EFFECTS OF PERINATAL LOSS ON BRITISH COLUMBIAN OBSTETRIC NURSES

by

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

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Abstract

Background: Perinatal loss is a common occurrence on obstetric units. The effects of perinatal loss are far reaching and have profound effects on the families experiencing it, and on the nurses who care for them. Explorations of what exactly these effects are on the nursing staff providing bereavement care is lacking. **Purpose:** To explore the experiences of obstetric nurses who have provided care to families undergoing a perinatal loss. **Methods:** A qualitative descriptive design informed by principles of interpretive phenomenology was used to explore the effects of perinatal loss on nurses. A purposive sampling technique included eight nurses. Open-ended questions using a semi-structured approach guided the interviews. **Results:** The eight nurses interviewed were unanimous in their descriptions of how the lack of support and time to care for families experiencing perinatal loss significantly impacted their own experiences of providing care. Both positive and negative experiences were shared about the impacts of perinatal loss; yet when support and time were lacking, participants reported significant negative effects. Conversely, when nurses had adequate supports in place and the time to spend with their bereaved patient, as well as time for self-care, positive experiences were described. Finally, participants described perinatal bereavement work as highly valuable work, for which their involvement was considered a privilege. **Implications:** This study highlights the importance of education, preparation and support for nurses within the context of perinatal loss. The study findings point to the importance of resourcing support and prioritizing the time needed for nurses to minimize the negative effects of caring for families experiencing perinatal loss. It also highlights that strategies need to be in place for nurses to support each other to promote experiences that are more positive. Nurse leaders emerged in the study as a significant resource

for shaping a climate of care and perinatal practice to mitigate the negative effects described in the literature and this study, while also advocating for the necessary resources, time and nurse-to-nurse support that can facilitate meaningful work for nurses as they care for families experiencing perinatal loss.

Lay Summary

The goal of this study was to explore the various effects of perinatal loss on obstetric nurses. This was accomplished by performing eight, one-on-one interviews with obstetric nurses, using a semi-structured approach via open-ended questions. The results of this study indicate that how a nurse is affected by perinatal loss is dependent on various factors, such as the availability of supports and time to be with the patient, as well as time for introspection. What this study offers are much needed insights to the effects of perinatal loss from a nursing perspective. Although more research is needed, this study gives nursing leaders, and nurses themselves a unique glimpse into how nurses experience (and make sense of) the provision of perinatal bereavement care.

Preface

This descriptive qualitative study is original work produced in collaboration with my supervisory committee. The data analysis and identification of findings were completed with the support of my supervisor, Dr. Helen Jean Brown. All members of my committee supported the writing of this thesis: Dr. Helen Brown, Dr. Wendy Hall and Dr. John Oliffe. This thesis received ethical approval for harmonized minimal risk study from the UBC Behavioral Ethics Board (BREB), as well as the Fraser Health Research Ethics Board. The REB Number is H17-01256.

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Acknowledgements

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I also want to thank all of the wonderful nurses who participated in this study. You are the epitome of resilience. Thank you for sharing your stories, tears and insights. I hope I have captured your stories in a meaningful way, a way in which together we can foster change and better experiences for ourselves, and the patients to which we dedicate our service.

Lastly, I want to thank my family. Mom and dad; you are both incredible. Thank you for always believing in me and never allowing me to think that anything is beyond my reach. I could not have done anything in my life without your unwavering love and support. To my husband, thank you for encouraging me to keep going. To my wonderful boys, thank you for inspiring me every single day to be the best version of myself.

Dedication

To my fellow nurses.

Chapter 1: Introduction

Experiencing a perinatal loss can be one of the most traumatizing and devastating life experiences; it is more than the immediate loss of a fetus or newborn, but also the loss of parents' hopes and dreams (Puia, Lewis & Beck, 2013). Enduring and overcoming such a loss is for many parents, unthinkable; yet perinatal loss is common. According to Statistics Canada (2009), 7.1 out of every 1000 parents are faced with such an event every year. With the prevalence of perinatal loss, there is a significant amount of research focusing on the lived experiences of families (Koopmans, Wilson, Cacciatore, & Flenady, 2013; Nowak & Stevens, 2010; Ward, 2012). While the family experience is an important focus for investigation, many, if not all families, at some point interact with nurses, and primarily nurses, during perinatal loss. Yet, knowledge about the nursing role and experience in caring for families experiencing a loss, and providing bereavement care is lacking in the literature. While there is a significant body of work examining nurse's experiences with loss in other practice domains such as: oncology, critical care and emergency (Johansson & Lindahl, 2012; Zheng, 2015), there is limited research focused on how perinatal loss impacts obstetric nurses (Ben-Ezra, Palgi, Walker, Many & Raz, 2014).

1.1 Perinatal Loss Defined

There are various definitions of perinatal loss within the literature. Barfield (2011) presents an extended conceptualization of perinatal loss by proposing it to be a live birth that resulted in a loss immediately after birth, as well as a loss of a child up to one year of age. Leduc (2006) defines the concept as the death of a fetus after 20 weeks of gestation. Other definitions also include the mode of loss: spontaneous terminations versus therapeutic terminations (Parker,

Swanson, & Frunchak, 2014). For the purpose of this study, perinatal loss will be defined as any event, regardless of mode, that results in the death of a fetus or neonate before or immediately after birth. Since nurses are engaged in providing care for any type of perinatal loss, this study employs a broad conceptualization of perinatal loss to maximize the opportunity to generate relevant and actionable findings for nursing practice.

1.2 Situating the Problem: Personal Context

My interest in studying this subject matter is twofold. First, I have always struggled with the lack of preparation and support I received in my education and clinical practice in regards to providing bereavement care to families. Although I acknowledge that preparing nurses to provide bereavement care is complex, in that each person's construct of loss leads them to experience the phenomenon in diverse ways, I would have appreciated some general guidance and mentorship. Secondly, my main motivation to study this topic arose after I worked as an obstetric nurse with a family a few years ago that has profoundly impacted me. The following is a description of that experience; it is included here as I believe it is critical for understanding how the question arose for this study, and why I feel further inquiry in this topic is important for obstetric nursing practice.

1.2.1 One Family's Story

They were just like any other couple I encountered in my practice. They were excited, afraid and ready to reap the reward that forty long weeks of gestation would produce. He led her by her hand as she breathed through her contractions. I helped her to a room, and she lay on the bed as I attached the fetal monitor. There was the typical hissing of the machine, but no galloping like sound of the fetal heart. She immediately panicked and I did my best to reassure her as I adjusted the fetal monitor. They held hands and intensely stared at me, waiting for more

reassurance that was getting harder to provide. I called for an obstetrician, and once more readjusted the monitor hoping my intuition was wrong. The family doctor arrived and performed a bedside ultrasound. I started to feel sick as she looked for the fetal heart. The image of a still chest appeared, but the doctor did not say anything and left the room. Now they were both crying, asking me what was going on and why no one was saying anything. I apologized, feeling absolutely helpless and said I would go and find the doctor and re-page the obstetrician. I walked out of that room and countless emotions flooded my mind. I was angry that the family doctor left, and angry that the obstetrician was not calling back. I was heartbroken for this wonderful couple who I just left hoping, despite knowing the answer that would undoubtedly change their lives forever. Mostly, I felt guilty for reasons I still cannot explain. I felt like there was something I should have done, there must have been something, because the alternative was too heartbreaking to accept. I tried to hold myself together and went to find the obstetrician. I found him chatting to a colleague, and when I told him what had transpired he told me: “sounds like the baby is dead, not much I can do about that”. That rush of sick encompassed me again, and I was not sure how much longer I would be able to go on.

He eventually came to deliver the worst news a parent could hear. Their baby was dead. He repeated the bedside ultrasound so they could see for themselves that the heart was still and not beating. She grabbed my hand as if we were old friends and sought my comfort as she sobbed. Her partner fell to the floor and cried. I looked at them unaware of my own tears streaming down my face and noticed that time had just stopped. It reminded me of that dream people describe; where something is chasing you, and you are trying to run, but your legs do not work, and you are unable to move or cry out, rather you are forced to just be still and feel the

fear of what is to come next. The only difference here is that this dream was a real nightmare and for better or worse, we were about to live it together.

The plan was to induce labor. She labored quickly and progressed to ten centimeters within only a few hours. As she was delivering, she looked at me and said ‘maybe you were wrong’ and I so badly wished we were. Then, the baby came: she was beautiful, heavy, even somewhat pink, but unmistakably lifeless. I placed her still body on her mother’s chest, walked to the corner of the room and finally vomited the anguish of the past few hours. I sobbed while I bathed her, dressed her and took pictures of their family. When my shift ended, and the time to go had come, I found myself unable to leave. I felt so connected to them as if they were my own family, the thought of leaving them made me ill. I said my goodbye and kissed her sweet head and sat in the room next door for an hour, crying, suspended in time. Eventually, I walked out of that room, the hospital, with an uncertainty of just how I was ever going to walk back in.

In the months that followed I dreamt about her beautiful locks. I saw her in other curly haired little girls, and wondered what her life could have been. Letting her go, has been one of the hardest things I have ever had to do in my professional life.

I communicated how difficult this experience was for me and received some sympathy but no formal support. I wondered about how other nurses coped with such situations. Is the expectation to suffer in silence? How do other nurses approach this type of care? Am I the only one who ever felt like this? How can we better support each other, or at very least acknowledge each other during this unfortunate, inherently difficult part of our job? It is through asking these questions that I began to discover that providing bereavement care can be incredibly empowering. I began to speak to my colleagues, and received accounts of cases they had and how they affected them. Some were incredibly sad, some were even so disturbing that I was in

awe of my colleague's ability to manage, but to my surprise some were even positive accounts of situations that nurses described as life changing and amazing. This piqued my interest, and led me here, to further investigate the multiple effects of perinatal loss described by my colleagues, but thus far, not represented in literature.

1.3 Situating the Problem: Professional Context

The research topic for this thesis was developed by bringing my question of the nurse's role in perinatal bereavement care to see what was known in the literature. Given nurses' proximity and provision of care for parents experiencing a perinatal loss, and after discovering a gap in the literature, it became evident that a greater understanding of this area was important. Although a few studies exist, these studies are guided by specific theoretical perspectives that frame the phenomenon in specific ways; for example, focusing on nurses' grief, experiential trauma, and ways of coping (Beck & Gable, 2012; Ben-Ezra et al., 2013; Firth & Britton, 2011). Thus far, I have been unable to locate any exploratory qualitative studies that investigate nurses' experiences of providing care to bereaved families, without imposing a theoretical fore-structure framing such experience through grief, loss, and coping constructs.

Because the knowledge that exists to guide perinatal policy and practice is conceptually oriented towards grief and coping, studies focused on broadly understanding how nurses experience perinatal loss are lacking. Without gaining nurses' perspectives it is difficult to identify their needs for continuing to provide care. Therefore, this study was undertaken to learn from the perspective of nurses who have provided care during perinatal loss; experiences which were presupposed to be diverse and complex. My analysis speaks to the shared experiences (positive and negative) across the interviews that are presented as themes. Questions not addressed in existing studies and that were important in this study given my purpose included:

Does every nurse find it difficult? Do some nurses find it rewarding? Does it get easier over time? What are nurse's varied emotional responses?

1.4 Purpose of Study

The aim of this qualitative study was to explore the experiences of obstetric nurses who have provided care to families undergoing a perinatal loss. The goal of this research was to develop knowledge about nurses' experiences of providing bereavement care to families to inform perinatal nursing practice. The research objectives were to:

1. Identify the meanings of obstetrical nurses' experiences when caring for bereaved families.
2. Generate knowledge to guide policy, education and nursing practice to improve care to parents experiencing perinatal loss.

1.5 Research Question

Using a qualitative descriptive approach informed by principles of interpretive phenomenology, the research question for this study was: What are the experiences of obstetric nurses who have cared for families undergoing a perinatal loss?

