2023; Kersting and Wagner, 2012). In its specifics, miscarriage refers to the loss of a baby before 20 weeks of gestation and includes terms such as early pregnancy loss or spontaneous abortion (Manning and Kuhn, 2023). This type of loss affects

* Corresponding author.
E-mail address: yhernandez@us.es (Y. Hernández-Albújar).

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approximately 10% of confirmed pregnancies (Lidegaard et al., 2020). In Europe, the incidence is estimated at 4.4 per 1000 women, and in Spain, where we conducted our study, it is 1.4 per 1000 (World Population Review, 2024). On the other hand, the American College of Obstetricians and Gynecologists (2020) defines stillbirth as the intrauterine death and subsequent delivery of a baby at 20 weeks of gestation or later, and it is estimated at 4.7 per 1000 births in Europe (Euro-Peristat, 2022), and 3.95 deaths per 1000 births in Spain. Finally, neonatal death indicates the death of a live newborn in the first 28 days of life. According to Euro-Peristat (2022), the neonatal mortality rate in Europe is 3.8 deaths per 1000 live births, while in Spain this rate is 1.77 deaths per 1000 live births.

Although each woman's experience of loss is deeply personal and unique (Arnold and Gemma, 2008), the sudden and generally unexpected event is emotionally overwhelming for most of them (Richards et al., 2015). In this respect, the scientific literature reports issues of depression, anxiety, and post-traumatic stress disorder as frequent effects (Davoudian et al., 2021). However, some studies affirm that mothers' responses and emotions are ambivalent and not always negative, as they also experienced moments of satisfaction and personal growth (Berry et al., 2021).

Thanks to medical advances, incidence rates have shown a downward trend in the Western world (Wolfson et al., 2024), but women who experience it still feel abandoned and uninformed (Cassidy, 2021). Perinatal loss continues to receive limited attention in the literature, reflecting its social invisibility and reproducing its marginalization at the community, academic, and research levels (Cala and Hernández, 2019; Golan and Leichtentritt, 2016; Hennessy and O'Donoghue, 2024; Rossen et al., 2023).

This study aims to identify and interpret the meanings and patterns in the grief experiences of Spanish women who have suffered a perinatal loss, examining how they make sense of this loss and its impact on their lives through reflexive thematic analysis. Although some qualitative studies on perinatal grief among the Spanish population exist, they are scarce, focus primarily on losses happening at week 24 or later, and date back more than 5 years (Camacho-Ávila et al., 2019; Fernández-Sola et al., 2020; Martínez-Serrano et al., 2019). Growing social awareness and improvements in clinical protocols suggest that lived experiences and medical care may have changed since then. This study expands prior work by including early pregnancy losses, from early miscarriage through neonatal death (Davoudian et al., 2021; Quenby et al., 2021). This approach moves beyond traditional perinatal-loss definitions tied to gestational age or birth weight, which do not capture mothers' grief (Kelly et al., 2021; Wright, 2011).

Methods

Study design

This qualitative study, grounded in a constructionist epistemological position, explored the experiences of Spanish women who had experienced a perinatal loss through semi-structured interviews. The study was conducted by a multidisciplinary team comprising two psychologists and a sociologist, all experts in qualitative methodology with prior research experience in motherhood studies. This expertise provided a deeper understanding of the phenomenon under study and helped ensure a more sensitive and contextually informed interpretation of the data. This reflexive thematic analysis enabled the researchers to collect detailed information about the experiences of the mothers, placing the women at the center of their own stories. This qualitative approach was particularly appropriate for this study due to the subjective nature of loss and the diverse experiences that can manifest in each person.

Reflexivity

Setting

The study was conducted in Spain, where public health services guarantee free and universal access to medical care during pregnancy, childbirth and the postpartum period. However, perinatal mental health services remain critically underdeveloped and are primarily available for high-risk cases like severe mental illness, so there is an urgent need for action to humanize protocols and prioritize perinatal mental health (Paricio del Castillo, 2024).

