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CROSS-CULTURAL ADAPTATION AND VALIDATION EVIDENCE OF THE PERINATAL GRIEF SCALE[1]

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ABSTRACT

Objective: to carry out cross-cultural adaptation and validation of evidence Perinatal Grief Scale into Portuguese of Brazil and French of Canada languages.

Method: a methodological study involving application of Perinatal Grief Scale from the set of cross-cultural adaptation procedures. The population was all women that had stillbirth in the year 2013 residents in the municipal district of Maringa-Brazil and participants of the *Centre d'Etudes et de Recherche en Intervention Familiale*, University of Quebec, Outaouais, Canada.

Results: the scale versions in Portuguese and French was reliable in the two populations. The Cronbach's alpha coefficient in the scale applied in Brazil was of 0.93 and applied in Canada was of 0.94. Only the Portuguese version, four items were not correlated with the total scale.

Conclusion: the Perinatal Grief Scale can be used to identify the grief state in women that had stillbirth, in its version of each country.

DESCRIPTORS: Fetal death. Grief. Psychometrics. Validation studies. Nursing.

ADAPTAÇÃO TRANSCULTURAL E EVIDÊNCIAS DE VALIDAÇÃO DA *PERINATAL GRIEF SCALE*

Objetivo: realizar a adaptação transcultural e evidências de validação da *Perinatal Grief Scale* para português do Brasil e francês do Canadá.

Método: estudo metodológico, envolvendo aplicação da *Perinatal Grief Scale* a partir do conjunto de procedimentos de adaptação transcultural. A população foram todas as mulheres que tiveram óbito fetal no ano de 2013 residentes no município de Maringá, Paraná, Brasil e por participantes do *Centre d'*Études *et de Recherche en Intervention Familiale*, *Université du Québec en Outaouais*, Canadá.

Resultados: a escala nas versões português e francês mostrou-se confiável nas duas populações. O coeficiente alfa de Cronbach na escala aplicada no Brasil foi de 0,93 e na aplicada no Canadá foi de 0,94. Apenas na versão português, quatro itens não se correlacionaram com a escala total.

Conclusão: a *Perinatal Grief Scale* pode ser utilizada para identificação do estado de luto em mulheres que tiveram óbito fetal, na respectiva versão de cada país.

DESCRITORES: Óbito fetal. Luto. Psicometria. Estudos de validação. Enfermagem.

ADAPTACIÓN TRANSCULTURAL Y PRUEBAS DE VALIDACIÓN DE LA *PERINATAL GRIEF SCALE*

RESUMEN

Objetivo: realizar la adaptación transcultural y validación de pruebas de la *Perinatal Grief Scale* para el portugués Brasil y Canadá francés.

Metodo: estudio metodológico, con aplicación de Escala de Duelo Perinatal desde el conjunto de procedimientos de adaptación transcultural. La población fue compuesta por todas las mujeres que tuvieron óbito fetal en el año de 2013 vecinas en el municipio de Maringá-Brasil y participantes del *Centre d'Études et de Recherche en Intervention Familiale* en la *Université du Québec en Outaouais* - Canadá.

Resultados: la escala en las versiones en portugués y francés demostró para ser confiable en las dos poblaciones. Coeficiente alfa de Cronbach de la escala aplicada en Brasil fue de 0,93 y aplicada en Canadá fue 0.94. Versión portuguesa, cuatro elementos no correlacionan con la escala total.

Conclusión: la *Perinatal Grief Scale* puede utilizarse para identificar el estado de duelo en mujeres que tenían la muerte fetal, en su versión de cada país.

DESCRIPTORES: Muerte fetal. Pesar. Psicometría. Estudios de validación. Enfermería.

