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The resilience of women who required hospital transfers during planned home birth: an exploratory study

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ABSTRACT

Aim: understand the resilience process of women who had the planned home birth transferred to the hospital. **Method:** this is an exploratory study that uses a qualitative approach performed with ten women who planned home birth, but who, for some reason, had to be transferred to the hospital. The data collection was performed through semi-structured interviews, analyzed by content analysis of the thematic type. **Results:** it was found that all the interviewees experienced the trauma due to the hospital transfer, but only one reached the final stage of the resilience process, the adaptation. **Conclusion:** the participation of obstetrical nurses in this process is fundamental, since it can help these women to find factors that can develop the process of resilience through dialogue, understanding, openness and acceptance. This will make it possible to understand the other in its totality, and to capture their pains and insecurities through a humanized relationship.

Descriptors: Obstetric Nursing; Home Childbirth; Resilience, Psychological; Women's Health.

INTRODUCTION

The gestational period in the life of a woman is a time of innumerable changes, physiological, psychological and social; nevertheless, it is a moment of choices, one of them being the way of a childbirth wished for, which can be by means of cesarean section, as a surgical event or vaginal route, also called normal delivery.

Besides the path of delivery, another element of fundamental importance in the process concerns the environment of its accomplishment. The most suitable place for a woman to give birth is directly linked to effective and safe care and respect for her rights, privacy, comfort and security, guaranteeing the integral care of the woman, either in a hospital or in her own home[1].

Faced with the power of choice, coupled with support and health assessments, a mode of delivery that is taking root in Brazil is the planned home birth. It is a form of delivery indicated for women of habitual risk, which develops naturally, without unnecessary interventions and in a comfortable and cozy environment. However, home birth, when addressed in the documents and publications of the Ministry of Health in Brazil, is still treated as an event associated with the lack of economic resources and the difficulty of access to health services[2].

According to the latest data provided by the Department of Informatics of the Brazilian Unified Health System (DATASUS, acronym in Portuguese) in Brazil in 2016, of the 2,857,800 live births, only 19,445 (0.7%) were born in a home environment. In the South, this proportion was even lower: of the 391,790 births, only 993 (0.2%) occurred at home (3). However, this study does not have data on how many were performed by a planned home delivery team.

Currently, the Ministry of Health informs the multiparous women of habitual risk that, considering the Brazilian context, home delivery is not available in the health system, thus there is no way to recommend it. However, the planning of home birth should not be discouraged in cases where access to maternity is available, in a timely and appropriate manner, if there is a need for transfer[4].

The safety of planned home delivery is demonstrated by studies indicating that there is no evidence that giving birth at home increases the risks for women[5]. Despite this, and even when there is the desire and planning of this type of delivery, it may not occur due to intercurrences such as hemorrhages, hypertensive crises, placental abruption, cord prolapse, uterine rupture, and non-reassuring fetal heart rate[6]. These are situations that require hospital support and can occur during the labor at the home, requiring a transfer to the hospital. Thus, the woman who planned it may face frustration, with the deconstruction of a desire, and could lead to psychological losses.

The adversities of life can psychologically mark the individual for a long period, due to the traumas they cause, which modify the being in the world, because they affect their multidimensionality[7]. Faced with the adverse situation, two possibilities present themselves to the individual: letting oneself be overwhelmed by suffering or seeking factors that aid in their psychological restructuring, placing it in a process of resilience.

Resilience is understood as a pattern of adaptive functioning against current and accumulated risks throughout life. It encompasses several important psychological resources to overcome setbacks, obstacles and difficulties, such as personal skills, self-beliefs and interpersonal control in interaction with social

supports[8]. One of the precursors understands that resilience is not in the elimination of the stressor event, but in the way the individual perceives this situation and manages to use self-confidence and social competence to master stress. Therefore, it is in "how" people deal with changes in life and what attitudes they take in these situations[9].