Participants and recruitment

We recruited participants through purposive sampling, leveraging a multidisciplinary network of professionals. We contacted psychologists, gynecologists, obstetricians, and midwives from public and private health centers in Spain to help us find women who had experienced perinatal loss and were interested in participating. We partnered with *Umamanita*, a leading Spanish non-profit organization that supports parents who have experienced perinatal loss. Umamanita first contacted potential participants. The first author contacted those who agreed to participate to provide more information about the study, confirm interest, and schedule an interview. No financial or other compensation was offered to participants. Our inclusion criteria were (a) having experienced a perinatal loss in the last two years, (b) having experienced it at least 6 months before the interview. These criteria were chosen to ensure that, on the one hand, the grieving experiences were not influenced by the exceptional circumstances of the pandemic and the particular medical context it entailed, and that, on the other, a reasonable amount of time had passed since the loss before the interview, in order to avoid acute emotional distress.

We contacted 16 eligible women, and 13 agreed to participate in the research. Although the reflective thematic analysis does not employ data saturation (Braun and Clarke, 2019), the sample size was determined following previous studies on perinatal grief experiences in similar contexts (Camacho-Ávila et al., 2019; Martínez-Serrano et al., 2019). The participants were identified as White women residing in Spain who ranged in age from 31 to 49 years old. All had experienced a perinatal loss within the past two years, occurring between 10 and 38 weeks of gestation. Three participants had experienced prior pregnancy losses, while nine were experiencing their first perinatal loss. One participant had experienced a perinatal loss and also lost another daughter at seven months old. Most participants were married at the time of the study; however, one participant separated from her partner as a direct consequence of the loss.

Data collection

The Ethics Committee of (anonymized) approved the study, and we provided each woman with a research information sheet and an informed consent form. Data were collected through semi-structured interviews conducted between March 2024 and March 2025 by two authors (C-R and H-A). Depending on the participants' availability, the interviews were conducted as in-person interviews (n = 10) or video calls (n = 3), with the time span of the interviews ranging from 50 to 180 min. The interviews were recorded with participants' consent, and confidentiality was ensured through pseudonyms. Recordings and transcripts were securely stored and accessible only to the research team.

We began the interviews with a general question, "What was it like for you to experience your loss?" and developed them according to each woman's needs. A general guide with broad questions was used to encourage new ideas and maintain consistency (Table 2) (Van Manen, 2016). During the interviews, if any signs of distress appeared, pauses were made as needed. Participants were also reminded throughout that

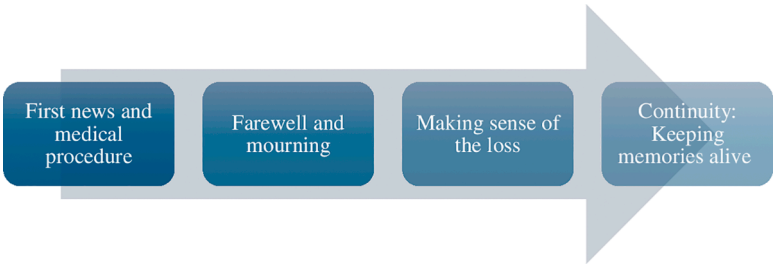

Fig. 1. Thematic Framework (Ordered by Manuscript Presentation).

Table 1
Sociodemographic characteristics of mothers.

Participant	Age	Week of loss	Previous perinatal losses	Marital Status
Naila	49	Week 10	No	Married
Paula	39	Week 12	Yes	Married
Sonia	34	Week 15	No	Married
Mariana	36	Week 19	No	Married
Ilsa	38	Week 20	No	Married
Nora	31	Week 21	No	Married
Sofía	39	Week 22	Yes	Married
Rocío	36	Week 25	Yes	Married
Alicia	32	Week 32	No	Married
Irati	32	Week 33	No	Married
Marta	33	Week 35	No	Separated
Leire	35	Week 36	No	Married
Patricia	41	Week 38	No*	Married

* Patricia suffered a perinatal loss in addition to losing her daughter at 7 months old.

they could stop the interview at any time or end it altogether if they wished.