INTRODUCTION

Approximately three million pregnancies end in fetal death each year around the world[1] due to complications at birth, infections during pregnancy, maternal diseases mainly related to hypertension and diabetes, congenital malformations and restriction of fetal growth.[2]

Fetal deaths most often occur in low and middle-income countries such as Southeast Asia and sub-Saharan Africa, where the highest rates of stillbirths occur with more than 30 stillbirths per 1,000 births. Other countries are in an evolutionary process of decline, such as Brazil, which varies from five to ten stillborn babies per thousand births, according to the region. Among the best situations in the world is Canada, with up to five stillbirths per thousand births.[1]

The reality of fetal death presents aspects that still need to be discussed, such as the issue of loss and mourning for the women. Studies have shown that acceptance of the loss is difficult for many women, and they may go through intense emotional distress and trauma, generating psychological disturbances[3] such as complicated bereavement/grief[4] and which requires time and help to overcome[3] their lack in understanding the birth of a lifeless child.[5]

Grieving is a normal, universal and habitual reaction to a significant loss. However, it is characterized by complicated grief when the individual manifests an excessive, persistent, distressing and disabling grieving process, representing a serious public health problem which reflects on the person, family and society.[6] Complicated bereavement/grief has recently been recognized as a mental disorder, and its inclusion in the 5th and last edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), and in the next International Classification of Diseases (ICD-11) has been proposed.[7]

The loss of a child before birth is one of the most common situations for the process of complicated bereavement/grief, elaborated at the imaginary level since there was no baby to hear crying, no memories and no shared life experiences. It is a contradiction of the so-called "natural order of life" that children die before their parents, as there is months of planning and expectation for the birth of a lifeless child.[5]

For identification of grief due to fetal death, reliable[4] and culturally adapted instruments for the researched population are necessary to ensure adequate time for identification and support.[8] The most commonly used grief identification tool for women who have experienced abortion, fetal and neonatal deaths and the one which has been evidenced as being the most accurate is the short version of the *Perinatal Grief Scale* – PGS (in Portuguese *Escala de Luto Perinatal - ELP*).[4]

The original scale in English was first applied to a population in Pennsylvania, the United States,[9] and has been used in several studies in different countries worldwide, most recently in the Czech Republic,[10] the United States,[11] India,[12] and Mexico.[4]

Regarding the literature for understanding the grief process experienced by women after fetal death, this study aimed to perform the cross-cultural adaptation and evidence validation of the Perinatal Grief Scale for Brazilian Portuguese and Canadian French. The main goal was to assure the process of identifying the grieving status of women who had experienced fetal death in two different countries in using the instrument for the first time, and a specialized professional qualification in the area through an agreement between the Universities of the two countries. Unfortunately, in Brazil for example, there is still no organized public policy proposal for professional reference groups for these women.

METHOD

A methodological study involving the application of the PGS from the set of translation procedures and a cross-cultural adaptation of self-applied instruments,[13] in order to guarantee the linguistic, cultural and metric equivalence of the concepts under study.

The study population was determined by convenience sampling with the census of women who had a fetal death in 2013 in the municipality of Maringá (PR), in the Southern Region of Brazil, and participants from the *Centre d'Études et de Recherche en Intervention Familiale* (CERIF), *Université du Québec en Outaouais* (UQO), in Gatineau, Canada. CERIF has been a reference center since 2010, with the main interventions being group accompaniment to parents who had experienced a perinatal loss, continuous meetings with professionals who act directly from the moment of the loss, and training professionals and students, both Canadians and foreigners, for later professional performance in perinatal family grief.

CERIF annually serves approximately 250 women who have experienced a perinatal loss, with them being accompanied by their partner, mother or other close friend, participating for the first time or returning for continued assistance by the professional support group.

In Brazil, free puerperal care after hospital discharge is available at the Basic Health Units, with remuneration by the public health system or in private practices when the consultations are paid directly by the client or indirectly through medical agreements or the health insurance system. Although improvement of information on fetal deaths in Brazil occurs by investigation of the Committees on Fetal and Infant Mortality, unlike Canada, in Brazil there are still few and isolated professional support references for these women regarding assistance for their state of grief after experiencing fetal death.

In the municipality of Maringá, four women were excluded from the address of the death certificate because they did not reside at the informed address, totaling 26. Among the women who participated in CERIF in Gatineau, 18 had experienced a fetal death.

A characterization chart for data collection was used for women including the variables age, marital status, pregnancy duration and pregnancy planning, and the PGS in the Portuguese or French versions according to the official language of each country.