In this understanding, resilience can be seen as a process that goes through the stages of coping, adaptation and overcoming. This process develops as a consequence of a negative life situation, in which the individual resignifies the experience and finds means, from the dynamic interaction existing between the individual characteristics and the complexity of the social context, to face, to accept the occurrence and search to adjust to the situation in order to find meaning and positive elements of the situation lived and then, to overcome the experience. It is, therefore, a dynamic psychological process[10].

Considering that the hospital transfer, after the yearning and planning of a home birth, can present itself as an adversity in the life of the woman who may face such frustration, the following concern emerged: did the women who opted for a planned home birth, but who had to be transferred to the hospital during labor, have an adversity? From this adversity, did they develop the process of resilience?

To answer this question, it is necessary to listen and understand this process through women who have experienced this situation; know if they have damaged their social, emotional and motherhood life and if, in any way, they have developed the process of resilience. Considering that there is a shortage of study on the theme proposed in the Brazilian literature and that nurses working in obstetrics, whether in the hospital or home environment, should be prepared for the reception of these women in the face of adversity and help them in their various aspects, aiming preserve or restore their health, this article aims to: understand the process of resilience of women who had the planned home birth transferred to the hospital.

METHOD

This is an exploratory, qualitative approach, carried out with women who planned home birth but who, for some reason, had to be transferred to the hospital. The women interviewed were residents in the region of Curitiba, Paraná, since in this city there are groups composed of obstetrician nurses who perform the planned home birth.

As inclusion criterion, all the women who started labor at home at some point in their lives, accompanied by a team that performed planned home birth, but who, at the request of women or the evaluation of health professionals needed to be transferred to the hospital. This experience was considered the phenomenon of interest in this study, since the occurrence of the birth route in the hospital context, whether cesarean or vaginal, differs from the expectation of delivery at home. The exclusion criterion was: women who had not been accompanied by teams of planned home births in the city of Curitiba.

The interviewees were recruited using the snowball method, also known as the chain-of--reference method. This model works so that the first respondents will indicate others, and so on, continuing the study[11]. In this study, the first interviewee was identified in the proximity group of the researchers, who, in turn, indicated other women. After the interviews, these women came in contact with other women who knew and who had been through the

same situation, explaining about the research. When they became interested in integrating the research, their telephone number was passed on to the researchers, who contacted them for explanations and for scheduling the interview. Ten women were contacted, none of whom refused to participate in the study.

The data collection took place between July and September of 2016, through semi-structured interview in the place, time and date agreed with each woman. After explaining the objectives of the research and accepting participation by signing the Informed Consent Form, the interview was initiated as follows: how was it that you had planned a home birth and needed to be transferred to the hospital?

The data collection was interrupted when the authors had the perception of repetition in the speeches. The interviews were recorded, which guaranteed the freedom of the participants to express themselves and made possible the establishment of bond with the researcher. Soon after, the interviews were transcribed in full and submitted to the content analysis of the thematic type, as proposed by Bardin. This technique is organized around three chronological poles: pre-analysis, which consists of the organization of the material, systematizing ideas; exploration of the material, definition of categories and systems of codification that made possible the richness or not of the interpretations and inferences; and treatment of the results, inference and interpretation, phase in which condensation and detachment of information occurred for analysis[12].

Two categories emerged from this analytical process: The trajectory by choosing the planned home birth and from adversity to the process of resilience. The discussion of the data was developed from scientific articles and books related to the theme. The research was approved by the Committee of Ethics in Research with Human Beings of the Positivo University on July 1, 2016, under opinion No. 1,617,799 (CAAE: 55315316.7.0000.0093).

RESULTS

Ten women aged between 21 and 37 years old were interviewed, and three were primiparous and seven multiparous. Among the latter, none had experienced the planned home birth prior to the fact under analysis, so that all their children were born in a hospital setting. It should be clarified that the interviews occurred from 40 days to three years after the hospital transfer.