Data analysis

The six stages of Braun and Clarke's reflexive thematic analysis were the basis for the data analysis (Bran and Clarke, 2006, 2019). These steps involved active immersion in the study material, which included familiarization with the transcripts, the generation of initial codes, the identification of themes, the review of these themes, the definition and naming of the themes, and the writing of the analysis, which combined interpretive narrative with representative excerpts. To ensure reliability and credibility, we employed a triangulation approach. The first author transcribed the data and, in collaboration with the second author, reached a consensus on codes and themes. The third author audited the preliminary results. This process was undertaken to minimize bias and ensure consistency with existing literature on perinatal grief. The findings were supported by direct quotations from the study participants, contributing to the credibility of the research (Braun and Clarke, 2020). In addition, the present study follows the recommendations of the SRQR checklist for qualitative research (O'Brien et al., 2014). The quotes were translated into English by the lead and corresponding authors, both fluent in English, and were double-checked to ensure accuracy and preserve the original meaning.

Results

The results are presented here in chronological order to facilitate reading (see Fig. 1). Based on the experiences and subjective interpretations of our participants, we have grouped their experiences into four main themes: first news and medical procedure, farewell and mourning, making sense of the loss, and continuity.

First news and medical procedure

One of the things our participants emphasized most was how unexpected the situation was. Although they were aware that a spontaneous loss was possible in the early months and had heard of isolated cases, they did not think that it could happen to them. It was never a topic of conversation with other people, and women who had experienced this were not a source of reference for our participants until it happened to them as well. “Before it happened to me, I thought it was impossible to lose a baby. And yet, since it happened to me, I have heard about many other people who have also lost their babies. It's much more common than it seems” (Rocío).

Participants narrated the intense shock and disbelief they experienced when receiving the diagnosis, which rapidly evolved into a state of denial as a protective mechanism against the pain they were feeling.

Table 2
Semi-structured Interview Guide.

Experience with the diagnosis and communication of perinatal loss

- What do you remember about the moment you found out you had lost your baby? How did you feel?
- What was your experience like with the healthcare professionals who cared for you?
- How do you remember being treated by them, and how did you feel around them?

Experience with childbirth or dilation and curettage in cases of early miscarriage

- What was your birth experience like, including planning, dilation, pushing, and meeting your baby?
- How did you feel throughout this process?

Postpartum experience

- What was your postpartum experience like, including the hospital stay, discharge, support, returning home, and physical recovery?
- How did you feel throughout this process?

General experience of the impact of perinatal loss on maternal mental health

- How are you coping with—or how did you cope with—the loss of your baby/child?
- How do you think perinatal loss has affected your mental health?
- What kinds of support or resources have you used or found helpful in coping with this loss and its impact on your daily life?
- Have you experienced changes in your relationships with your partner, family, or friends following the loss?
- How have you been able to express your grief?

Table 3
Themes and Representative Quotations.