With an overview of the phenomenon and research question now introduced, in the next chapter I will discuss the literature context that underscored the significance of and the need for the study.

Chapter 2: Literature Review

2.1 Search Strategy

The search strategy employed for this literature review included searching common medical and nursing databases: CINAHL, PubMed, PsycINFO, and MEDLINE. Keywords employed in the search were: perinatal loss, nurse, perinatal death, fetal death, caring, coping, obstetric nurses, qualitative. MESH headings were also used and examples include: perinatal loss, infant, caregiver, health care workers, stillbirth, stress, health care services. Use of Boolean operators was also undertaken, as suggested by Cronin, Ryan and Coughlan (2007), to broaden the search results.

2.2 The Literature

The vast majority of literature on this topic utilized qualitative methodologies, although one quantitative study and one mixed methods study were located. An editorial was also reviewed since it provided a clinical account of implementation measures to prevent and manage staff traumatization, and was thus deemed important to incorporate in the literature review. It is also imperative to note that, although the selected work reviewed focused on experiences of nurses during perinatal loss, the methods and definitions of the concept of loss varied. Because the definition of perinatal loss used in this this study was broad, these studies, although possessing different definitions of loss, were still included in this review. Four areas of research emerged during the analysis of the research studies, and these provide an overview of what is currently known about the topic under study. The literature has been organized to provide a synthesis of the research in four domains:

1. The Impact of Loss.

2. Influential Factors.

3. Coping Strategies.

4. Moving Forward.

The four areas used to structure the literature review focused on identification of the effects of perinatal loss and identifying what factors affect nurses' responses to loss, their coping strategies and how they move forward in their practice and personal lives after caring for families. Each of these domains overlaps in the literature despite the discussion of them as distinct here; however, they share a focus on the impact and trajectory of perinatal loss for obstetric nurses.

2.2.1 The Impact of Loss

Existing studies indicate, for the most part, that the effect of perinatal loss on nurses is negative. Beck and Gable (2012) used a mixed-methods approach to extrapolate the frequency of secondary traumatic stress occurrence in perinatal nurses. A random sample of 464 nurses was obtained and a measure of their stress index was undertaken via surveys. Of those, 322 took part in the qualitative inquiry, for which the author analysed their responses for rich descriptions of the impact that the loss had on them. The findings indicated that the nurses perceived perinatal loss as the most trauma-inducing birth outcome. Specifically, descriptions of extreme traumatization in perinatal death cases were reported following direct involvement (being the primary nurse responsible). Although the authors indicated that only the nurses who described the perinatal loss as traumatic were sampled, the findings suggest that perinatal loss had a major effect on nurses' work and lives.

Puia, Lewis and Beck (2013) conducted a qualitative study to examine the impact of perinatal loss on nurses; their findings outlined four areas of impact most reported by nurses:

grief, trauma, blame, and professional burnout. These results highlight the severe negative effects of dealing with perinatal loss, specifically the substantial personal effects on the nurses. The analysis in this study extended to focus on how the effects on the nurses from perinatal loss influenced the broader health care context. Puia et al. (2013) discussed burnout within the current health care system, linking their findings to those of Firth and Britton (2011) who contended that, nursing, as a profession, has one of highest rates of professional fatigue. Both authors argued that purported harmful effects of perinatal loss such as: secondary traumatization, loss of job satisfaction and caregiver fatigue, to name a few, were detrimental to retention of nursing staff. Despite the importance of these findings about the negative effects, a lack of knowledge exists about *why* nurses are feeling this way; specifically, we do not know that loss experiences have a singular negative impact, and what, if any, other factors are influential. For this reason, this study aimed to explore nurses' experiences to learn how they understand perinatal loss care, and to use the findings to inform practice and create actionable change deemed necessary in the aforementioned studies.

Jonas-Simpson, Pilkington, MacDonald, and McMahon (2013), conducted an interpretive phenomenological study through visual arts research methodology by audio and video taping nurses in interviews who described their experiences of grief when present during a fetal death. The authors found that nurses required multidimensional support such as: education, workplace training, and mostly acknowledgment, in order to move past the trauma of being a part of perinatal loss cases. Although the authors acknowledged that, with the right supports in place, nurses can move past the traumatizing nature of fetal death, they described that in reality such support was not always available; thus perinatal loss was still described to be 'grief' work by

most nurses in their study. This again signifies that most nurses' experiences of perinatal loss are described as largely negative.

McCreight (2004) asserted that, although dealing with perinatal loss is inherently difficult, nurses wanted to engage with whatever emotions these experiences created. Contrary to most studies on this topic, McCreight (2004) found that it was not the negative aspect of care that caused the greatest challenge, rather the unwillingness of their institutions to address these concerns. McCreight (2004) described this process for the nurses as 'emotional labor', which they viewed as a result of their institutions dismissing the negative effects perinatal loss can cause, thereby adding further strain to the nurses' work. The nurses in this study described that a structured environment, one that acknowledged the psychological difficulty of caring for bereaved families, was necessary in order to understand and aid nurses in effectively curbing potentially negative effects (McCreight, 2004). Given their position, additional research, such as this study, is well suited to explore the multitude of experiences bereavement care can elicit, and in turn continue to build knowledge that can guide policy change that can better serve the nurses providing such care.

2.2.2 Influential Factors

Several factors have been identified that influence how nurses perceive the magnitude of perinatal loss. Parker, Swanson and Frunchak (2014) studied the psychosocial, educational, and administrative support needs of nurses who were involved in bereavement care. Their results signified gaps in all three domains of needs. First, nurses felt inadequately prepared by their educational programs, as well as specialty training, to care for bereaved families undergoing a loss. In addition, nurses described many in-services and educational opportunities in all other practice areas (diabetes care, HELLP syndrome, and twins' management), but none described

receiving on the job training or education regarding perinatal loss. This lack of preparation led to nurses' feelings of inadequacy, incapability, and overall heightened stress responses. Secondly, the lack of psychosocial support also had a deep impact on the nurses' reactions to the loss. Two subthemes were described under the psychosocial domain encompassing intrapersonal and interpersonal support (Parker et al., 2014). Intrapersonal psychosocial support referred to the nurses' intrinsic coping strategies and their drive to "…fulfill the nursing role, manage moral distress and develop a therapeutic relationship", despite the fact that they felt unprepared and unable to do so (Parker et al., 2014, p.480). Nurses described putting their needs aside in order to provide the best possible care to their patients. In fact, one nurse in this study even described that this was a coping strategy, a way of escaping the traumatizing reality of seeing an infant die and the all-encompassing grief of the parents (Parker et al., 2014). The theme of interpersonal psychosocial support alluded to the fact that peer support and acknowledgement were vital for coping with the situation when it occurred (Parker et al., 2014). In cases where activities like debriefing, physician support, and guidance from experienced nurses were employed, nurses reported their needs being met. Conversely when these needs were not met, the negative aspects of providing bereavement care were much more deeply felt.

In an editorial, Foreman (2014) further solidified the need for meeting nurses' needs or addressing the influential factors by developing a 'tool' that aimed to support nurses during cases of perinatal loss. The author indicated that by utilizing the 'tool' the nurses were given a debriefing opportunity immediately following a loss case and offered additional psychosocial support. A checklist was also developed that gave team members different responsibilities so that the onus and weight of care during a traumatizing case was shared amongst the team members, rather than managed by just one nurse. In addition, a self-care packet was created that nurses

could take home that included education and support, information regarding self-care, as well as counselling and community support resources. The feedback from staff on the implementation of this ‘tool box’ was positive, which signified that the influential factors identified were key to understanding how nurses are affected by perinatal loss. Lastly, administrative support factors indicated that, when organizations fail to recognize how perinatal loss can create severe negative effects for staff, they do not address the influential factors. Ultimately, this devalued the effect that loss can have on nurses. On the other hand, the tool kit described and developed by Foreman (2014) is an example of administration taking an active role to address an organizational gap and provide a supportive measure for their staff.

Although these studies and initiatives are positive steps in finding a solution, they are all based on findings from studies that drew their conclusions based on the assumption that perinatal loss can only have negative effects on nurses. What continues to be lacking, and is necessary to generate knowledge for nursing practice, is a qualitative descriptive study wherein nurses can describe their experiences through an unstructured and open-ended interview approach. By creating the opportunity for this type of inquiry, experiences such as the ones shared by my colleagues can be brought forward to inform current nursing practice.

2.2.3 Coping Strategies

While acknowledging that there are numerous coping-focused theoretical frameworks cited in the literature, a limited number of studies examined coping within the context of perinatal loss. Hutti et al. (2016) conducted focus group interviews to explore how nurses coped while caring for families who have experienced a perinatal loss. The authors found five themes that highlight nursing coping processes, and these are: strategies for coping in the moment, situations that make care easier, situations that make care more difficult, priorities of care, and

feelings associated with care (Hutti et al., 2016). The study results signaled that, for this study population, coping strategies were intrinsic in nature and involve ‘self work’. In other words, the authors asserted that it was difficult to generalize how nurses cope as each nurse's conceptualization or construction of what coping ought to be is unique; however, in general, they proposed nurses would fit into one of the aforementioned themes.

Gardner (1999) explored nursing and midwifery needs in regards to perinatal death. She found that, when health care providers felt that they were well informed and equipped to perform the care (they received some formal training on what to expect and say), they described their ability to cope with providing such traumatizing care with confidence and without fear. Although these studies have acknowledged that traumatization is not the only experience an obstetric nurse might face in the duty of caring for bereaved families, there are no specific descriptions of any experiences except trauma. I argued here that qualitative inquiry into nurses’ experiences of providing bereavement care has questioned whether the phenomena is potentially spiritual, transcendent and even rewarding, thereby potentially contributing important knowledge to inform perinatal nursing care.

2.2.4 Moving Forward

As perinatal loss is common within the practice of obstetrics, there is some research indicating how nurses cope to move past the trauma. In their study of the impact of perinatal loss on obstetric nurses Ben-Ezra et al. (2013) described the concept of resilience based on Selye's (1976) general adaption model. First, the authors stated that how perinatal nurses directed their efforts in order to minimize the effect of the trauma profoundly impacted their coping ability. Secondly, based on the nurse’s conceptualization of each stressor, a new reality was realized and established. In light of this, nurses described that they were able to move on from the trauma, and

even indicated the ability to grow once they realized their own concept of grief was self-regulated. Differently put, the nurses reported a sense of empowerment and even maturation despite the traumatizing nature of perinatal loss, after they realized that they were in control of how and to what extent the loss could impact them. Although this study reported that nurses could benefit and grow from providing bereavement care, it was focused on coping with the traumatization of perinatal loss; once again framing the experience in a negative manner.

Wallbank and Robertson (2008), in a meta-synthesis, contributed to the theme of moving forward by contending that concrete steps must be laid out by organizations to ensure that staff members are well equipped to effectively deal with perinatal loss. These include ensuring that the staff members have the necessary education, support during the case, and time to be reflexive about the event. The implications of ignoring their findings are that nurses continue to silently suffer. In addition, the fact that the majority of the studies conceptualized the impact of perinatal loss through a negative lens, misses the opportunity to access nurses' perceptions of positive effects of providing this type of care. This perpetual negative framing of perinatal loss, although true for some nurses, requires expansion through research in order to glean a broader, fuller understanding. Limiting knowledge development by using pre-theorized constructs to guide inquiry does not allow for full discovery of the phenomenon. In this study, I approached the phenomena without pre-theorizing to allow for an open-ended inquiry that can contribute to knowledge generation for perinatal nursing care in the context of fetal or newborn death.