The choice of planned home birth

The women interviewed reported the reasons that led them to choose the planned home birth, including the role of parturition in the process of parturition and the humanization of care, as observed in the speeches presented in the sequence:

> I promised myself that if I were to have a second child, I would prepare myself better; and I very much wanted a normal birth for fear of having another birth stolen; so I decided to try it at home. (M1)

> [...] the best thing is for my son to be born in the environment where he will live, in the comfort of our home, with people who care about us. (M2)

> [...] and the option to stay in my house, with the participation of my eldest son; the possibility of not having to move away from him during labor and even after the baby was born; the chance of him meeting his brother, being able to cut the umbilical cord, and participating in the delivery as well; and I could wake up and be able to have breakfast with my family the next day, but not in that hospital environment. These were the factors that weighed the most for my decision for home birth. (M5)

> After I had a gestation in the fallopian tubes, I suffered a lot because I really wanted to be a mother, so I chose home birth because I wanted to go through this process without anyone interfering with it; I wanted to feel everything that the delivery could give me. (M8)

> [...] I really need to be the protagonist of my labor, so I chose home delivery, since the woman has more voice. (M10)

From adversity to the process of resilience

All the interviewees presented traits related to the trauma, to the adversity experienced due to the hospital transfer and the hospital care, according to the statements below:

> [...] I thought, "Well, it's not really going to be in the house." I cried a lot, I cried a lot, because one thing is to listen to everyone outside saying to you that you don't have dilation and that you do this and that, and I went through this whole process of deconstructing this image that I didn't have that strength for that image that I could do all this. (M2)

> [...] I was building this inside of me. So when they told me (about the need of the transfer) I understood that it was not going to be that way; so I said: So it means that there really is something wrong with me [...] (M8)

> [...] and then comes the frustration, quite big, because he was almost born at home, and in fact I carry this frustration even today. It was a year ago. (M9)

> [...]the worst is not you being transferred, it's the fear of what's going to happen in the hospital, the violence you're likely to suffer [...] but what hurts the most is that you are poorly assisted in the hospital; that was my biggest frustration [...] Frustration makes me really angry, it mixes everything. Because of your innocence, you feel grateful that your child was born, but then you think that it shouldn't have been like this [...] I get angry at them (in the hospital), at the staff, at those professionals who don't update themselves [...] the frustration I'm going to carry for life. (M5)

> It was very hard, very difficult [...] I thought in a very positive way that I would give birth; I didn't prepare a maternity bag, nothing, because I thought: I'm going to give birth at home. I was quite sure [...]; we think it will never happen to us. It was a difficult process, but it might not have been so difficult if I had not suffered so much violence in the hospital [...] but since the surgery was really terrible, and what they told me there was shocking, you know? So the healing process takes much longer. It was not easy, and it's still not very easy. (M4)

After the need for hospital transfer, women reported several protective factors that led to the confrontation and the triggering of the resilience process, such as acceptance, support from the family and the women's wheel:

> [...] I went there for help, and in the process of seeking help I went through a group of women [...] which is an intensive treatment process with regard to women's issues. (M7)

> One of the things that helped a lot was my entire family: my father, my mother, my grandmother, my sister, who were here with me [...] having the support of my husband there by my side; he cried with me; we cried together and everything. My family being together was the best thing, this support of having the people you love around you is what helps you, helps you do these things. (M2)

> [...] I can tell you that in this second delivery there was the frustration of having to go to the hospital, but it was a very conscious process, you know, because it was studied; I did everything, participated in many pregnant women groups, so it was much easier to overcome... The decision was all mine, even though I still had the frustration of not doing it for the second time. I knew there were real reasons for this; I didn't have the sense of stolen birth again; I just had the frustration of not being able to go through my expulsion period because I had already had the labor at home, and I was well advised, with people that I had chosen. (M1)