Theme	Representative Quotations
First News and Medical Procedure This section includes quotes about the unexpected impact of the news, as well as the wide range of reactions mothers had during the medical process.	When they gave us the news, it was shocking, denial, and the desire to end it as soon as possible. The feeling I had is that I want to close this chapter, I want it to end now, I want to give birth, and for it to be over. (Leire) It changed the way I think, the way I see life… To be honest, I didn't think it would happen to me, and when it did, you're not aware of what you're going through. (Mariana)
Farewell	It's like I don't want to miss anything [of the medical information]. I don't want to miss what they're telling me because this is mine, you know? I'm not a little girl who's sick and needs to be told something; I'm an adult who has gone through something that has to do with life. Being a mom means this. (Naila) You must put me to sleep, because this is going to kill me. I can't take this anymore (…) this is overwhelming. I know I have to give birth, but I don't want to be there; I don't want to be aware. (Ilsa)
Farewell and Mourning This section includes quotes about the range of emotions and reactions mothers experience when saying goodbye to their babies.	I could only touch him, I didn't even pick him up, I couldn't. I felt like I was going to hurt him. Stupid me. I should have picked him up and hugged him. (Sofía) We both spoke to her. We thanked her for being there, for giving me my first taste of motherhood. And We thanked her for having existed. (Rocio) I was just saying: "I want to get out of here". It's all over now, I want to get out of here. But that was a lie, it wasn't over; the worst was just beginning. (Nora)
Making sense of the loss: Asking questions and finding answers This section includes quotes about how mothers felt when they returned home, and how each of them coped with their loss in their own way and the meaning they attributed to it.	I wondered what had happened to my little girl… where… what they had done with her body… I had abandoned her… so much despair, so much sadness… (Mariana) When I got home, I removed the ultrasound scan, and we haven't talked about it since. I took the ultrasound scan off the refrigerator, put all his things in a folder, put away all the maternity clothes I had bought, and stored them in a drawer. (Ilsa) I felt like my life had stopped. In fact, I felt that I didn't know if I was going to be able to live again. In fact, many times I did not want to go back to living, I mean, I wanted to go with him, I wanted to go with my son, I did not want to live, I did not want, I wanted to be with him, to take care of him, to be with him, I did not want to live this life without him. (Marta) I am religious, God sent him to me, because I already had my two children and that [losing the baby] made me spend more time with my youngest son. That comforts me. (Sonia) Dolores [her baby] came somehow to teach me, and also to heal things from my past (…) so I have started with my psychologist, and I already told her, well, I want to work on childhood wounds. (Mariana) It's already part of my life. It still hurts me, of course it hurts, but it no longer hurts with that intense pain. I don't know, he's here with me. (Nora) I have given myself space, I have given myself a place, I have given myself love, I have given myself the answers that I believe are best for me. So that I can move forward. (Ilsa)
Continuity: Keeping memories alive This section describes how the mothers came to terms with the loss of their babies until they reached a point of acceptance—not in the sense of forgetting, but rather of integrating the experience, since preserving the memory was important to most of them.	We decided to keep the ashes. In fact, it's something we've been thinking about, but we don't have a place nearby that's very special to us where we could scatter the ashes. But for now, I don't feel ready to let go of him. In fact, I didn't know what it would be like to come home with his ashes. Where would I put them, and what would it be like for the three of us to live together in this situation? We've normalized it just like everything else, like conversations and things we've been doing. It's on the shelf in the living room with a little light that we turn on at night, and it's part of us. (Rocio) The photograph is the only memory I have. I could keep it engraved in my memory, but after a while, you forget. And for me, it's the most valuable thing I have, honestly. Sometimes when I'm feeling down or whatever, I look at it and it calms me down. (Alicia) The girls are where they are; they are deceased (…). Our feet are on the ground, and we know what is going on. Still, we feel them with us (…) yesterday, those stars we have [refering to decorative stars] suddenly fell, and we said to the girls [jokingly], "sweeties, stay still." Well… in our everyday lives, we continue to keep them in mind, and we continue to mention them. (Patricia) I like to talk about her because it's a way of bringing her into the present and making her present for other people. Because I've seen her, my husband, my mother, the midwives. But no other person met her. So, I keep mentioning her. Let other people know that she existed and that for me she still exists. It's continuing her legacy. One of the things I wrote in the letter was that I would always be there for her and that I would fight for her to be and do whatever she wanted in life. My way of fulfilling that promise I made to her is to do things like this, collaborating in any way I can on perinatal grief. (Leire)

"When I heard the news, I went crazy. I started screaming, saying no, that it wasn't possible, denial above all else". (Patricia)

After receiving the news, each mother underwent a medical procedure depending on her situation, primarily determined by whether the loss occurred before the 20th week of pregnancy ($n = 4$) or after ($n = 9$). Mothers whose pregnancy loss occurred before 20 weeks of gestation discovered their losses during routine clinical appointments. Following the diagnosis, they were discharged and required to wait until the scheduled hospital or clinic intervention, where they underwent a dilation and curettage procedure. During this waiting time, mothers had different challenges depending on the circumstances. For most participants, these days were an opportunity to say goodbye to their babies. But it was also a time of profound dissonance between what they wanted to do and what they had to do.