Instrument

The PGS is composed of 33 psychometric statements divided into three subscales, aiming to evaluate the thoughts, current feelings and adaptation symptomatology of the woman's loss in relation to fetal death.[9]

In order to evaluate the psychometric characteristics, the PGS involves a Likert type scale with five response options ranging from 1 to 5 points, respectively corresponding to "strongly agree", "agree", "neither agree nor disagree", " disagree "and" strongly disagree". In order to calculate the total PGS score, only the score order in the Likert scale has not been reversed/inverted for the affirmations "It feels great to be alive" and "I feel I have adjusted well to loss".

Each PGS subscale has 11 affirmations, with scores of at least 11 points and a maximum of 55 points each. The sum of the three subscales varies from 33 to 165 points.

Transcultural translation and adaptation process

In order to ensure the adequacy of the PGS in both Portuguese and French versions, a methodological framework for cross-cultural adaptation of instruments was used[13] according to the steps in the following paragraphs.

The authors were asked to authorize the translation of the original version in English into Portuguese and French.[9] The authors replied that the PGS was part of the public domain and authorized the translation, which was carried out by two translators in each language, with one being a specialist in the Health field and informed about the research topic and another sworn translator, not knowledgeable in the area and without research information.

The translations were reconciled by the two translators of each language and by a study researcher to identify the disagreements and to achieve a consensus of the first version of the PGS in Portuguese and French. Subsequently, the back-translation was carried out by two translators from each language who were not knowledgeable in the health area and did not have the research information in English.

Following this, a committee of expert judges was specifically composed for each language of the two translators, the two back-translators, two authors of the research, two observers (lay women who had experienced fetal death), four nurses spe-

cialized in obstetrics with experience in research in the area of maternal health and creating questionnaires, and two linguistic professionals specific to each language. A consensus was made by the committee of expert judges from the translated versions, reconciliation and back translations and based on the semantic, cultural, conceptual and colloquial equivalence of the official language for each country. All items were considered absolutely equivalent, with 100% agreement and understandable for the culture of each country.

The final version of the instrument was submitted to the pre-test with all the women who had experienced fetal death in 2013 living in the municipality of Maringá (n = 26), and the Canadian participants of CERIF (n = 18). Data collection was performed by a nurse specialized in the area of obstetrics, in a private environment with average duration of 12 min each. The women's PGS understanding was adequate seeing that all participants answered that they had no doubt about the inquiry of the propositions at the end of the research.

Psychometric properties of the scale were analyzed using the answers from the instruments; in other words, to confirm if the scale measures what it proposes. In order to evidence the PGS's validation, we performed the most commonly used statistical tests, namely the Cronbach alpha coefficient reliability and the item correlation scale by the Statistica statistical program. Finally, an audit of all the recommended steps and an analysis of the statistical results by the authors of the research was performed.

The study followed the standards of research involving human beings according to Resolution 466/12 of the National Health Council and was approved by the Research Ethics Committee of the *Universidade Estadual de Maringá*, under opinion number 407.840/2013 (CAAE 20291013.3.0000.0104).

RESULTS

Both translated versions of the PGS into Portuguese resulted in differences in the use of the pronoun "I". The translator of the health area with knowledge about the research topic used the pronoun, and the sworn translator being unfamiliar in the area and topic of research did not use it. In the reconciled version of the translations, according to Brazilian grammar where the first person is subtended, the items 2, 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, 16, 18, 19, 21, 23 and 27 did not begin with the pronoun "I" and in some cases the reflective pronoun "me" was inserted in the items 1, 11, 17, 20, 24, 25, 26, 29, 30 and 32, to indicate that the subject's action reflects upon themselves.

Both back-translations to the Brazilian language present similar propositions to the original scale, therefore they were not forwarded to the authors of the original English version.

In the committee of expert judges, because of Brazilian popular culture, the fetus inside the womb is (popularly) called "baby," and the term "baby" was maintained in the Portuguese translation, in the items 3, 4, 6, 7, 8, 10, 16, 21, 24, 25, 28 and 29. To focus on fetal loss, the term "baby" ("losing a baby in pregnancy") was standardized when, in the original scale, the terms "he" or "she" were used in items 9, 11 and 30. In the response options, the term "partially" was added to the single words "agree" or "disagree".

Both translated versions of the PGS into French resulted in difference with respect to the English expression "*second-class citizen*". The translator of the health area, being knowledgeable in the research theme, kept the grammatical structure closest to the literary translation. The uninformed translator in the research area and theme adjusted the expression to a meaning of having less value to society ("33. *d'avoir moins de valeur pour la société*"). In the reconciled version of the translations, the expression adequacy had consensus with the intention of better understanding among the respondents.