> I've created a group in a social network called Humanized Childbirth in Curitiba, and this group has taken on a gigantic proportion, as it helps other women to seek professionals; we discuss about professionals, teams, doulas. This group became very well-known; we are 70 women in the group, so we help these women a lot. (M4)

As for the second stage of the resilience process, the interviewees demonstrated that they are in the process of overcoming, according to excerpts from the speeches:

> The moment I forgave myself, I understood that it was not my fault, then I began to feel completely like a mother, because before I kept blaming myself, I kept looking at my son and feeling less mother for not having given birth to him. (M9)

> When you start to hear what people who love you say, I mean, truly, not when I pretended to listen, things get lined up, then things make sense [...] (M7)

> [...] It was easier to overcome, you know. The first big reason was a better preparation, and the second reason was because I was already in the middle of women's groups and everything, and I continued to participate in these groups, and that is what made me overcome it faster [...] today I can talk about it, but I still get emotional. A delivery is a beautiful experience for any woman, and I get really emotional, but not because I couldn't do it, but because of all the support I had in the women's groups and everything else... because I planned what I wanted, because I have managed to get through it... Because we suffer prejudice [...] (M1)

Regarding the adaptation, it was evidenced that only one interviewee presented traits in the following speech:

> I have overcome it, but I always think, I keep remembering, I always remember, because it's a super magic moment. Whenever I see the video, I keep looking at myself feeling pain there, and I saw that it really wasn't, you know? [...] I was going to give birth at home anyway, that's what I said, but actually, I didn't need to feel as much pain as I felt, you know? There is a phrase that I always say: "before giving birth to your baby, you have to give birth to your fears", because no one is going to give birth to a baby to feel relieved. So I didn't want to do that, and I had the consequence of that, I couldn't give birth to her at home without the help of a medicine [...] but it worked, it worked for me, you know? It's just that it wasn't at home. (M3)

DISCUSSION

Currently in Brazil, planned home birth at usual risk is an alternative for women who want it and can afford it. A national survey that evaluated 667 women who planned childbirth at home revealed that, of these, 104 required a hospital transfer. Of the 667 women, most were primiparous, with high adherence to prenatal care, high schooling and access to information, factors that may justify the choice for this mode of delivery, since they question the hegemonic model of current hospital care and seek home autonomy and active participation in their parturition process[13].

Women who opt for planned home births are expected to be the protagonists of their labor, to be in a warm environment and to exercise self-confidence. Given the ability to give birth allied to a humanized professional care, they yearn for an approximation and self-assertion of their body. The home favors the attention focused on the woman and her family, facilitating the emotional support, stimulating the autonomy of the parturient and reducing the unnecessary interventions.

Women who opt for planned home birth experience greater connection to one's own body and greater satisfaction, in the sense of relying on bodily physiology, of feeling a grea-

ter connection with one's own nature, and of the possibility of control over the labor process and their environment. Positive feelings of life after birth at home are experienced by the possibility of the presence of family members. However, they present negative feelings about the social judgment of other family members, as well as health professionals who do not work at home[14].

The women in this study had a labor that was marked by the adversity of the hospital transfer, since the choice of home birth was an expected, desired and planned moment by women, based on studies, research and/or previous negative delivery experience. The need for transfer, even if informed at the time of hiring the specialized team, was a surprise that generated anxiety, and the form of negative treatment they received at the hospital, loss of autonomy and control of the body itself were elements that generated frustration and psychological suffering.

In the face of uncontrollable situations during childbirth, the woman may feel responsible for a different outcome than the one planned and expected by her, so that anxiety and distress can emerge and, thus, being a path of suffering. Coping with one's own guilt over what has happened can be seen as a coping strategy[15].

The adversities are not experienced in a passive and unshakable way and when the individual finds positive factors that lead him to a dynamic process of coping and overcoming adversities, the process of resilience is triggered. It is, therefore, a path of transformation to be followed, of personal and social metamorphosis[16]. In this sense, the confrontation of the adversity lived by the interviewees was possible through the meeting of internal and external factors, such as acceptance and the network of social and affective support, which provoked internal mobilization that led to the process of resilience.