From the time they told me until the day of delivery, nine days went

by, it was hell. Because you don't want him to go away, you want to have him, but, on the other hand, you think, I have to do it and I want it to be over now, because I don't want to hold on to him anymore. (Sofía)

Each mother lived the medical procedure in a different way. For instance, one mother had the need to know and understand everything that was happening, while others had the need to escape from reality and preferred to ignore the details due to the physical and emotional distress they felt. Coping mechanisms depended largely on each mother's individual experience, especially since there was no specific protocol focused on grief. This lack of a framework lead to confusion since they did not know how to act or what feelings to expect. In addition, the lack of clear information increased doubts about what had really happened to their babies.

It keeps coming back to me that I haven't seen her. They didn't ask me if I wanted to see her either. If they had asked me, I would have said no because I was afraid of meeting her. But now, today, I would say yes (…) I think what about my baby? Did she die before or in the process? Did she suffer? No one informs you about that. (Ilsa)

Within this group of early loss, only one mother (Naila) was provided with a photo of her baby's last ultrasound and was given all the necessary information about what was going to happen next. She recalled those moments as a time of closure and felt treated with compassion and empathy by the health professionals.

Mothers who lost their babies after the 20th week of pregnancy followed a different medical protocol: one had a caesarean section, while the others delivered vaginally after being admitted to hospital immediately for labor induction. Depending on hospital policy, three were offered the option of going home until contractions began, though only one chose this option.

Giving birth was lived differently by each woman, but all emphasized the need they had at those moments to feel the emotional support of their partner, and to receive professional yet compassionate care from professionals. They also expressed the importance of keeping some sense of control by being informed and participating in decision-making. For two mothers, the experience also brought feelings of pride and empowerment, reinforcing their confidence in their ability to give birth and be there for their babies. More importantly, it helped them find meaning in loss, deepening their bond with their children and, somehow, building memories together.

I wanted to make it beautiful, to make it beautiful for him, and I thought a lot about the connection I had with him all the time. In that strength that he had given me, in those moments that he had given me, I wanted to do everything beautiful for him. (Marta)

Farewell and mourning

Mothers who experienced pregnancy loss after 20 weeks described a medical protocol that offered them the opportunity to say goodbye and spend time with their baby. The mothers appreciated receiving professional guidance during the grieving process, especially the recommendation to see and spend time with their baby. The majority of participants (8 out of 9 mothers) decided to practice various bonding and maternal care activities, such as hugging, holding, talking, singing, storytelling, or reading letters to their baby. Once again, the mothers' responses were deeply personal. For example, two of them decided not to hold or hug their baby, as they believed that doing so would make the final separation even more painful: “I was able to see my son, be with him, kiss him, touch him, and tell him everything I wanted to tell him, but I could not hold him in my arms (…) It was very hard for me to feel that he was going to be taken from my arms.” (Marta)

The opportunity to spend time with their babies, the creation of memories, and the treatment of the professionals who accompanied them were fundamental supports to initiate the mourning process. In these moments, the presence of family members at farewell was also essential for mothers. The family not only provided emotional support but also acknowledged her child and her role as a mother. They expressed this through their interest in seeing and spending time with the baby, sharing emotions of sadness and distress with the parents, and expressing loving comments toward him/her.

They took her to a room next door and brought her to the family so they could say goodbye… And I think that was very good, anyone who wanted to, could go in. I think it allowed the rest of the family to grieve too, and for the rest of the family to see her face, to see her just as we did, to allow us to grieve. And yes, she existed; she was a real girl; she wasn't just something imaginary that you had in your belly. (Patricia)

Regardless of the timing of the loss, all the participants who had the opportunity to say a final goodbye found, contrary to what they first imagined, that the hardest part began when they left the hospital without their child. The farewell was only the beginning of their mourning process.