2.3 Limitations of Current Research

The effects of perinatal loss on parents and families are profound, with nurses also experiencing its devastating consequences. While the phenomenon is beginning to be described in the literature, there is a lack of research evidence to guide practice-relevant knowledge for

perinatal nurses. Some studies were designed to focus on experiential knowledge; however, they did not focus specifically on obstetric nurses, rather they investigated nurses in all domains of practice. Other studies using phenomenological approaches have used written analysis provided by nurses to understand nursing experiences without benefitting from the potentially rich data that can be generated from face-to-face interaction during interviews (Polit & Beck, 2017). The studies quantifying stress or trauma, by utilizing scales via surveys, relied on small samples and written descriptions again without talking to the participants. Only one study used audio and video recording through a phenomenological approach to glean nurses' experience with a perinatal death (Jonas-Simpson et al., 2013). However, that same study was limited by the focus on grief while ignoring other potential experiences nurses may feel when faced with a family's perinatal loss. Overall, no studies have been located that provided knowledge about potentially positive effects from caring for families experiencing perinatal loss. Open-ended exploration could potentially generate alternate conceptualizations of the effect of perinatal loss on nurses. The findings from this literature review indicate that perinatal loss carries potentially harmful consequences for nurses and other health care providers; additional research is needed to understand a wider array of meanings for nurses associated with caring for bereaved families. By remaining open to possibilities, this study's aim of exploring the experiences of obstetric nurses who have provided care to families undergoing a perinatal loss fills this gap in research. The following chapter will outline the utilized methodology.

Chapter 3: Methodology

Qualitative research has been the cornerstone of many nursing, sociological, and philosophical inquiries. Qualitative inquiry allows for an in-depth understanding of how individuals experience phenomena; it is a holistic method, used to investigate the many possible experiences and meanings associated with phenomena within their natural settings (Taylor, 2015). Qualitative researchers aim to derive meaning and interpretation of a phenomenon by situating themselves within the context of the study, and engaging with the participants during the discovery process (Barker, 2013). Multiple types of qualitative designs aid researchers in this undertaking. Phenomenology is one design that aims to reveal the meaning associated with human experiences.

There are two originators of phenomenology. Husserl (1962) developed descriptive phenomenology as "careful description of ordinary conscious experience of everyday life" (as in Polit & Beck, 2017, p.471). In other words, Husserl's descriptive phenomenology aims to uncover human experience through description of phenomenon as seen and experienced by the study participants. As a student of Husserl, Heidegger (1962) then took this concept further and expanded on the notion that one cannot simply understand experience by describing it, as postulated by Husserl, but a certain level of interpretation must also take place. Furthermore, he argued that to describe experiences, one must explore what those experiences mean, thereby delving further into the process of meaning-making (Heidegger, 1962). Therefore, interpretive phenomenology focuses on exploring the meanings of human experience as interpreted by the individuals describing them.

Although many more researchers since Heidegger have conceptualized what interpretive phenomenology is, and how it can be applied to nursing and research, the historical perspective is included here to foreground IP and its roots. Benner (1994), who cites both Husserl and Heidegger, argued that the central tenet of IP was to "study the phenomenology in its own terms" (p.99). Put differently, it involves taking the participants' contributions and analyzing the data to articulate as accurately as possible a meaning or presentation of findings. This study is informed by Heidegger's interpretive phenomenology within a qualitative descriptive project, as the tenets of IP are synonymous with the study aim, to explore the experiences of obstetric nurses who have provided care to families undergoing a perinatal loss. The fit between methodology and the research aim reflects the assumption that each person's conceptualization of loss is different and that, by exploring these unique variations of shared nursing experiences, important insights into how to understand, interpret and learn can be constructed.

3.1 Theoretical Framework

A constructivist view of knowledge underpins this qualitative descriptive study. Constructivism, originating as a theory of learning, has been used in various disciplines including psychology and philosophy (Raskin, 2002), and aligns with how I have approached the study of nursing experiences within the context of perinatal loss. Constructivist theorists postulate that knowledge and meaning of certain experiences are unique to the individual and integrate previous experiences (Fosnot, 1996). Furthermore, these previous experiences guide the person in how they perceive the current experience. In the event that a person has no relatable experiences new knowledge is constructed; this knowledge is unique to the person and their own patterns of thinking and experiencing that shapes their interpretation of specific phenomena. A

constructivist view also underscores the important notion that people are continuously experiencing and constructing meaning as it relates to specific phenomena.

As a researcher, I remained conscious of my assumptions in relation to nurse's perinatal loss experiences for how it may have influenced my analysis and interpretation. This means for a study on experiences of perinatal loss that I was reflexive and attentive to how an individual person plays an"…active role in the personal creation and the [constructed] importance of the experience, [and only then, I posited that the derived meaning is] an accurate representation [of their] reality" (Doolittle, n.d, p.1). A constructivist theoretical perspective in this study underscored the importance of not imposing specific meanings at the outset of the study in order to remain as open as possible to the varied experiences the nurses described. Existing research in the area, which has focused primarily on the challenges and negative impacts of perinatal loss, only served to situate the study findings in what is currently known, but not to impose any a-priori meaning. This approach was consistent with how theoretical notions and perspectives may sensitize the qualitative researcher to some degree prior to undertaking the study, yet supports the importance of remaining open to the possibilities of the varied meanings described by the participants.

3.2 Ethical Considerations

As this study involves human subjects, ethical approval from the University of British Columbia Behavioral Ethics Board and the Fraser Health Authority Ethics committee was obtained prior to the initiation of recruitment. Additionally, the primary contact holds a Tri-Council Policy Statement Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE) Certificate, in accordance with university guidelines when engaging in human research. In addition to meeting the institutional ethics requirements, the research was

conducted in an ethical manner following ethics approval. Measures were taken to ensure that participants provided free and informed written consent, and had their confidentiality and privacy protected. I accomplished this through the removal of names and identifiers from the interview data, utilizing codes, as well as securing the data in password-protected computer. In addition, I took measures to ensure that participants did not experience coercion or lack the opportunity for full disclosure of how I would use the data. I openly informed the participants that their enrollment in the study was voluntary and that they could withdraw from the study at any time without consequence. Participants were also informed that they could refuse to answer any questions or request that their data be withdrawn from the study. Finally, prior to every interview I reviewed the study goals, aims and expectations, in keeping with the goals of informed consent. Although there was minimal risk in participating in the study, I did inform the participants that their participation may raise distressing memories and as such informed them of their Employee Assistance Program, or that they were to refer to their family doctor for additional resources. As the participants were all British Columbian nurses, I reminded them of their extended health benefits, which include psychological and counselling services.

3.3 Recruitment

3.3.1 Sampling

I recruited eight registered nurses by employing a purposeful sampling technique, which is defined as a "select[ion of] cases that will most benefit the study" (Polit & Beck, 2017, p.493). The inclusion criteria for the study were set as the following: a) the participants must have at least two years of obstetric experience; b) be between 30-65 years of age; and, c) have cared for a client who has experienced a loss within the last 12 months of practice. Two years of experience as an inclusion criterion was set since perinatal loss cases are not generally assigned

to novice nurses. The age range was selected in order to capture nurses from diverse ages reflecting different life experiences, with the goal of adding depth to the data; however, I do acknowledge that life experience is not necessarily related to chronological age. Specifically, it was interesting to explore how different life experiences intertwined with longevity in a career, has shaped nursing perceptions on the construct of loss. Finally, the last criterion of having cared for someone with a loss within the last 12 months was chosen to include nurses who would be willing to reflect on recent experiences of caring for bereaved families.

3.3.2 Recruitment Plan

Upon ethical approval, and unit manager support, recruitment commenced by using a recruitment email to invite potential participants, (See Appendix A). Additionally, recruitment posters (See Appendix B) were placed at the hospital in areas commonly frequented by staff (staff room, hallways, and bathroom). Since the sampling strategy was purposeful, staff members that indicated interest in joining the study and met the eligibility criteria were invited to participate. A thank you gift in the form of a $25 gift card was provided to the participants at the end of the interview.

3.4 Data Collection

3.4.1 Setting for Study Design

After obtaining ethical approval from the Fraser Health Authority and the University of British Columbia Behavioral Research Ethics Board, this study took place within a tertiary hospital, within the aforementioned health authority. A letter of study information was sent to the unit manager describing the purpose; a poster and email invitations to participate were distributed to the staff at the hospital. All interested participants were invited to contact the primary contact for eligibility screening (See Appendix C). After providing any additional

information and answering questions, those participants interested in joining the study were asked to meet at a location and time of their choosing.

3.4.2 Data Collection Method

Nurses who saw the email or poster contacted the MSN student (primary contact) via telephone or email. At that time, the primary contact used the eligibility criteria questions (Appendix C) to determine if the participant was suitable to enroll in the study. If eligibility criteria were met, an interview was scheduled at the participant's convenience and location of choice. Each interview was preceded by the consent process (Appendix D), as well as a review of the study materials, aims and objectives, and took between one to two hours. The interviews were guided by semi-structured questions (Appendix E); however, opportunities were provided for participants to deviate from the questions at their discretion in order to elaborate on their experiences. The interviews were audio-recorded, transcribed and subsequently analyzed. Although there was minimal risk in participating in this study, given the emotional nature of exploring the meaning and experiences of perinatal loss for nurses, resources to help alleviate the emotions associated with the topic and potential coping strategies were reviewed as stated above. Participants were also given the opportunity during the interview to end the interview if they so wished or had become too distressed to continue.

Reflective notes were kept and shared with the study supervisor throughout the research process to provide documentation of the reflexive process and create the audit trail, accounting for the researcher's prior experiences and the potential impact this could have had on the findings. The evolving analysis was discussed with the supervisor as a means to validate the process and the thematic analysis. Data were collected until theoretical saturation was achieved. While there are authors who argue that theoretical saturation is impossible (Morse, 1995;

Sandelowski, 1995), given the scope of the study, I was looking for a point where no new information seemed to arise, or a point where the data that were being collected appeared redundant across the interviews.

3.4.3 Interview Guide

The semi-structured questions were constructed to explore the multiple ways the participants perceived the phenomenon. My intent was to remain consistent with the study aim, which was to explore the experiences of obstetric nurses who have provided care to families undergoing a loss.

3.5 Data Analysis

Data analysis in qualitative work is not a linear process but some structure is necessary to undertake a thematic analysis. Although many models exist to guide qualitative interpretations of phenomena, Diekelmann, Allen and Tanner (1989) proposed a seven stage analytic method guided by principles of phenomenology. The following is a description of the seven stages in relation to their application in this study.

3.5.1 Diekelmann and Colleagues' Seven Stages of Data Analysis

The purpose of stage one is to have the researcher undertake a thorough reading of the data collected in order "to obtain an overall understanding" (Diekelmann et al., 1989, p. 12). The interviews from this study were transcribed and the transcriptions were read to support a general interpretation of the data.

In stage two, the goal is to create a summary of each interview based on the researcher's understanding of the data, as well as to begin the process of categorizing surfacing patterns using verbatim statements from the data (Diekelmann et al., 1989). In addition, the authors contend that at this stage it is vital to obtain consensus on the categories within the research team

(Diekelmann et al., 1989). In my case, this was done with my research supervisor before moving forward with any further analysis of the data. I read the transcripts thoroughly, made notes and summarized the interviews. Next, I generated broad categories and shared them with the supervisor for validation prior to moving forward. In stage three, the aim is to have any idiosyncrasies of interpretation that arise within the team addressed by referring back to the interviews to solidify the categories of data (Diekelmann et al., 1989). This stage was undertaken after the supervisor reviewed the student's work as presented in stage two.

The aim of stage four as described by Diekelmann et al. (1989) is to construct 'relational themes'. The authors define this concept as a theme "…that cuts across all texts" (Diekelmann et al., 1989, p. 12). In this study, it meant that I constructed themes across all of the interviews. Any discrepancies between the emerging relational theme and the data led me back to providing an explicit rationale as the why the theme was chosen as suggested by Diekelmann et al. (1989). Once consensus was reached in stage three with the supervisor, the emerging themes were solidified and once more shared with the supervisor.