The support and presence of the partner and family and the existence of social networks of women who share similar experiences were positive factors, initiating the process of resilience. Communication as a therapeutic process was a lever; similarly, to situations lived and the identification of the female brought comfort and decreased the feeling of isolation, frustration and failure, resulting in the installation of self-forgiveness. It appears that safe and positive affective relationships have strengthened their personal self-efficacy resources and directed them toward resilience[10].

Nursing research involving the process of resilience and the health of women victims of sexual violence has demonstrated that the protective factors are internal mobilization, such as the force of love and maternal responsibility and faith, or external mobilization, as the family and social support, through space of reception and possibility of reporting without judgment, are drivers of resilience[17].

The drive towards therapeutic group care actions, discussion groups, follow-up programs for identified populations at risk and educational programs aims to empower people to find in them the resources needed to cope with difficult life situations[18].

In this perspective, the nurse, as a caregiver, can be a positive element in this process; for this, she must strip herself of judgments and prejudices to understand the totality of the woman who is before her, with her fears, frustrations and vulnerability.

Unlike other countries, planned home birth is a model still little known in Brazil, which contributes to the dissemination and construction of non-truthful information[19], making society marginalize those who opt

for this type of delivery and promoting clashes between health professionals. The care promoted by the nurses who receive in the hospital environment the parturient who tried a planned home birth should be a factor that drives them to the confrontation, through real approximation, dialogue and active listening and not as a negative element, of reprimand. It takes intentionality to be willing to help, in order to make the women find protective factors in the environment, including the nurses themselves as one of these factors. In this movement of meeting with the other, nurses can promote health and consequently improve the quality of life after the adversity experienced[7], in this case, the transference of home to the hospital.

Thus, promoting resilience is helping the other to meet their potential for the adaptation and transformation of the lived in ability to overcome adversity. It is important to emphasize that the discussion on this topic is still recent in the field of health sciences and nursing[18].

Nurses, both those on the planned home delivery team and those receiving these women in the hospital after transfer, need a sensitive eye to understand that the transfer alone can be a moment that triggers an internal conflict, of psychological adversity, in the parturient. In this way, the reprimand goes against the ethical principles of the professional. The reception, the guarantee of qualified assistance and the fetal and maternal well--being, the empathy and the humanization of the care must be priority in the care.

Actions such as constant presence, attention, dialogue, listening and even small acts, such as physical contact, are positive factors, since they allow establishing a relationship of trust and interchange between the professional and the parturient, a relationship with emotional support. Understanding, tenderness, sensitivity and respect for feelings are fundamental elements for the configuration of a humanized nursing care[20].

After facing adversity, a new step towards achieving resilience must begin: overcoming[10]. This phase is configured at the moment when the subjects re-signify the lived and accept the help of the environment as a form of support, as an act of overcoming the negative, aspiring positive aspects in the experience towards adaptation. In the interviewees of this study, the overcoming is manifested by the non-blame for the hospital outcome, the exercise of motherhood without frustration and the maintenance of environmental protection factors in the face of adversity, such as continuing to take part in the women's groups, maintenance of affective bonds and internal movements of resignification of the lived, which make it possible to overcome, to look at oneself and to overlap acceptance to the detriment of pain and guilt.

The process of resilience can be compared to walking along a road; it means being in the movement of transformation, of entering, and of continuing to walk the road, a fundamental and propelling condition of resilience[16].

In the encounter of adaptation, people can feel rebuilt, transformed and adapted to their new reality. It is an active movement of personal transformation in order to achieve the desired overcoming of adversity. It is when one "looks back" and understands that crossing the road of the process of resilience has led to freedom, the withdrawal of the negative feelings of life, a differentiated and positive look at the adversity experienced[10]. In this sense, achieving resilience involves successful adaptation in the process of human living, defined as the ability of the person to

overcome, with renewed strength, a situation that could have been traumatic and negative for their existence[18].