The judges' committee for the Canadian population of Quebec normalized the item "6. I very much miss the baby" with the addition of the expression in French "of the baby I never had" for better understanding by the interviewees/respondents. In the response options, the item "neither agree nor disagree" was replaced by "Indecisive".

The final versions of the PGS in Brazilian Portuguese and Canadian French are presented in table 1.

Table 1 - Final versions of the Perinatal Grief Scale cross-cultural adaptation for Brazilian Portuguese and Canadian French

		Final version in Brazilian Portuguese	Final version in Canadian French	
Subescala I - Sofrimento ativo	1	*Sinto-me depressiva*	*Je me sens déprimée*	***Sous-échelle I - Deuil actif***
	2	*Sinto um vazio dentro de mim*	*Je me sens vide à l'intérieur*	
	3	*Sinto necessidade de falar sobre o bebê*	*Je sens un besoin de parler du bébé*	
	4	*Estou de luto pelo bebê*	*Je suis affligée au sujet du bébé*	
	5	*Estou assustada*	*J'ai très peur*	
	6	*Sinto muita falta do bebê*	*Le bébé que je n'ai pas eu me manque beaucoup*	
	7	*É doloroso relembrar memórias da perda*	*Il m'est douloureux de me rappeler ma perte*	
	8	*Fico incomodada quando penso no bebê*	*Je suis bouleversée quand je pense au bébé*	
	9	*Choro quando penso no bebê que perdi*	*Je pleure quand je pense au bébé*	
	10	*O tempo passa muito devagar desde que o bebê morreu*	*Le temps passe trop lentement depuis que le bébé est décédé*	
	11	*Sinto-me muito só desde que o bebê morreu*	*Je me sens si seule depuis que le bébé est décédé*	
Subescala II - Dificuldade de enfrentar a situação	12	*Acho difícil me relacionar com certas pessoas*	*J'ai du mal à m'entendre avec certaines personnes*	***Sous-échelle II - Difficulté à surmonter l'épreuve***
	13	*Não consigo dar conta das minhas atividades habituais*	*Je n'arrive pas à poursuivre mes activités habituelles*	
	14	*Tenho pensado em suicídio desde a perda*	*J'ai pensé à me suicider depuis la perte du bébé*	
	15	*Sinto que me adaptei bem à perda*	*Je sens que je me suis bien adaptée à la perte*	
	16	*Já decepcionei outras pessoas desde que o bebê morreu*	*J'ai laissé tomber des gens depuis que le bébé décede*	
	17	*Irrito-me com amigos e parentes mais do que devia*	*Je me fâche contre mes ami(e)s et ma famille plus souvent que je ne devrais*	
	18	*Às vezes sinto que preciso de aconselhamento profissional para me ajudar a retornar à minha vida normal*	*Parfois je ressens un besoin d'avoir un soutien psychologique pour reprendre ma vie en main*	
	19	*Parece que somente existo e não estou viva de verdade desde que o bebê morreu*	*J'ai l'impression que je suis juste en train d'exister, mais que je ne vis pas vraiment depuis que le bebé décede*	
	20	*Sinto-me um tanto afastada e distante, mesmo entre amigos*	*Je me sens à l'écart et en retrait même en compagnie de mes ami(e)s*	
	21	*Tem sido difícil tomar decisões desde que o bebê morreu*	*Je trouve difficile de prendre des décisions depuis que le bebé décede*	
	22	*É ótimo estar viva*	*La vie vaut la peine d'*être *vécue*	
Subescala III - Desespero	23	*Tomo remédios para os nervos*	*Je prends des médicaments pour mes nerfs*	***Sous-échelle III - Désespoir***
	24	*Sinto-me culpada quando penso no bebê*	*Je me sens coupable quand je pense au bébé*	
	25	*Sinto-me fisicamente doente quando penso no bebê*	*Je me sens physiquement malade quand je pense au bébé*	
	26	*Sinto-me desprotegida num mundo perigoso desde que o bebê morreu*	*Je me sens non protégé(e) dans un monde dangereux depuis le bébé décédé*	
	27	*Tento rir, mas não acho graça de mais nada*	*J'essaie de rire, mais rien ne me semble drôle*	
	28	*A melhor parte de mim morreu junto do bebê*	*La meilleure partie de moi-même est morte depuis le bébé décédé*	
	29	*Culpo-me pela morte do bebê*	*Je m'en veux pour le décès du bébé*	
	30	*Sinto-me sem valor desde que o bebê morreu*	*Je me sens sans valeur depuis le bébé décédé*	
	31	*É mais seguro não amar*	*Mieux vaut ne pas aimer ni s'attacher aux autres*	
	32	*Preocupo-me sobre como será o meu futuro*	*Je me fais du souci à propos de mon avenir*	
	33	*Ser uma mãe enlutada significa ser uma "cidadã de segunda classe"*	Être *en deuil donne l'impression d'avoir moins de valeur pour la société*	