In stage five, the authors described articulation of 'constructive patterns' or differently put, repetitive meanings in relation or in support of the 'relational themes' (Diekelmann et al., 1989). Data were clustered by using the initial summaries as well as verbatim statements that were in accordance with the identified relational themes in this stage. Stage six of the model involved validation of the preliminary analysis by the team (Diekelmann et al., 1989). Once refined, the analysis was sent to the entire team, including the committee members for review and interpretation. Finally, stage seven of the model speaks to the "preparation of the final report, using sufficient excerpts from the interview to allow for validation of findings" (Diekelmann et

al, 1989, p.12). After the final report was constructed, it was shared with the team for final refinement.

The seven-stage process for qualitative data analysis described by Diekelmann at al. (1989) provided a helpful structure for me as a novice researcher completing a thesis. Multiple reviews, and the integration of verbatim statements to support the emergence of categories, patterns and themes, were imperative when aiming to stay true to the participants' data during the analysis.

3.6 Rigor

Maintaining rigor in qualitative work is crucial in order to present meaningful, relevant and trustworthy findings that can be applied to practice (Barker, 2013). Lincoln and Guba (1985), coined the term 'trustworthiness' and have outlined four specific components that constitute this concept, which are credibility, dependability, transferability, and confirmability. Credibility, at its core refers to the truthfulness of the researcher's claims (Lincoln & Guba, 1985). In order to achieve credibility, the primary contact kept in close contact with the research supervisor in regards to the fit of the findings to the interview data. This form of debriefing supported the verity of the findings and ensured complete analysis of the research data by assisting the primary contact to avoid misinterpreting the findings as discussed by Billups (2014).

Secondly, dependability refers to the stability of the study findings (Lincoln & Guba, 1985), meaning that the "data collection methods [will] yield the same or similar results" (Billups, 2014, p. 3). For this study, three PhD prepared researchers supervised the primary contact and frequent feedback was sought by the student from the supervisor to ensure the interviews were being conducted in accordance with phenomenological and ethical principles.

Transferability in qualitative work serves to answer to what "extent the conclusions drawn are transferable to other times, settings, situations and people" (Lincoln & Guba, 1985, p. 306). These authors suggest that transferability is accomplished by ensuring rich descriptions of the phenomenon. To achieve this, field notes detailing the specifics, such as the setting, atmosphere and general observations were kept throughout each interview, without decreasing efforts to be present and fully engage in each interview. A reflective journal was kept by the primary contact as a source and method for critical reflection about how and where the researcher was influencing the analysis. Ortlipp (2008) argues that engaging in reflective journaling in qualitative research is vital to maintain transparency to one's own influence within the analytic process, which will inevitably enhance the rigor of the study.

The fourth criterion, confirmability, refers to the degree of researcher neutrality and lack of bias (Lincoln & Guba, 1985). According to Billups (2014), two strategies to enhance confirmability are audit trails reflexivity. An audit trail was kept, including the intent to keep the interview data for five years in an encrypted folder on a password protected computer with only the primary contact having access. After five years, all data will be destroyed. In regards to reflexivity, close attention was paid to how my employment in the study setting could potentially have influenced the collection and analysis of data, as well as my professional experience related to the topic of study. A detailed journal was kept, which included notes, observations, preconceived ideas about the topic of study, personal values, and feelings as they arose during the interviews and analysis. These notations were reflected on and shared with the study supervisor to ensure I remained conscious of any influence I may have had during the data collections and analysis. I also debriefed with my supervisor regarding the necessity of support services for myself.

3.7 Study Team

The study team was comprised of four university-affiliated individuals. The primary contact is a Master of Nursing student, completing her thesis in partial fulfillment of the requirements for degree completion. A primary supervisor and two committee members- all PhD prepared university faculty who are well versed in qualitative methodologies, were also on the team. All faculty members are avid supporters of young emerging nursing researchers. There is neither a declarable conflict of interest between the primary contact and the supporting faculty nor a declarable conflict of interest with the institutions.

3.8 Knowledge Sharing

The Canadian Institute of Health Research (2016) defines Knowledge Translation (KT) as a “dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically-sound application of knowledge” (p. 5). Various approaches will be applied in an attempt to stay true to the goals of KT. Specific goals in relation to knowledge sharing will involve presenting the final findings at conferences, pursuing publishing after thesis approval, and pending manager approval, offers of unit teaching sessions and presentation of findings at the hospital level will also be undertaken.

Chapter 4: Findings

In this chapter, I present the findings constructed from the interviews with obstetric nurses who shared their perspectives on the effects of perinatal loss. Eight nurses volunteered and were interviewed for the study; each of eight participants met the eligibility criteria. They ranged in age from 30 to 57, with the mean age being 44.8. All of the eight nurses identified as female. Their years of experience ranged from four years to 32 years, with a mean of 19.3 years. A full demographic table is included as appendix F.

The analysis of the data resulted in the construction of three major themes reflecting the participants' perspectives of effects of perinatal loss: (1) the lack of supportive contexts; (2) the significance of time; and (3) the gifts of grief work. The first theme, the lack of supportive contexts, surfaced in each of the eight interviews. When speaking about the lack of support, the participants made reference to education, training and interpersonal interactions. The nurses highlighted the importance of support by specifically identifying when it was lacking; the lack of leadership support described by the participants influenced their ability to carry out the work related to perinatal loss and provide effective care for bereaved families. Therefore, the subthemes: *Peer Support* and *Leadership Support* were constructed within this broader theme. The second theme captures the significance of time as it shaped the nurses' perceptions of their ability to process loss, manage it, and move on. The sub-themes related to time include *Time to Process*, *Time to be Present*, and *Time for Respite*. The third theme, the gifts of grief work, captures what the nurses described as an 'incredible privilege' to work with bereaved families; specifically detailing the rewards of walking alongside bereaved families, and how it facilitated perspective and became an opportunity for personal and professional growth. Collectively these

themes and sub-themes depict how bereavement work within the context of perinatal loss is *both* inherently challenging *and* rewarding for nurses, thereby having both positive and negative effects. Specifically, the nurses associated the positive impacts of bereavement with available supportive infrastructures that could facilitate their care of families while also helping them respond to their own personal experiences and needs.

4.1 The Lack of Supportive Contexts: Invisibility

All of the nurses described how the lack of supportive practice contexts influenced their responses to perinatal loss. Participants described support as education, learning practical skill and training, and interpersonal support via peers and the leadership team. Nurses generally felt unprepared to provide bereavement care to families experiencing perinatal loss, both from the perspective of having knowledge as well as clinical skills. Most participants could not recall receiving any formal education about perinatal loss or how to care for bereaved families in their undergraduate studies or specialty training. Their lack of education contributed to their expressed feelings of anxiety and fear. Further, some nurse participants described limited training in their clinical settings. The nurses that could recall receiving some training stated that it was associated with legal/ethical implications for practice or in neonatal resuscitation courses (Nurse 8); in both of these examples, the focus was specific to topics that, while related to perinatal nursing, are not focused on preparing nurses for bereavement care. One nurse stated:

> I definitely didn't have enough training…we had pretty much zero training on how to deal with this kind of stuff. We did one workshop, I recall, where they talked about perinatal loss…they tell us some things that are appropriate to say and not to say. Some of that is helpful (Nurse 4).

Another nurse stated:

> It wasn't really anything that got taught to us in nursing school or in any of our, kind of, formal type of training of how to deal and cope with families and in situations and kind

> of, I guess the ramifications of, doing that stuff at work and what not and having to go home at the end of the day and acting like it was just another day at the office (Nurse 7).

All of the eight nurses reported that, in addition to their lack of education or training to prepare them for bereavement care, there was minimal information that prepared them to care for themselves. For the nurses who could remember receiving some education, they recalled the focus being on the families' perspectives, which they all agreed was an important emphasis. Yet, they also indicated that the effect on nurses also mattered in terms of their learning since they repeatedly carry out this work. The lack of attention to nurses' needs and perceptions led to them feeling not only unprepared and invisible, but also devalued and irrelevant. One nurse described how the lack of attention to the nursing perspective on bereavement care is perceived negatively by the nursing staff:

> Old people are supposed to die, sick people are supposed to die, babies aren't supposed to die, that shouldn't happen, but it does… People don't stop to think about what it would be like for the healthcare provider and how hard it is for them. A family maybe goes through this one time and yes it is their experience and it is their family member, so yes it's more of an acute pain and always will be. But think of somebody who keeps going through it. The emotion of over and over and over again over the course of a career. That's not something you should see… and because of where we work, it is a part of our reality… Because we've become not important, we are basically on the sidelines (Nurse 6).

Feeling invisible and undervalued by the leadership team affected the nurses' preparedness for repeatedly caring for families experiencing perinatal loss. This feeling of invisibility was also highlighted when the nurse's spoke of the role leaders ought to play in supporting nurses to care for bereaved families, and when resourcing and promoting self-care for the nurses themselves. The nurses described feeling unsupported and uncared for by leaders, particularly when they made no effort to contact them following a perinatal loss. During the infrequent occasions when the nurses recalled a leader's presence, it was understood to

contribute to the nurse's ability to accept and process the event. Further emphasizing how a lack of a support affected the nurses, there was data depicting the important role of peer support. Contrasting unsupportive contexts, peer support could go a long way to minimizing the negative effects, particularly those impacting collegial relationships. For example, one nurse said:

> The support of my team just realizing that was hard for me, and hugs and being there. Understanding cause most of us have gone through some sort of this kind of situation…just seeing understanding faces and people that are there for me and concerned about how I am doing. That helps (Nurse 1).

4.1.1 Leadership Support

Acknowledgement of the grief work by the leadership staff was widely discussed as important in all of the interviews. The nurse participants described the importance of being acknowledged for the challenges and difficulties of providing care during perinatal loss. They spoke of feeling perplexed when they entered the profession to find that such support was lacking. Many nurses described feeling disconcerted about why this part of their work was never discussed, nor supported. One nurse stated:

> It's a weird feeling because it's a part of our job, so we are supposed to be able to deal with stuff like that and we're supposed to have like, you know, that's something we deal with. But I can't imagine like unless there is more out there for people to have these outlets and different people to talk to more, more support we can get aside from chatting to your colleagues, which is very helpful. It's just sometimes that doesn't seem enough (Nurse 6).

While most of the nurses appreciated that teaching bereavement care would be difficult, and associated some of this difficulty as reflecting the uniqueness of how individuals experience and respond to perinatal loss, they agreed that *some* practical guidance, potentially from research evidence or from qualified nurses, was not only warranted, but essential. One nurse compared her experience of working on a non-obstetric unit when her patient passed away, the clinical nurse educator reached out to her via telephone the next day. She regarded this offering of

support as highly valuable, and validating to the traumatic experience of having her patient die. In fact, she stated this interaction allowed her to let the situation go and move on. When reflecting on her practice in obstetrics, she attributed the silence in regards to perinatal death from educators and leaders as dismissive. She also considered if the reason for the lack of support reflected the view that perinatal loss was not expected and therefore did not require support. Thus, in the obstetrical unit she was not active in seeking support despite reflecting on its importance on another unit:

> There is nothing I can ask help for, I don't know what I need help with [and] its kind of weird to think that when you have something so tragic like that, no one really follows up, no one wants to know how you are? That was tough … It'd be nice if you had someone that's there five days a week, all day, someone you can go in and talk to (Nurse 5).

The nurse's sentiment was echoed through all of the eight interviews. Nurses unanimously reported the lack of support from leadership as having negative effects on how they responded to the situation and subsequently managed the effects. Conversely, on the rare occasions when leaders did offer support, nurses responded extremely positively. They described feeling validated for the difficulty of their work. They described how cathartic it was to talk about the experience with people that really understood. In addition, they saw the chance for support and discussion as potentially revealing learning needs that they may not have considered before. This finding reflects how the participants viewed leaders as having a role in supporting nurses to learn about the impact of perinatal loss and their related needs.