Coming out of the hospital and saying, what do I do now? We were going to leave three and we left two. They give you the memory box and you take that box with you while you see another family leaving with their baby. (Irati)

Making sense of the loss: asking questions and finding answers

Arriving home signaled the painful realization of participants´ loss, evident in acts like disassembling the crib or putting away clothes. The change also implied restructuring their envisioned future and redefining their sense of self. They all went through a wide range of emotions, such as sadness, grief, guilt, and feelings of emptiness, which did not follow a linear or logical order, but emerged in a changing and fluctuating manner throughout the process.

The worst part was dealing with those difficult nights and the urge to cry every day. I cried every day, now every other day. I needed to cry for her, because she was mine. Pain, emptiness, I had no consolation. (Ilsa)

Faced with this emotional chaos, some mothers ($n = 4$), especially those whose losses occurred before 20 weeks of gestation, used avoidance behaviors, such as going out, avoiding conversations about the loss, or focusing on work. The ones who had not shared their pregnancy with others but their closed ones, felt that they could not even talk about it and opted to keep it private. Similarly, they felt that their early miscarriage could be judged as unimportant if compared to other women’s loss. To this respect, Naila reproduced for us a difficult conversation she had with herself self, trying to convince herself not to appear as a victim:

Where do you go with the drama? It was only a few weeks old. It was not like for other mothers who lost their babies at birth (…) Where do you go with the drama? There was this side of me getting upset with myself, telling me, 'Do not make drama, you know, do not make drama, cam’on girl, it was not a son… you know…’ But yes, to me he was.

In contrast, the remaining participants ($n = 9$) employed isolation as their initial coping strategy, seeking to process what had happened in their own time and within their personal space of safety and security, primarily supported by their partners as their main source of emotional support. “I locked myself in my house, and I didn't feel like talking or seeing or leaving my house, they didn't ask me or see me or anything”. (Sofia). This self-isolation was born mainly from the idea that nobody could understand them. As Mariana puts it, “there is a lot of pain and, somehow, loneliness, because no one feels that pain as you do”.

During the initial processing time, it was common for participants to try to find a reason behind their loss. As a result, they wondered why it had happened to them. For instance, Nora told us: “I did not understand why everything happened (…) why did it happen and why me. (…) There are many people in the world, why did it happen to me?”. In the absence of an answer, some mothers turned to faith and spirituality. Searching for emotional comfort, they reevaluated their beliefs about life and death; some turned to God, whereas others found relief in nature or even tales about destiny to help them find meaning in their pain.

I have them buried in the family tomb, and I laugh because I say they're with Grandpa, keeping him warm, and I say, well, my eldest

daughter was in a hurry to go with her sister because her sister tells her how well they take care of her up there. (Patricia)

Regardless of the strategies each participant embraced to cope, all asserted that losing their children marked a "before and after" in their lives. The experience led them to reassess their priorities, value the important things, and take better care of themselves. "It's like you think more about yourself, you become more selfish. (…) Everyone has their own worries, but you see people attaching importance to things that are completely unimportant". (Irati)

Continuity: keeping memories alive

After the initial period of acute pain and disorientation, most participants gradually moved into the process of acceptance of the loss and reconfiguration of their lives. To do so, it was crucial to maintain a bond with their child and ensure that they were not forgotten. Mothers made sure to keep the memory of their child alive through various tangible acts, such as keeping pictures of their baby on their phones or at home, discussing them with siblings, or purchasing meaningful objects. They also engaged in symbolic practices, like celebrating their birthdays, writing them letters, or singing them lullabies. I talk to my daughter every night before I go to bed. I spend a little time talking to her and singing her songs. (Leire)

In coping with their loss, the mothers reshaped their identity and the meaning they assigned to their lives, that is, new purposes adapted to the emotional needs they were experiencing. Some mothers, for instance, decided to join perinatal bereavement associations to support other women in similar situations. One mother started helping medical centers to improve protocols and raise awareness among professionals. Another mother created an association in her town, and her first action was to develop a space in the cemetery where mothers and fathers could mourn. Giving meaning to what they had experienced helped the mothers find a sense of purpose beyond their grief and honored their children's memory.