Regarding the grief level measurement due to fetal death in both populations, the PGS was shown to be reliable, with a Cronbach's alpha coefficient of 0.93 on the overall PGS applied in Brazil, and 0.94 on the overall PGS applied in Canada (Table 2).

Table 2 - Item reliability and correlation with the total scale score according to the scale's dimensions, in the Brazilian Portuguese and Canadian French versions

Perinatal Grief Scale - Brazilian Portuguese version					Perinatal Grief Scale - Canadian French version			
		Item-total Correlation	Alpha deleted item	Alpha	Item-total Correlation	Alpha deleted item	Alpha	
Subscale I – Active Grief	1	0.646	0.937	0.896	0.785	0.871	0.892	*Sous-échelle I - Deuil actif*
	2	0.453	0.939		0.664	0.875		
	3	0.118	0.942		0.662	0.875		
	4	0.365	0.940		0.747	0.871		
	5	0.533	0.938		0.337	0.894		
	6	0.136	0.941		0.490	0.885		
	7	0.228	0.940		0.648	0.876		
	8	0.941	0.934		0.659	0.875		
	9	0.323	0.940		0.517	0.885		
	10	0.874	0.935		0.653	0.876		
	11	0.541	0.938		0.630	0.877		
Subscale II – Difficulty coping	12	0.667	0.937	0.822	0.436	0.858	0.863	*Sous-échelle II - Difficulté à surmonter l'épreuve*
	13	0.773	0.936		0.684	0.837		
	14	0.620	0.937		0.423	0.852		
	15*	0.564	0.938		0.513	0.845		
	16	0.485	0.938		0.580	0.841		
	17	0.561	0.938		0.301	0.857		
	18	0.595	0.937		0.671	0.831		
	19	0.732	0.936		0.678	0.837		
	20	0.836	0.935		0.817	0.817		
	21	0.767	0.936		0.767	0.823		
	22*	0.460	0.939		0.334	0.859		
Subscale III - Despair	23	0.185	0.941	0.809	0.588	0.815	0.869	*Sous-échelle III - Désespoir*
	24	0.176	0.942		0.595	0.815		
	25	0.481	0.939		0.417	0.828		
	26	0.760	0.936		0.399	0.831		
	27	0.809	0.935		0.527	0.829		
	28	0.763	0.935		0.478	0.824		
	29	0.357	0.940		0.499	0.825		
	30	0.673	0.937		0.639	0.815		
	31	0.653	0.937		0.546	0.826		
	32	0.502	0.938		0.750	0.799		
	33	0.337	0.940		0.488	0.827		
Total				0.939			0.945	

* As recommended, by not reversing the order of scoring on the Likert scale.

Regarding the correlation of each item with the scale total, a difference was found between the populations studied. In the Brazilian population, the propositions "3. I feel a need to talk about the baby", "6. I very much miss the baby", "23. I take medicine for my nerves" and "24. I feel guilty when I think of the baby" did not achieve good levels of collaboration with the grief identification scale compared to the other items.

On the other hand, if the total item-correlation analysis allowed to identify which items were considered more important to assure greater scale reliability, specifically for the Brazilian population, the items that remained in the questionnaire at risk of reducing the reliability of the questionnaire due to its removal were the statements: "8. I get upset when I think about the baby"; "10. Time has passed so slowly since the baby died"; "13. I can't keep up with my normal activities"; "20. I feel somewhat apart and remote, even among friends"; "27. I try to laugh, but nothing seems funny anymore".