One nurse described a situation where she had been invited to an interdisciplinary team meeting for de-briefing. This meeting was attended by the other nurses involved in the event, the doctors (both primary and in supportive-reviewer roles), and staff with administration and nursing leadership roles. The goal of the meeting was to review the case from the point of view

of each discipline, and examine the care provided, as well as to make recommendations for future practice. The nurse described this experience as providing the opportunity, at long last, for closure. During the meeting, the nurse thoroughly reviewed the case, thereby having the chance to see more detail beyond her own involvement. This experience allowed her to objectively review the case without feeling blame or guilt, which can be inherent in perinatal loss cases. She stated:

> It is so interesting and I feel like there is a really good attitude of no blame. It was focused on' just how can we do things differently or is there anything we should do going forward. Those are really good (Nurse 1).

Although she appreciated being a part of this significant opportunity for closure, she highlighted how these meeting dates and times were often not well communicated to the staff. Nurses often found it difficult to attend due to working or finishing a night shift. Therefore, accessibility to these types of meetings, which she did describe in terms of bringing closure, was limited. Other nurses also mentioned this meeting as being helpful but encountered similar barriers.

Overall, leadership support was regarded as highly significant for minimizing the negative effects of perinatal loss; however, the nurses were clear that such support was currently lacking in practice. The nurses described the importance of the acknowledgment of the perinatal loss, further training, and opportunities to share their experiences; however, thus far, they had no experiences to share about how such support and resources were being endorsed by the leadership team. The nurses interviewed did emphasize the critical role their coworkers played in providing the support they gave each other when caring for families experiencing perinatal loss.

4.1.2 Peer Support

This sub-theme distils the wide variety of support the team of nurses offered each other, and the positive effects that were noted as a result of those interactions. All nurse participants spoke highly of their team members. In cases where they recalled being novice nurses, and in lieu of formal education and training, they recalled turning to their peers to learn how to approach and deal with bereavement care in relation to perinatal loss. It was this form of peer learning that the nurses reported as extremely helpful. One nurse described an event where during her shift, another nurse had a perinatal loss case and encouraged her to come and perform part of the care with her. She described this interaction as such:

> She did it with me, she allowed me to come in when we were taking photographs and doing measurements of the baby, the deceased baby. And it really helped me a lot because at the time I was very scared, and I didn't... and I cried when I was in there looking at this baby. She cried too, but I thought it was a really good thing she had told me to do… to bring me in on it and explain to me that its normal…its ok to cry, its okay to feel the way you do about it because it's only … its normal for us to feel that way (Nurse 6).

This form of peer mentorship was deeply appreciated by this nurse and, not just because she had learned how to do the skill-related tasks, but also because she deeply felt her peer's thoughtfulness and leadership. Specifically, she valued being included in order to gain some experience before she would be called upon to care for a bereaved family on her own. Having her peer's mentorship and understanding eased her mind in regards to providing bereavement care, and decreased feelings of anxiety and fear -feelings that were partly attributed by other participants to lack of education and preparation. Due to this outreach on her colleague's part, this nurse regarded this as a *positive experience*. She went on to describe how she continues this in her current practice with new staff, in order to ease new nurses into this inherently challenging work. Another nurse described how a specific doctor, well known for how he takes care of

families who have had a perinatal loss, or are undergoing a loss, influenced these peer support practices. She described how she takes every opportunity to learn from him, as he models the type of care she would like to give. She stated:

> You learn things to say to families that you've seen work with other care providers. [This doctor] would say the most amazing thing … and I sort of adopted some of his phrases… he made them face it at the time, I guess, and whereas other people may be trying to dance around on eggshells and not be real (Nurse 6).

The examples of nurses, as well as other medical professionals, reaching out to one another for peer support were described as a valuable learning opportunity, as well as helpful with managing with the emotional aspects of providing perinatal bereavement care. The nurses highly valued having 'a partner co-worker" to share this work due to its highly strenuous nature. The nurses described how, whenever they worked with different coworkers, they learned something new; this informal learning provided something valuable to take away to the next family they would be called upon to care for; thereby, growing together as a team, which was regarded as a positive outcome.

One nurse described how a 'mentorship program' that currently does not exist in practice would be useful when caring for perinatal loss patients. This is especially important given that new graduates are frequent in specialty areas, and are already declaring their fear of perinatal loss cases. For example, one nurse stated:

> I can see a lot of the new girls. It's their biggest fear is having a loss, is being involved in a loss. They want to stay away from that and I try to tell them, I'll be there for you, I'll help you, and I'll support you. But it's a fear and they don't know what to do and it's scary… they're in the same shoes, I was in, so that's why I think, we as nurses try to help each other (Nurse 5).

Overall, the nurses appreciated the mentorship opportunities provided by their peers, and they were eager and willing to form a mentorship team to ensure new nurses were supported

while giving this type of care. This type of peer-to-peer mentorship and informal learning led to nurses feeling like they were bonded and, that together, they were increasing their team capacity; that is, they could rely on each other during difficult times, which made them a more cohesive team. Being a stronger team is significant within the context of how they described caring for bereaved families as difficult work. In addition, the nurses described how in lieu of knowing whom to talk to and what they could share, that talking to their peers was often the most beneficial.

Participants described how peer support enhanced support from partners in their personal lives. They described how their nursing peer relationships were therapeutic in their practice when caring for families experiencing perinatal loss. One nurse said, “I can talk to my hubby about it a little but you can’t, like, to a certain point, but, they don’t really understand it (Nurse 7). Another nurse similarly described how she often talks to her husband to help her cope with perinatal loss cases; however, went on to elaborate that it is the peer debriefs, the informal ones, that are most beneficial in successfully managing what has happened. She stated, "…they are completely understanding because they are in the pot with me” (Nurse 2). This shared experience, regardless of the temporalities that separate them, was an event to bond over, work through together, and help one another. Participants regarded this support and capacity to empathize as a positive element of an otherwise difficult situation.

Finally, for most participants, there was an unhelpful strategy, usually organized by the leadership team following either perinatal loss cases or situations where birth outcomes were poor and/or traumatic. This was the formal debriefed led by an external counsellor immediately after or soon after the event. The nurses unanimously stated these meetings were not constructive – specifically citing the informality, the lack of specificity to their case, and the unique nature of

perinatal loss that was not acknowledged. The nurses described this type of loss, the loss of a baby, as so unique, that the same principles could not possibly be applied as other types of loss; therefore, the generic or generalist approach of the formal debrief did not apply and subsequently had little benefit. The nurses stated they made no positive or negative difference; they did not see the value. Furthermore, because the nurses appreciated the bonding with their peers, and the capacity building and support received from peers, they talked about the importance of a more organized way they could offer and receive peer support specifically. All participants viewed themselves as possessing the right skills to help ensure that perinatal loss was not a traumatizing event, with even some potential for it being somewhat positive; however, the nurses spoke also about the lack of resources and support needed to foster a positive outcome. For instance, one nurse described how this could be as simple as just facilitating the peer support that already exists, but in a more organized, accessible fashion. She stated "I think it would be good to have a little support group amongst your peers...right, just to let it out…but I think it would be helpful to people…even a very informal thing" (Nurse 3).

4.2 The Significance of Time

The significance of time theme was a contributing factor to how perinatal loss affected the nurses, and was apparent in all of the interviews. Time, for the purpose of this theme, is depicted in three subthemes: *Time to Process, Time to be Present, and Time for Respite.* Across all of the sub-themes, time had both positive and negative dimensions, based on whether the nurses had sufficient time to process, be present, and to recover. The absence of sufficient time was regarded as having negative effects for all participants. Despite the overt difficulty of being a part of bereavement care, many nurses reported that, when they had the time to invest in being

with the families experiencing a loss, this work formed some of their most memorable nursing moments.

4.2.1 Time to Process

It was clear that perinatal loss, as a part of obstetric work, never became easier with experience despite peer support and the opportunity to share experiences. Many participants described the long-term and lingering memories of their clients who experienced a perinatal loss. One nurse said, "I don't really remember the birth I had last week but the losses. I remember all the losses" (Nurse 5). Another nurse echoed the concept of the lasting impression perinatal loss cases make and stated “each experience shapes you and there is something that you remember very, very clearly and perinatal loss is pretty much, every time it is cemented in your memory” (Nurse 2).

Given the busy nature of the unit where this study was undertaken, the nurses mostly reported having inadequate time to process what had taken place, often leading to confusion about what to do and what to feel. One nurse described a situation where she was asked to assist a doctor in a case, and she did not even know that a loss had taken place.

> I went in with the OB cause there was nobody else to go in. I just ended up going and I found out with them it was a loss. And I’m like, I don’t know anything about this person, I don’t know how many weeks she is, I don’t know if she just found out. I don’t know…you don’t know how much you should feel, how much you shouldn’t, what you need to be doing, what you shouldn’t be doing, and what’s okay to say, what’s not ok to say. It’s just a very hard thing, I don’t know (Nurse 5).

Although a part of the shock was being asked to be present without any warning about what to expect, Nurse 5 went on to describe how there was not even adequate time to process what just took place or what part she was expected to play. This led to feeling confused and unable to provide the care that the family needed and rightfully deserved. Another nurse

described how, if it were a busy day, she would often be assigned a laboring patient and someone experiencing a perinatal loss; in these situations there was the expectation to go between the two, which led to her feelings of apathy or confusion. Put differently, in an attempt for self-preservation, she would go on 'autopilot' just to complete the expected tasks. It was not until later, once she got home, that she would even think about what had just occurred (Nurse 5). In a similar scenario, another nurse described that, as soon as her patient who had a loss was discharged, she would get another family to look after. She explained, "when I've had a patient that has had a loss, if she goes home on my shift, as soon as I don't have a patient I'll have another patient. Just continuing on … because you were available" (Nurse 8).

The lack of acknowledgment by leadership and the lack of space within institutional structures for nurses to process and receive support for perinatal loss exacerbated nurses' feelings of anxiety, fear and sadness; these kinds of experiences were emotionally draining for the nurses and often resulted in them suppressing their emotions. Another nurse described how she was still haunted by a particularly graphic death of an infant. Even with the recognition of how deeply disturbing the death was, she was expected to come back to work the following day. She stated "even that day, it was just business as usual, you know. There was no… you know, 10 minutes crying in the coffee room... or the bathroom and that was it. … So I put it on the back burner. I'm very good at it" (Nurse 3). This particular situation occurred five years ago, and this nurse was still shaken when recalling the events of that day. When asked if she ever received the opportunity or time to talk about this event, she stated "no, it was very much left to deal with on your own" (Nurse 3).

Taking time to process an event at hand was vital to these nurses' abilities to process the situation, understand the events that led to the outcome, and, hopefully, to be able to integrate

this experience in a positive way for future practice. In the absence of support and time to processes, many of the nurses, some eleven years later, indicated this lack of understanding left residual effects. For instance, during the course of some of the interviews, some nurses were even surprised at their own emotions that were surfacing while telling their stories. Given that some of the cases they described happened years ago, they were not expecting to be emotional about them but, in fact, they found themselves distraught. In fact, in one of the interviews after a nurse described one of the loss cases that occurred, she was asked how long the emotions lasted, and through tears, surprised at her own emotions, she stated "well, obviously they still do" (Nurse 3).

4.2.2 Time to be Present

The nurses suggested that having the time to be present with a client and family was an important factor in achieving closure. Most of them; however, indicated they did not have the necessary time to spend with the families. For the nurses the lack of time to be present had negative effects. Many nurses described how taking the time to just *be there*, not necessarily to speak, but be present was important to the family, as well as to the nurses themselves. They elaborated by saying that, more often than not, while there is often nothing that can be said or done, genuine presence and authenticity in an impossible situation is always noticed by the clients. At least being present as a nurse made the nurses feel that in some small way they had helped. One nurse described a time where she could follow the family into the recovery room after a caesarean section (which is often not the case) of a deceased baby.