As a result, I have created an association. I am promoting spaces in the cemetery, which is really important, so that more families have a place to visit, a physical place [there]. We have planted an olive tree and placed stars with the names of the babies and their dates of birth, and we have planted flowers. (Alicia)

The desire to help others was also the main reason why most participants decided to join the study. For some, sharing their experiences and reflecting on what they had lived through turned out to be a space for acknowledgement and renewed gratitude towards their child, which could help them advance in their personal healing journeys. Marta's words were very touching:

The night of the interview, I had a beautiful dream, I can tell you that it is the first dream where I felt my son. We were playing together, but he was 4 years old, he had grown up, I felt his energy, (…) I could feel my son and for me it was a gift… I felt that he wanted to tell me that he was happy for all that I am doing and all that I talked to you. I felt his love reminded me of the brave mom I was being and the strength I draw from every day to keep going.

Discussion

The main objective of our study was to comprehensively understand the experiences of mothers after a perinatal loss. Our findings reveal that the experience of perinatal loss begins at the time of diagnosis and evolves into a complex emotional process influenced by various factors, which, depending on each woman's individual experience, may either facilitate or hinder the process of coming to terms with the loss.

On the one hand, our findings show that women did not have sufficient information about perinatal loss. The impact of the loss was evident from the beginning of the interviews, where mothers showed that the opacity and silence surrounding perinatal loss aggravated their experience. Although a stillbirth occurs every 16 s (UNICEF, 2023) and a fetal death every 17 s (UNICEF, 2025), mothers are unaware of the possibility of experiencing perinatal loss during pregnancy or think that it cannot happen to them (Escañuela Sánchez et al., 2023). Our results also highlight the low awareness of perinatal loss, a finding that has been previously noted in qualitative research (García et al., 2020; Martínez-Serrano et al., 2019).

On the other hand, for mothers who had the opportunity to say goodbye, the farewell moment was the most meaningful experience. Creating a farewell ritual, where mothers could see and spend time with their baby in the way they needed to, was crucial, as it helped dispel the feeling of unreality and disbelief they had held since receiving the news (Martínez-Serrano et al., 2019). In this regard, our results are consistent with those of the Spanish study by Martínez-Serrano et al. (2019), which found that mothers experience a dual emotional journey: they incorporate their child and their shared experiences into their lives and memories while also processing their child's death. Furthermore, being able to see and be with their child gave the participants the chance to reaffirm their identity as mothers, both to themselves and to others. This explains why family participation in the farewell was so significant for mothers in this and other studies (Martinez-Serrano et al., 2019; Persson et al., 2023). While validation and recognition as parents are reinforced when family members meet their child, the way in which healthcare professionals treat the baby (the compassionate and humanized care they provide) — also plays an important role.

However, it is important to note that this option is not available in all hospitals and is not accessible to mothers whose loss occurs before the 20th week of pregnancy. In our research, specifically, it was not possible for three of the participants who experienced early pregnancy loss to see or say goodbye to their baby and did not receive enough useful information about their situation. This had an impact on their grieving process (Chen et al., 2024). Although the literature highlights the benefits for mothers of being able to see their baby after a miscarriage (Worden, 2013), this evidence has not yet been clearly incorporated into official protocols. On the contrary, early losses are often approached by professionals in a more depersonalized manner, which tends to minimize the suffering of mothers and accentuate their feelings of shame and guilt, thus hindering the integration of the loss (Chichester and Harding, 2021). As demonstrated in the research by Robinson et al. (1999), the emotional bond with the baby is established during the pregnancy planning stage and becomes more apparent as the pregnancy progresses, particularly through ultrasounds and the detection of fetal movements. Therefore, it is essential to recognize and assess the emotional bond on a case-by-case basis and avoid making assumptions based on factors such as gestational age, since the degree of attachment, regardless of the week of gestation, can define the intensity of grief (Chichester and Harding, 2021; Robinson et al., 1999).