In the Canadian French PGS version, analyzing each item and its total correlation with the scale, all items correlated well with the construct, resulting in no very low correlation items.

The items that were kept in the questionnaire for the Quebec population at risk of reducing the reliability of the questionnaire due to their removal were the statements "11. I feel so lonely since he/she (the baby) died"; "20. I feel somewhat apart and remote, even among friends"; "21. I find it difficult to make decisions since the baby died"; "30. I feel worthless since he/she (the baby) died"; "32. I worry about what my future will be like".

Characteristics of participants and scores on both versions of the Perinatal Grief Scale

Regarding the characteristics of the Brazilian women, the mean age was 29 years (standard deviation of 7.6, range from 16 to 43), 84% had a partner, the average duration of gestation was 30 weeks (standard deviation of 6.0, ranging from 21 to 39) and only 35% had planned the pregnancy. For Canadians, the characteristics were mean age 31 years (standard deviation 3.7, range 25-38), 100% had a partner and planned gestation, and mean gestation duration was 26 weeks (standard deviation of 6.7, ranging from 20 to 37).

Both the Brazilian Portuguese and Brazilian French PGS versions presented a mean grief score for Brazilian women of 81±28 points (minimum of 52 and maximum of 136) and 68±23 points for Canadians (minimum of 33 and maximum of 119). In the Brazilian PGS version, the subscale "active grief" had a mean score of 34±8 points (minimum of 22 and maximum of 54), the "difficulty coping" subscale had a mean score of 23±11 points (minimum of 11 and maximum of 46), and the "despair" subscale presented a mean score of 23±10 points (minimum of 11 and maximum of 42).

In the Canadian PGS version, the "active grief" subscale presented a mean score of 29±9 points (minimum of 11 and maximum of 51), the "difficulty coping" sub-scale presented a mean score of 18±8 points of 11 and maximum of 39), and the subscale "despair" had a mean score of 21±8 points (minimum of 11 and maximum of 38).

DISCUSSION

The cross-cultural adaptation of the PGS in this study allowed for inserting the scale to be applied in health services for recognizing the grief process in women who had experienced fetal death. Its application has helped to better identify the suffering of bereaved/grieving mothers,[4,9-12] enabling the nursing approach in investigating grief as a result of fetal death and increasing the quality of psychosocial care.

In the process of transcultural adaptation of the scale in previous studies,[10] modifications in the expressions according to the cultural identity of each population were also carried out.[4,9-10] For example, challenging the subscales by adding items for guilt,[10] depression, active grief, and acceptance,[4] and/or modifying the propositions for feelings of worthlessness, social isolation and painful recollection (bereavement);[10] due to the reliability presented in each subscale, the three subscales proposed by the original instrument remained for the populations of this study.[9]

Other implemented modifications were related to the original response options for "definitely yes", "probably yes", "probably not" and "definitely not", and eliminated the central response option of the scale due to the high proportion of responses.[4] For the Czech Republic population this was adapted to "I do not know".[10]

The instrument's reliability measured by Cronbach's alpha was considered satisfactory due to the values above 0.80, and were consistent with the results of the studies carried out in the Czech Republic (α=0.95),[10] India (α=0.91),[12] and Mexico (α=0.85).[4]

Cronbach's alpha values ensured the reliability of the PGS in its overall dimension and isolated in the

three subscales when, due to clinical issues, there is a need to consider the subscales separately. However, it is recommended that the three dimensions are used together for adequate identification of grief, which include active grief, difficulty coping and despair.

The items of the Brazilian population that did not obtain good levels of collaboration with the scale for grief identification in relation to other items (considering that they presented values lower than the minimum (0.200) recommended) was due to women with and without complicated bereavement/grief answering the questions equally, and consequently the low correlation of the item with the scale. In the Mexican population, "I have considered suicide since the loss"; "I feel as though I am just existing and not really living since he/she (the baby) died" and "it's safer not to love" did not correlate.[4]

It is believed that the items "I feel a need to talk about the baby" and "I very much miss the baby" did not correlate with the scale due to the cultural issues of each country. In Brazil, this is due to the absence of professional assistance in hearing the needs of women and the lack of contact between the mother and the baby. Having observed that these propositions in the adaptation to Canadian French were dependent with the total scale and that the women are listened to by the professionals and stimulated to have contact with the baby, even when they do not want to.[14]

Furthermore, as this study only related to fetal death and the original version of the scale was also directed to women who had neonatal death, meaning those who had a baby beyond the imaginary point with more possibility to have seen them and/or hold them, the suggestion of adding "the baby I did not have" in each statement in the PGS for women who had a fetal death in order to better fit in context was identified in the best results of the Canadian scale and included this suggestion.