> I had a good relationship with the family and they expressed that they were grateful for the care I provided, which was huge for me because being in that kind of situation I always ask myself was there anything else I could have done. That really helped me… and it was good that I got to go with them to the recovery with the baby…I got to spend

> time with them and I got to give them the feeling that they had all the support we could give (Nurse 1).

Being present during perinatal loss was vital to many nurses. They felt that the common practice to transfer the patient to postpartum or to discharge them quickly led to them wondering what happened with the patient. In other words, not having the time with the patient that they would have otherwise liked prevented them from having closure. For example, one nurse stated:

> I just remember not wanting to leave. I just didn't want to leave them. And then it was so weird because I just thought once I leave, that's it. I'm not going to see these people again and that's the end of this story. It's weird. …It just ended in such a way that I was just shocked and confused and I don't know, it was just really weird (Nurse 5).

In contrast to the above description, when time was not a factor and nurses could be with their patients even during a difficult situation, they did not report negative consequences. In fact, they reported feeling empowered and felt that they respectfully and effectively carried out their duties. For example, one nurse described a situation where a delivery of a premature (non-viable) infant was imminent and the family did not want to see the baby, especially because the doctors believed the baby might live for some time before she died. She said:

> We were busier than anything, nobody had breaks, and people are running around like crazy, somebody took over my [other] patient because I was able to go sit in there and sit with this little one, every so often listened to the heartbeat … and I held the baby until the heart stopped beating… [I got] to be present and to be, you know, even despite what happens on our unit… because nobody should have to die alone (Nurse 6).

Although a heartbreaking situation, this nurse felt it was only humane to take the time for to be present with this baby. She, with the support of her charge nurse, realized that the logistical factors ought not to outweigh what felt like the right thing to do. This gesture, in part placed emphasis on valuing the life of this child; thus, it helped the nurse reconcile that she had done all she could for gaining closure. In fact, she stated:

> It was really important because I don't know what it would have felt to leave the baby in a cot, somewhere. At least that baby was warm and loved for the time it had… it was amazing what she [the charge nurse] did , I might have not learnt that if it weren't for her" (Nurse 6).

Worth noting is how peer support and peer recognition were critical for this particular situation to be regarded as positive, as team building and team bonding, despite the factors that otherwise could have been potentially traumatic. Overall, the time to be present with the clients and their families, without interruption or other duties, significantly contributed to the nurses' abilities to manage and provide the type of care they felt that their patients deserved. On the other hand, when the opportunity to be present with the client and families was absent, the nurses described feeling as if they were not able to provide the patient and family with necessary care, which, in turn, led to the nurses feeling desolate and inept in their ability to care for bereaved families.

4.2.3 Time for Respite

Lastly, the participants also described having the time for respite as a significant influence on their experiences of a perinatal loss. There were both positive and negative effects of the relationship between time and recovery. For the nurses in this study it depended on whether time to heal was offered/taken or was unavailable. Many of the nurses felt that having time away from patient care, whether it was during the same shift or subsequent shifts, was an important factor in the healing process. For instance, one nurse described a loss where a mother required an emergency caesarean section, under general anesthesia. The mother was troubled by not being awake for the delivery, and feared she would not be able to see her infant. The nurse had assured her that she would stay with her baby and show her the baby after the mother was awake. Unfortunately, the baby had been so fragile and had been dead in utero for so long that

the fetus was delivered in pieces. The nurse described feeling so awful, that she proceeded to, at the very least, take footprints that she could show the mother. She went on to say:

> It was horrible, and you know trying to keep it …trying to put these, like, little footprints on and just being I don't think anyone should have to do that. …Anyway I just remember coming back from [the] OR and like immediately went into the lounge … [and the Patient Care Coordinator came back] and was just like you need a break from being here, you need to …Just go (Nurse 7).

The nurse described her appreciation for receiving permission to leave. She had felt she could not even focus let alone provide safe patient care for anyone else. In addition, she stated that, although there is definitely room for improvement, and that even though no one offered her time off again, she did not feel "hung out to dry, so to speak…where I felt nobody understood what I was feeling and going through kind of thing, so that's good" (Nurse 7). This relates to the theme of presence or absence of support in order to recover, and have positive feelings after having experienced caring for the bereaved patient. Ultimately, the nurses desired validation and acknowledgment of their feelings. In contrast to this nurse's experience, many of the other nurses described not having the necessary time to heal from perinatal loss cases. In fact, they stated that not being afforded this essential time to heal led to a decreased ability to manage, learn and potentially change the experience of perinatal loss care from negative feelings to, if not positive feelings, at least a feeling that the process had been constructive. In lieu of being offered recovery time, they would sometimes have to use their earned sick time. For example, one nurse explained:

> I remember coming home that day [after a loss] and crying cuz I didn't really know what else to do... And luckily I didn't have to go to work the next day but I can't imagine if I did. I can't imagine. I don't think I would have been able to go. I probably would have called in sick" (Nurse 5).

This quotation, and others like it, symbolizes what the nurses described as the importance of taking the time to recoup in the short term so they could return to work able to perform at their expected, desired, and safe levels. Noteworthy, at this stage, is that the nurses did not mention long-term recovery; signaling that for most of them, even the initial stage of recovery like having the time to recoup was mostly absent form their experiences.

4.3 The Gifts of Grief work

Despite all of the challenges and negative effects that the nurses described, most participants regarded providing bereavement care in the context of perinatal loss as rewarding and valuable work. The nurses indicated that this type of assignment was not one they would prefer; however, it was not an assignment that they avoided. The nurses were acutely aware of gaps, and freely discussed the gaps in practice as outlined in the other themes, but they were also committed to carrying out this work in a respectful and loving manner. In fact, many nurses indicated that, although perinatal care of a live infant was rewarding, providing bereavement care to perinatal families was a privilege unmatched by any other obstetrical experience. They described the opportunity to witness and take part in some of the greatest examples of family resilience as a deep honor, one in which they took significant pride. One nurse explained:

> I feel like its kind of an honor to be a part of. I get emotional to talk about that. I feel like it's an honor to be there for somebody when they're going through such a hard thing in their life (Nurse 5).

The nurses' descriptions conveyed how they regarded witnessing and supporting another person's resilience and ability to manage the unthinkable as an amazing example of human ability. Furthermore, they described the experience of perinatal loss as an opportunity for self-reflection and growth. For example, one nurse stated:

> It [perinatal loss] has made me more empathetic. And these situations add to that, I think, which is good. Because I feel like this world we live in, it is easier to be insensitive and hard, and its good for people to be sort of brought down to their basic human level from time to time… It hasn't just made me a better nurse, it's made me a better person (Nurse 4).

The nurses' view of perinatal bereavement care as a positive experience was common, as illustrated via this statement:

> It does make me so grateful for my life, the chance that I have to be there with these women and help these women through that, I feel really lucky to have that… you can make it into something good… And I try to tell myself all the time, use it as a good thing, and use it as a good experience (Nurse 5).

The nurses participating in the interviews were unanimous in stating that bereavement work with perinatal families was not easy work. The psychological and emotional effects were long lasting and profound. They were clear; however, that the nature of those effects was highly dependent on the conditions wherein the perinatal loss took place. It was often not the loss per se that the nurses framed negatively, rather the context in which the loss happened. The nurses were clear that the environment and even the culture of obstetrical care that shaped practice has significant effects on whether they regarded the experience as positive or negative.

4.4 Summary of Findings

The findings of this study were organized into thematic descriptions reflecting the various effects of perinatal loss described by the nurses. The first theme, *lack of supportive contexts*, captured the various types of support, both preparatory and interpersonal, that nurses deemed vital – through their absence – to how they perceived the loss. Specifically, in regards to interpersonal supports, nurses identified two subthemes of the absence or presence of peer and leadership support as affecting their outcomes from experiencing perinatal loss with patients. The second theme of, *the significance of time*, captured the importance of having time to process

the effects of the perinatal loss, time to be present with the families, and the importance of having time to begin recovery from having provided this difficult type of care. The third theme, *the gift of grief work*, captured how all of the nurses described bereavement work in context of perinatal loss as honorable work, and how they deeply appreciated the opportunity to be a part of such an emotional time. Overall, the findings highlight how providing bereavement care during or after a perinatal loss is highly challenging work with profound effects, both negative and positive; the effects described were complex and contextual, dependent on extrinsic factors such as the availability of support and time. The following chapter will discuss the findings presented in this chapter and situate the results within the context of current and related literature.

Chapter 5: Discussion

In this chapter, I discuss the research findings in relation to current knowledge about the impact of perinatal loss on nurses. Specifically, I discuss the findings in relation to what they add to existing gaps in published literature and their potential effects on knowledge development.

The research aim of this qualitative descriptive study was to explore the experiences of obstetric nurses who have provided care to families undergoing a loss. After an extensive literature review, I recognized and addressed a gap in the literature in regards to the wide range of loss experiences that could exist. Specifically, the literature review revealed that the topic of perinatal loss was commonly framed as a negative experience, with negative effects (Jonas-Simpson et al., 2013; Polit, Lewis, & Beck, 2013; Roehrs, Masterson, Alles, Witt, & Rutt, 2008). Being an obstetrical nurse myself, and having had many patients who have undergone a perinatal loss, I knew there was more to this topic beyond the limited, negative framing I found in the literature. In fact, it was my professional practice that motivated me to delve deeper into this topic, while keeping in mind that this assumption could shape the research in ways that required critical reflexivity throughout the analysis. My goal was to remain as open as possible in order to fully capture the impact – both positive and negative – of such experiences on nurses.

5.1 Discussion of Findings

The constructed themes of the *lack of supportive contexts, the significance of time* and the *gifts of grief work* reflect the novel contributions to existing literature that I will detail here. These findings contribute to knowledge in relation to nurses' experiences of perinatal loss because they differ from current empirical conceptualizations. It is important to note that although I have organized the findings as three separate domains, they are interconnected and

overlap in terms of how the participants understood the effects of bereavement work and care for women and families experiencing perinatal loss.

5.1.1 Perinatal Loss Education and Training

The nurses in this study unanimously reported a lack of education and training in relation to perinatal loss. Most expected to receive some level of education while completing the perinatal specialty courses; however, they were disappointed to find that this was not the case. In addition, they expected that the topic of perinatal loss would be addressed in some way through in-service education in clinical practice. Unfortunately, the nurses also reported that this did not occur in their practice settings. The failure to receive any formal education or training in clinical practice led to nurses feeling unprepared, and unqualified to provide this uniquely sensitive care to such vulnerable patients. As a result, the nurses in the study described significant negative effects. Surfaced were feelings of failing to adequately serve their patients because they felt ill prepared to provide such care. These findings fit with existing literature. Roehrs et al. (2008) reported that half of their nursing participants (N = 10) could not recall any education or training in relation to loss, which led to feelings of inadequacy and inability to perform expected tasks. The ones that could remember some education reported it to be brief and informal, without specifically addressing the unique nature and potential impact of perinatal loss. Other studies have echoed these findings (Puia, Lewis & Beck, 2013, Rondinelli et al., 2015; Steen, 2015,). Chan et al. (2008) found that 89.8% of nurses in their study (N = 300) required more training and preparation in order to feel equipped to care for bereaved families.