As Fernández-Alcántara et al. (2020) indicate, in Spain there is a lack of organization, coordination and attention that leads to significant variability in family care practices and affects both the experience of mothers and that of healthcare professionals. Therefore, it is essential to research and incorporate protocols or guidelines that respect the individuality of each woman's experience. In cases of early miscarriage, it is important to raise awareness among professionals and to develop protocols that include providing clear information throughout the entire process, offering the possibility of a final ultrasound as a way to say goodbye, facilitating the creation of meaningful memories, and encouraging family participation, Measures that may help the beginning of the grieving process support mothers' current psychological well-being, and positively impact their mental health in future pregnancies.

Implications for practice

Although there is currently greater visibility surrounding perinatal loss, our results highlight the need to continue developing awareness and normalization strategies, as well as to continue improving current

protocols. In light of the positive impact of specific grief care protocols, it is important that hospitals integrate and implement them with the sensitivity and support that this experience requires. This requires the presence of mental health professionals who can offer individualized and specific support that begins at the time of diagnosis and continues over time, in order to prevent complicated grief and possible comorbid disorders that can significantly affect subsequent pregnancies.

In addition, it is essential to legitimize early losses and avoid using gestational age as the sole indicator of maternal attachment or as a measure of the intensity of grief (Chichester and Harding, 2021). In this vein, it is necessary to develop specific protocols for early losses that actively involve mothers in decision-making, which will likely involve revising the very definition of perinatal grief and the criteria by which miscarriage is recognized and recorded in healthcare systems (Welsh et al., 2025).

Strengths and limitations

This research has some limitations. First, the sample lacks cultural diversity, so it is not possible to generalize the results to other sociocultural contexts, as the processes of meaning-making may vary in more diverse sociocultural settings. Secondly, recruitment through referrals from health professionals may introduce a bias in the sample, potentially skewing it towards women with greater access to medical or psychological care. Thirdly, the retrospective nature of the study introduces the possibility of recall bias, given that the participants reported experiences of perinatal grief that occurred up to two years prior. Furthermore, the variation in care protocols between hospitals introduces inconsistencies in the conditions under which the processes studied are carried out. Despite these limitations, this study draws on the profound experiences of mothers who have experienced loss in unique and individual ways and allows us to identify unmet needs to guide more humane and adequate healthcare protocols. Furthermore, the rigorous thematic analysis process and the team's multidisciplinary approach contribute significantly to greater analytical depth. Additionally, the broad gestational range, which encompasses perinatal loss regardless of gestational week, brings early losses to light and allows for a comparison of experiences of early and late losses.(Table 1, Table 3).

Conclusions

Our research shows that the experience of perinatal loss can be profoundly transformative for mothers. The process of coming to terms with loss begins from the moment the diagnosis is communicated and is generally facilitated when care protocols recognize their role as mothers. While each mother experiences grief uniquely, those who were able to find meaning in their loss, maintain a bond with their baby and honor them were able to integrate the experience, understand their idiosyncrasies and redefine their maternal identity following the loss. By contrast, mothers who experienced early losses found it more challenging to incorporate the experience into their life history and identity, primarily due to the absence of protocols that legitimized their experience, a legitimization that also extends to the social sphere. For these reasons, it is crucial to raise awareness of perinatal loss and recognize and validate each experience of grief, regardless of gestational age, while continuing to develop personalized perinatal grief protocols with mental health professionals present.

Ethical considerations

The study was evaluated and approved by the Ethics Portal of Universidad Loyola Andalucía.

Consent to participate

All participants provided written informed consent prior to their inclusion in this study.

Consent for publication

Written informed consent for publication of all participants' data and materials was obtained prior to the study.

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CRediT authorship contribution statement

María Consuelo Cruz-Ramos: Writing – original draft, Methodology, Formal analysis, Conceptualization. **Yolanda Hernández-Albújar:** Writing – review & editing, Validation, Supervision, Methodology, Investigation, Conceptualization. **Davinia María Resurrección:** Writing – review & editing, Supervision, Conceptualization.

Declaration of competing interest

None.

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Supplementary materials

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