Low correlation of the item "I take medicine for my nerves" has shown that women with complicated bereavement/grief who probably need some treatment were unassisted, as women without complicated bereavement/grief also responded similarly/equally, thus the correlation of this item with the scale was low. In some populations, the search for professionals in the area of mental health is still a stigma.[15]

For the Brazilian population, the word "guilty" in the item "I feel guilty when I think about the baby" is probably due to the lack of professional assistance in explaining the possible reason for the death,[14] thus casting doubts in women relating to the conduct they had and relating them to the cause of death. In Brazil, only in cases of anencephaly can a pregnancy be interrupted; thus, for women the lack of explanation as to the reason for the loss may evolve into guilty feelings about the baby's death and be related to the crime of abortion. In Canada, abortion is not characterized as a crime. Another study using the PGS also drew attention to the state of guilt that, together with depression, explained the greater variance in cases of grief, thereby assigning the necessary observation of pathological grief in cases of guilt and depression.[4]

Even if the items of the Brazilian instrument that did not cooperate with the scale were altered or eliminated, and statistically the overall alpha would increase, the items for the Brazilian population do not necessarily have to be revised since the overall PGS presented a satisfactory alpha value. Although a possible cause for the low correlation of these items could be the fact that they are poorly written or associated with other concepts (as women with and without complicated bereavement/grief answered the questions equally by the low correlation of the item with the scale), the cultural reality[14] that compromised the correlation of the items with the PGS was evidenced. Keeping the instrument according to the original scale facilitates comparison in previous and future studies.

Despite the initiatives of the Ministry of Health to assist health professionals and services in ensuring comprehensive health care in Brazil in accordance with the principles and guidelines of the current health system, the training of health professionals is still very far from what is recommended.[16] The profile of health professionals demonstrates insufficient qualification for the needs of women who have had fetal loss, reporting little interaction with women, conducts focused on clinical aspects, and an ambivalent contact between good and discriminatory according to the etiology of fetal loss.[17]

The sociodemographic and reproductive characteristics of women in studies covering grief due to fetal death should be included, and it has been observed that social norms according to each country can contribute to the high levels of grief.[12] The different means of the PGS score between the populations of this and other studies with perinatal (m=88±27),[10] and fetal losses (m=91±21),[9] prove that although loss may be a universal experience, its representation and influence on an individual's life are modified by their personality, culture, and society.[10]

Among the limitations of the study we can include the study duration, as it influenced the num-

ber of participants in the annual census of women with fetal death in a Brazilian municipality and of the Canadian women who participated in a referral center to support families, although the statistical tests showed robust results.

CONCLUSION

The present study evidenced that the Perinatal Grief Scale provides reliable information for the population of Brazil and Canada. The cross-cultural adaptation and validation evidence of the PGS for Brazilian and French Canadians has been proven and can be used to identify the state of grief in women who have experienced fetal death, in the respective versions for each country.

The studied scenario demonstrated the grief phenomenon in the two different cultures, and evidenced the precarious condition in greater prevalence of complicated bereavement/grief cases in Brazilian women in relation to Canadians. Based on the assumption that nursing care may involve anticipatory care in the grief process with planning of the necessary interventions in each case, the importance of incorporating PGS application in health services for the early detection of pathological conditions and structuring of adequate care is apparent.

From this study, it is also possible to reflect on the need to update university and technical curricula, in addition to permanent education for health professionals in Brazil on the subject, so that professional practice is adequate in cases of fetal death. Developing professional skills directed towards providing service excellence in the area of grieving needs due to fetal death is implied in care practice, directed toward health promotion and in the expansion of new healthcare models of early identification of complicated bereavement/grief cases.

This was the first study so that future research could involve reapplying the PGS and verifying the stability of the grief process due to fetal death over time and in other locations of the studied countries.

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