The current study findings add to the literature wherein participants indicated that, being unable to provide the type of care that they felt their bereaved patients expected and deserved left them feeling inadequate and dissatisfied with their nursing practice. In the absence of having

formal education or training, the current study participants relied on each other for emotional and professional supports in learning the intricacies involved with providing perinatal bereavement care. The nurses described guiding each other by way of mentorship and 'on the go training'. They specifically discussed as seminal when they were novice nurses, and felt that the peer teaching moments were significant in helping them manage and learn the complexities involved in providing bereavement care to families. Andersen and Watkins (2018) asserted that educators and health care leaders and decision-makers ought to be aware of just how effective peer-to-peer learning can be. In fact they stated that encouraging participants to take part in peer mentorships creates a space for "a social experience and truly embodies the concepts of learning from each other, building a base of support, and sharing activities" (Andersen & Watkins, 2018, p.219). Although this review specifically focused on nursing students, the principles of andragogy and adult education still apply to practicing nurses. In addition to the intrapersonal benefits outlined above, learning from peers also supported my participants' experiential learning. The notion of experiential learning in relation to bereavement care was an important concept. Rondinelli, Seelinger, Long, Crawford and Vladez (2015) postulated that, although formal educational settings play a vital role in ensuring nurses comfort in providing bereavement care, learning through experience may be as equally valuable. This is encouraging as the nurses in this study highly valued the training and experiences they shared with their peers.

Overall, the current study findings supported the view that additional education and training is essential in preparing nurses to care effectively for the families experiencing the loss and themselves, notwithstanding the importance of peer support. What this study highlighted is that traditional methods of delivering the education to nurses may not be the solely viable method. In fact, exploring peer mentorships, mock scenarios, in-services, and sharing sessions

between leaders and peers may be just as effective and valuable to nurse's learning, especially in the context of perinatal loss. Drawn into question however is the timing of this education and the extent to which bereavement care practice norms can muster openness, support and inclusivity amongst nurses.

5.1.2 Workplace Support and Time

Nurses in the current study pointed to lack of workplace support available for nurses as undermining nurses' efforts to feel prepared and to access interpersonal support. The nurses held the leadership team accountable because they spoke of the lack of acknowledgment of the difficultly associated with perinatal loss care and the tendency to normalize the event. The nurses reported that they regarded the unit culture as embracing the notion that perinatal loss was just another part of the job. In fact, many of the nurses felt they were inadequately prepared or unaware of the frequency and difficulty of providing perinatal bereavement care when entering the profession. They perceived the silence from the leadership team as dismissive to the arduous nature of this type of work. They regarded bereavement care as ultimately an unsupported domain of their practice even if they requested help.

In addition, the nurses reported that when they were not given the time to process what had happened, and to be present with the families, the lack of time significantly altered their perceptions of events and their views of their effects. Specifically, the nurses felt that being afforded the time to be with the bereaved families and not being expected to carry out multiple duties (i.e. having other laboring patients) was essential in ensuring that their experience was not traumatic. The available literature strongly supports this finding with the majority of the studies focusing on the occurrence of nurses' secondary traumatic stress, burnout and some level of impaired coping when nurses failed to receive required resources such as education, emotional

supportive measures, and time away from work. (Ben-Ezra et al., 2013; Puia, Lewis & Beck, 2013).

Moreover, the literature suggests that the result of ignoring these findings can have significant negative impacts on not just nurses, but also on the families, they serve. In fact, Sessions, Henley and Roth (2017) in their study on emotional burnout amongst maternity workers argue that repeated exposure to stressful events, without adequate supports, leads to burnout, which "…may encourage workers to distance themselves from their work and patients" (p.117). It was apparent in my study that long lasting effects of perinatal loss could ensue if awareness of the possible negative effects remains dismissed by or invisible to leaders. Lown (2018) asserted that nursing leadership support could play a big role in mitigating the negative effects such as the ones described by the nurses in this study. In fact, the author postulates that exercising compassion in high stress nursing environments can positively affect nursing experience, which inadvertently affects patient experiences and satisfaction (Lown, 2018). This is important as the nurses in this study reported highly valuing the responses and involvement of their leadership team and linked their abilities to be present to better care for their patients and families.

On the rare occasions when the nurses in this study described receiving leadership support, they regarded the leadership presence as extremely positive; thereby facilitating their personal resources to manage and deal with the stress that accompanied providing such care. This finding illuminates the importance of leadership teams becoming more aware and involved with their staff in times when they cared for bereaved perinatal families. In an editorial, Foreman (2014) described developing a pilot project as a manager. In that project, leaders took steps to acknowledge the nurses when providing bereavement care by explicitly building in time to heal,

providing care packages, and affording them time off work to initiate self-care. The nurses utilizing this program reported widespread positive effects due to this implementation of action that simply recognized the stressful and potentially traumatizing nature of working with bereaved families. Having a written plan and support of leadership to implement that plan significantly affected these nurses' ability to manage and recover in positive ways after a perinatal loss case.

The nurses in my study also referred to the importance of peer support. This was another key finding for this study. All of the nurses reported that their peers were instrumental in helping them manage during and after the loss. While many other studies reviewed on this topic also noted the importance of peer support (Gardner, 1999; McCreight, 2004; Parker, Swanson, and Frunchak, 2014), the findings of this study clearly depict the effects that peers can have on outcomes. Specifically, the nurses described how peer support led to team building, capacity building, and even improving overall patient experiences. Overall, there were no negative findings in relation to peer involvement, and most of the nurses reported their desire to develop further initiatives involving peer-to-peer mentorships and support groups in relation to perinatal loss. The current study findings highlights the worth of emotional work, and the value of effective leadership that explicitly acknowledges the weight of bereavement amid protecting and honoring those who provide that labor.

5.1.3 Fostering the Benefits: Loss Reframed

The literature depicts undergoing a perinatal loss as arguably one the greatest challenges a family can face, which also has negative effects on nurses (Beck & Gable, 2012; Firth & Britton, 2011; Jonas-Simpson, Pilkington, McDonald, & McMahon, 2013). The current study findings contribute to the literature because the findings indicate that perinatal bereavement care can also have positive effects and be rewarding. The nurses in this study reported that, although

providing care to families undergoing a loss is undoubtedly difficult, it is also the most rewarding type of service one can provide to families with potential for personal and professional growth for nurses. The published literature has failed to acknowledge positive effects from caring for families experiencing perinatal loss. The lack of discussion of positive effects in the empirical literature may reflect the potentially pervasive stigma associated with perinatal loss. In fact, the nurses in this study felt that, at least in part, this is why they received limited, or if any, formal education or training on the subject.

The effects of perinatal loss described by the nurses in this study were multifaceted. Many attributed the external influences of time and support to strong negative or positive effects on their experience of loss; however, every nurse interviewed described providing care to families undergoing a loss as the most rewarding and inspiring type of care. Specifically, they described how witnessing another person's profound pain and resilience gave them a new perspective on life. They reported that, although it was certainly among the most difficult work, they perceived the opportunity to be present with a family at such a time as a privilege and honor. These findings are not to Pollyanna bereavement experiences but rather offer authentic efforts for making sense of this tension-filled work, as described by participants.

The following chapter will delve deeper into utilizing the discussion points made here to make recommendations for nursing practice, education, and research.

Chapter 6: Implications, Recommendation and Conclusions

The effect of perinatal loss is undoubtedly one of the hardest experiences parents can face, yet the impact on nurses is also profound and long lasting. Nurses can and do experience an array of effects; however, thus far in the literature, those effects have widely been described as profoundly negative (Puia, Lewis & Beck, 2013; Roehrs, Masterson, Alles, Witt, & Rutt, 2008; Rondinelli, Seelinger, Long, Crawford, & Valdez, 2015). Steen (2015) found that, for obstetric health care providers, the rate of burnout in relation to perinatal loss is high, and that practitioners even consider leaving the field due to the negative effects. As this study highlights, there is a need for ongoing research to generate evidence for practice, leadership, and education decisions for supportive environments to reduce the negative effects and promote positive experiences.

6.1 Recommendations for Nursing Education

Education for nurses that focuses on perinatal loss in postgraduate specialty training is an integral initial step towards addressing the lack of knowledge captured by my findings. Enhancing the perinatal loss and bereavement content within specialty education programs, as well as the possible effects on health care providers, would raise nurses' consciousness about perinatal loss in obstetric care. The nurses in this study reported that they were unaware of how frequent perinatal loss was in practice, and as such, they felt inadequately prepared. Roehrs et al. (2008) argued that, in addition to clinical education on perinatal loss, grief training and specialized communication skills need to be addressed and explored in educational programs. In fact, Wakanako (2016) concluded that when nurses took part in grief training, they reported more positive personal outcomes, even when they were engaged in emotionally difficult situations. Educational programs, such as postgraduate perinatal specialty programs, are uniquely

positioned to provide grief training and can contribute to raising awareness about perinatal loss. Such programs ought to integrate learning about the range of experiences nurses have when caring for families experiencing perinatal loss, and acknowledge the potential for positive impacts. The findings of this study highlight the importance of surfacing an alternative understanding about implications of care for families suffering perinatal loss and contributions to the practice culture of perinatal bereavement work, one that can be positive when properly supported by leadership, education and supportive systems of care.

6.2 Recommendations for Nursing Leadership/Practice

Although there is limited research on this topic, the research that does exist is unanimous in recommending more involvement or, at the very least, acknowledgement from perinatal practice leaders as part of ensuring the availability of supports to the nurses who care for bereaved families. There are three specific recommendations for leadership.

First, more resources are needed that are aimed specifically at supporting nurses to respond to and manage their own emotional work associated with perinatal loss. Foreman (2014) described a ‘care package’ that some nurses receive after a perinatal loss case. In that package, there are self-care tips, resources for counselling, as well as other supportive documents that might be useful given the varying response nurses will have. Such actions acknowledge the nurse and the difficult experience in which they were involved. Care packages can be tracked as they are given out, which can increase awareness about the frequency of nurses’ experiences with loss and create an opportunity for follow-up and support. For example, leaders can follow-up with nurses and ask: what resources in the care package did you access? What resources were the most helpful? What resources do you think are missing?

Effective nurse leaders are pivotal for operationalizing changes to foster positive nursing experiences (Asamani, Naab & Ofei, 2016). Accounting for the myriad of leadership styles available, Asamani et al. (2016) stated that, when leaders employed the 'supportive' or 'transformational leadership style', nurses generally reported more positive emotional responses and effects (Asamani, Naab, & Ofei, 2016). Transformational leadership is defined as a leadership style that aims to understand needs and work alongside constituents in order to achieve a commonly set goal (Transformational Leadership, 2018).

The nurses in this study reported that leadership support was a major contributing factor to their perceptions about and effects of perinatal loss cases. Asanabi et al. (2016) claimed that nurse leaders have a responsibility to ensure that their staff members have the resources required to perform the duties of their roles. Not taking this responsibility seriously can: 1) exacerbate the negative effects of perinatal loss and 2) lead to missed opportunities for reframing perceptions of perinatal loss and bereavement care in everyday practice. While the impact on nurses points to critical recommendations, so do significant impacts on patient outcomes. Wong and Cummings (2007) found that, in care areas where transformational leadership was practiced, there were lower rates of poor outcomes or patient complaints. While Wong and Cumming's study was not focused on perinatal loss specifically, it emphasized an important finding from this study; the critical role that supportive clinical environments play in optimizing nursing bereavement work, and nursing care for patients.

A practice recommendation from this study underscores the critical importance of limiting patient assignments and other duties when nurses are caring for bereaved families. Nurses in this study reported feeling extremely distressed when assigned to a laboring patient and a bereaved patient at the same time. They reported providing care in these two situations as

emotionally exhausting. Currently, the Perinatal Services of British Columbia (PSBC) guides all practice recommendations for nurses providing obstetrical care in British Columbia. In addition, the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN) obstetric care guidelines also heavily influence nursing practice. I have thus far been unable to find any direct recommendation by the PSBC or AWHONN in regards to nurse to patient ratios in relation to managing perinatal loss. In labor, nurses are guided by the one-to-one patient assignment ratio during the second stage of labor, due to the acuity involved in this stage (PSBC, 2017). That ratio increases to two nurses per patient for deliveries (AWHONN, 2010). There seems to be a clear gap between practice recommendations and the nature of nursing care required in specific situations, such as perinatal loss. From this study, one recommendation is for a one to-one nurse-patient ratio for caregiving situations with perinatal loss. My findings support the recommendation by emphasizing how a supportive environment can reduce the negative effects on nurses and create spaces for reflection, colleagueship and self-care.