CONCLUSION

The study made it possible to identify among the interviewees that the support of the family and the partner, the existence of social networks and the wheels of women who open the dialogue, so as not to find themselves guilty or failed by the hospital transfer, are factors that have triggered the process of resilience. During the overcoming phase they were able to re-signify the experience and understand the real need for the transfer, leading to the acceptance and recognition of the event. The stage of adaptation, however, was only noticed in one interviewee, who puts herself in the position of looking back and perceiving the experience as a form of personal transformation, for not letting down by suffering and being able to report what happened without suffering or psychological damage.

It is worth noting that nurses, whether obstetricians or not, and regardless of whether they work at home or in the hospital, as part of the health team should reflect their position with a view to abolishing judgment and recommending care in a humanized way, through active listening and qualified action, so that the woman does not feel alone and is not afraid of the transfer or the way it will be received by the hospital staff. It is hoped that these professionals understand the psychological damage as real and of aggravation to health and, in this way, be drivers of the process of resilience, this being an instrument of care.

It is suggested that studies such as this be replicated in other places where there are planned home delivery teams, since the number of professionals who perform this type of care and the number of pregnant women seeking this mode of delivery are still small in Brazil. This fact justifies even the small sample of women interviewed, this being a limitation of this study.

REFERENCES

1. World Health Organization (WHO). Recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization. 2018 [internet]. Available from: https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/
2. Ministério da Saúde (Brasil), Secretaria de atenção à saúde. Parto e nascimento domiciliar assistido por parteira tradicionais: O programa Trabalhando com parteiras e tradicionais e experiência exemplares. [internet]. 2010 [Cited 2016 Mar 03]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/parto_nascimento_domiciliar_parteiras.pdf
3. Ministério da Saúde (Brasil). DATASUS. Nascidos vivos [homepage internet]. 2015 [Cited 2017 July 12]. Avaible from: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sinasc/cnv/nvuf.def
4. Ministério da Saúde (Brasil). Diretrizes nacionais de assistência ao parto normal: versão resumida [recurso eletrônico] / Ministério da Saúde, Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. [internet]. 2017 [Cited 2017 July 23]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
5. Olsen O, Clausen JA. Planned hospital birth versus planned home birth. Cochrane Database Syst Rev (Online) [internet]. 2012 [Cited 2016 June 25] 9:cd000352. Available from: https://www.ncbi.nlm.nih.gov/pubmed/22972043
6. Amorim MMR; et al. Indicações de cesariana baseada em evidencias: parte I. Femina

(Online) [internet]. 2010 [Cited 2016 July 06];38(8). Available from: http://files.bvs.br/upload/S/0100-7254/2010/v38n8/a1585.pdf

7. Labronici LM. Resilience in women victims of domestic violence: a phenomenological view. Text Context Nursing (Online) [internet]. 2012 Jul-Sep [Cited Aug 16]; 21(3). Available from: http://www.scielo.br/pdf/tce/v21n3/v21n3a18.pdf
8. Fontes AP, Neri AL. Resilience in aging: literature review. Cien Saude Colet (Online) [internet]. 2015 [Cited 2016 Aug 16];20(5). Available from: https://www.ncbi.nlm.nih.gov/pubmed/26017950
9. Rutter M. Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. British Journal Of Psychiatry. 1985 [Cited 2019 Jan 3];147.
10. Poletto M. Resiliência: nova perspectiva sobre as potencialidades humanas. Polêm!ca. 2008 [Cited 2018 Aug 20];7(3).
11. Dewes JO. Amostragem em bola de neve e respondent-driven sampling: uma descrição dos métodos. Porto Alegre. Monografia [Bacharel em Estatística] - Universidade Federal do Rio Grande do Sul; 2013. Available from: https://lume.ufrgs.br/handle/10183/93246
12. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2016.
13. Koettker JG, Bruggemann OM, Freita PF, Riesco MLG, Costa Ra. Obstetric practices in planned home births assisted in Brazil. Rev Esc Enferm USP (Online) [internet]. 2018 [Cited 2019 Jan 03];52:e03371. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080--62342018000100460&lng=en.
14. Jouhki MR, Suominen T, Åstedt-Kurki P. Giving birth on our own terms – women's experience of childbirth at home. Midwifery (Online) [internet]. 2017 [Cited 2019 Jan 3]; 53. Available from: https://www.midwiferyjournal.com/article/S0266-6138(17)30525-9/fulltext
15. Tomsis Y, Gelkopf M, Yerushalmi H, Zipori Y. Different coping strategies influence the development of PTSD among first-time mothers. J Matern Fetal Neonatal Med (Online) [internet]. 2018 [Cited 2019 Jan 3];31(10). Available from: https://www.ncbi.nlm.nih.gov/pubmed/28372468
16. Mattar M, Yunes MAM. A resiliência no relato Livre: a jornada de uma mulher em busca do recomeço. Revista de Educação, Ciência e Cultura (Online) [internet]. 2016 [Cited 2017 Feb 15];21(2). Avaible from: https://revistas.unilasalle.edu.br/index.php/Educacao/article/view/2236-6377.16.41/pdf
17. Trigueiro TH, Labronici LM, Merighi MAB, Raimondo ML. The process of resilience in women who are victims of domestic violence: a qualitative approach. Cogitare Enferm (Online) [Internet]. 2014 [Cited 2019 Jan 3];19(3). Available from: https://revistas.ufpr.br/cogitare/article/view/34726/23208
18. Silva LWS, Silva DMGV, Silva DS, Lodovici FMM. Resilience as a construct in nursing practice: reflective concerns. Revista Kairós Gerontologia (Online) [internet]. 2015 [Cited 2019 Jan 3];18(4). Available from: https://revistas.pucsp.br/kairos/article/view/27067/19188
19. Sanfelice CFO, Abbud FSF, Prognolatto OS, Silva MGS, Shimo HKK. From institutionalized birth to home birth. Rev Rene (Online) [internet]. 2014 [Cited 2017 Fev 15];15(2). Available from: http://www.revistarene.ufc.br/revista/index.php/revista/article/view/1561/pdf
20. Souza CM, Ferreira CB, Barbosa NR, Marques JF. Nursing staff and the care devices in the childbirth process: focus on humanization. J res: fundam care (Online) [internet]. 2013 [Cited 2017 Mar 05];5(4). Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/2380/pdf_923

Authors' Participation

Carolina de Lima: substantial contributions to the conception or design of the work; in the collection, analysis and interpretation of data; in the writing of the article or in its critical revision.

Tatiane Herreira Trigueiro: substantial contributions to conception and design of the work; in the collection, analysis and interpretation of data; in the writing of the article or in its critical revision; and on the final approval of the version to be published.

All authors participated in the phases of this publication in one or more of the following steps, in according to the recommendations of the International Committee of Medical Journal Editors (ICMJE, 2013): (a) substantial involvement in the planning or preparation of the manuscript or in the collection, analysis or interpretation of data; (b) preparation of the manuscript or conducting critical revision of intellectual content; (c) approval of the version submitted of this manuscript. All authors declare for the appropriate purposes that the responsibilities related to all aspects of the manuscript submitted to OBJN are yours. They ensure that issues related to the accuracy or integrity of any part of the article were properly investigated and resolved. Therefore, they exempt the OBJN of any participation whatsoever in any imbroglios concerning the content under consideration. All authors declare that they have no conflict of interest of financial or personal nature concerning this manuscript which may influence the writing and/or interpretation of the findings. This statement has been digitally signed by all authors as recommended by the ICMJE, whose model is available in http://www.objnursing.uff.br/normas/DUDE_eng_13-06-2013.pdf