Finally, peer support was essential to the nurses in this study as they managed the emotional work and self-care associated with caring for families experiencing loss. The initiation of a peer-to-peer support team that keeps track of nurses who have had perinatal loss patients with a goal of peer outreach would ensure comprehensive and timely follow-up. In addition this intervention would help to ensure that outreach be tailored to specific nurses' needs and experiences. Having an established peer support network can be mutually beneficial. Kramer (2018) asserted that both the mentor and mentee could benefit from their interactions. While the person receiving support can benefit from having an understanding, compassionate and empathetic listener, mentors also benefit by sharing expertise and continuing their own knowledge development (Kramer, 2018). In

essence, both parties contribute to a creative, sustainable approach for increasing positive nursing experiences within the context of perinatal loss.

6.3 Recommendations for Nursing Research

There is a lack of research focused on the range of effects for nurses who provide perinatal loss care. To date, I have been unable to locate any studies without a theoretical orientation or particular framing of perinatal loss at the outset of the research. Although the sample size for the study was small, the findings provide a glimpse into the array of effects of perinatal loss. They raise for consideration that perinatal bereavement work can be experienced by nurses as rewarding and positive. Further research is necessary to capture more contextual differences that could account for variation within nurses' experiences, such as those working in rural and remote settings, or for those nurses in leadership positions supporting more novice nurses.

6.4 Limitations

This study has the following limitations. First, the sample size was small, limited to eight participants who took part in the study. While sample size is not a limitation of qualitative research, a larger sample could have enhanced the breadth and depth of the findings. Although saturation of the constructed themes emerged within the data, perhaps a larger sample of participants and different contexts could have also deepened the findings. Another potential limitation was my investment in the topic understudy itself. While I worked diligently to be reflexive, there is potential for one's own experiences to shape the analysis and interpretations. We are, in the end, interpretive beings, such that our experiences can never fully be "bracketed" from the data. Nonetheless, I surfaced, where possible, potential conclusions that required my ongoing critical awareness. Finally, because all of the participants in the study were known to me

our relationship may have influenced how the participants answered the questions and what they chose to share. Because I have previously debriefed with many of my peers after loss cases, they may have felt that their ideas on the subject ought to be synonymous with mine. Their responses might have been influenced by this prior experience, which could have led to them holding back their views and experiences.

6.5 Conclusion

The effects of perinatal loss on obstetric nurses are complex and diverse. There are intra- and interpersonal factors that contribute to how the loss is perceived, processed, and understood by a nurse. Despite these variations, nursing education and leadership support and time and presence in this study were significant areas in need of improvement in order to meet the needs of the nurses providing perinatal bereavement care. Highlighted are the potential benefits of supporting families through loss, as described by the nurses in this study. Ultimately, the findings highlight opportunities to improve nursing practice and create supportive care giving environments for bereaved families as they experience such a significant loss in their lives.

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Appendices

Appendix A Recruitment Email

Hello,

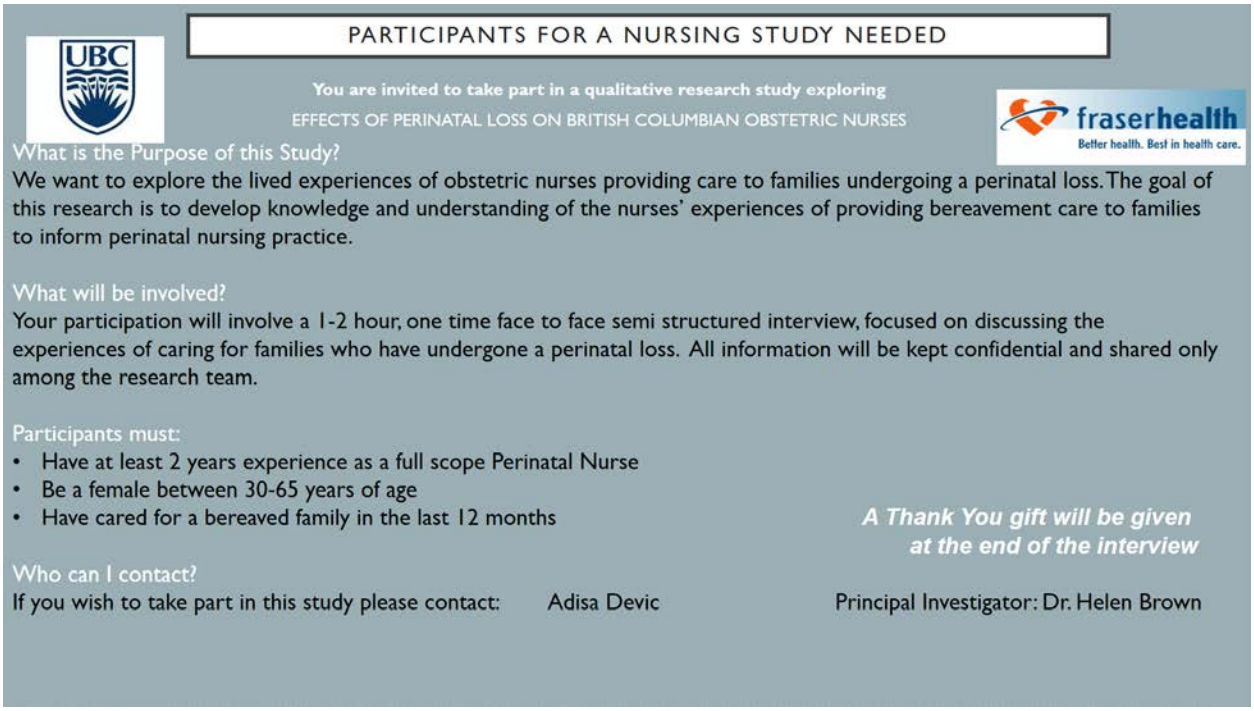
My name is Adisa Devic, and I am a Master of Science in nursing student working under the supervision of Dr. Helen Brown, Dr. Wendy Hall, and Dr. John Oliffe, in the Faculty of Graduate and Post-Doctoral Studies at the University of British Columbia. The purpose of this email is to seek your participation in our study titled: The Effects of Perinatal loss on British Columbian Obstetric Nurses, which aims to explore the experiences of obstetric nurses providing care to families undergoing a perinatal loss. We are currently seeking nurses as volunteers from the Perinatal Unit at Royal Columbian Hospital to participate in this study.

Participation in this study involves attending a screening interview (over the phone), an information and consent process and participating in a face to face, 1-2 hour semi-structured interview, aimed to answer the research question. In appreciation of your commitment, you will receive a thank you gift at the end of the interview in the form of a $25 spa gift card. The study has been reviewed and received ethics approval by the University of British Columbia Behavioral Research Ethics Board, as well as the Fraser Health Authority Ethics Committee.

If you are interested in participating, please contact me to discuss the eligibility criteria and schedule a meeting at your discretion for time and place. I will then send a confirmation email indicating that we have agreed to a time and place, and provide you with further resources, which will also be discussed at the interview. If you have to cancel your appointment, please email me. Please note that I am the primary contact, and that the primary investigator is my supervisor, Dr. Helen Jean Brown.

Sincerely,
Adisa Devic

Appendix B Recruitment Poster



Appendix C Eligibility Questions

The eligibility questions for the study are:

1. Do you have at least two years of obstetric nursing experience?
2. Are you between 30-65 years of age?
3. Have you cared for a client/family who have experienced a perinatal loss in the last 12 months of practice?

Appendix D Consent Form

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

CONSENT FORM

THE EFFECTS OF PERINATAL LOSS ON BRITISH COLUMBIAN OBSTETRIC NURSES

I. STUDY TEAM

Principal Investigator: Helen Brown, RN, PhD
Associate Professor, Researcher, School of Nursing
The University of British Columbia
Faculty of Nursing

Co-Investigators: Wendy Hall, RN, PhD
Professor, Associate Director of Graduate Programs,
Researcher, School of Nursing
The University of British Columbia
Faculty of Nursing

John Oliffe, RN, PhD
Professor, Associate Director, Researcher
The University of British Columbia
Faculty of Nursing

Adisa Devic, RN, BScN

Primary Contact, Graduate Student, School of Graduate and Post-Doctoral Studies, School of Nursing

The University of British Columbia

This study is a thesis, being conducted in partial fulfillment of the requirements for the degree of: Master of Science in Nursing.

II. SPONSOR

The graduate student named above funds this study, and there are no actual or potential conflicts of interest with respect to remuneration for conducting or being involved with any part of the study.

III. WHY SHOULD YOU TAKE PART IN THIS STUDY?

You are being invited to take part in this research study to help us explore the experiences of perinatal nurses providing care to families undergoing a perinatal loss. We need nurses like you to help us develop knowledge and understanding of nurse's experiences of providing care to bereaved families in order to inform perinatal nursing practice.

IV. WHAT HAPPENS IF YOU SAY YES, I WANT TO BE IN THE STUDY?

Participation in this study involves attending a screening interview (over the phone), where the primary contact will assess your eligibility criteria. If you meet the criteria, you will sign the informed consent form and take part in one 1-2 hour face-to-face semi-structured interview, aimed at answering the research question. The interview will be audio-recorded to help us accurately capture your insights, in your own words.

Only the primary contact and a transcriptionist, who will transcribe the data for the purpose of the study, will hear the tapes. Only the primary investigator and contact will have access to the transcripts and tapes. If you feel uncomfortable with the recorder, you may ask that it be turned off at any time. Direct quotations from you may be used in the text; however, all identifying information from the tapes and transcriptions will be coded, and kept anonymous on a password-protected computer in an encrypted file.

You have the right to withdraw from the study at any time. In the event that you choose to do so, all information (tapes, forms, notes, transcriptions) will be destroyed and not used in the analysis or included in the findings or final paper.

Information gathered from you and other participants will be used in analysis and generation of themes, and written as a formal report in the thesis and may be put forward for publishing in nursing literature.

V. HOW WILL THE STUDY RESULTS BE USED?

The results of this study will be reported in a graduate thesis and may be published in journals. The findings will be presented at conferences and possibly at unit meetings. If you wish to receive your transcription and the preliminary findings, please indicate this on the bottom of this form.

VI. IS THERE ANY WAY THE RESULTS COULD BE BAD FOR YOU?

We do not think there is anything in this study that could harm you or be bad for you. Some of the questions we ask might upset you. Please let one of the study staff know if you have any concerns. You do not have to answer any question if you do not want to. Should you experience adverse emotional effects we encourage you to seek

counselling through EFAP (Employee Family Assistance Program) or a personal counselor/psychologist of choice? Please note these services are covered under PBC Extended Benefits. If you need immediate, free, and confidential emotional support, you can contact the Fraser Health Crisis Line at 604-951-8855 24 hours a day-everyday.

VII. WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

By participating in this study, you will help advance the understanding of what it means for obstetrical nurses to care for bereaved families. In addition, you will directly contribute to the generation of knowledge that could guide policy, education and interdisciplinary practice to improve nursing experiences and even care to parents experiencing a perinatal loss.

VIII. MEASURES TO MAINTAIN CONFIDENTILAITY

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator, and the UBC Research Ethics Board and Fraser Health Research Ethics Board for monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. Information that contains your identity will remain only with the

Principal Investigator and/or primary contact. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law.

IX. WILL YOU BE PAID FOR TAKING PART IN THIS STUDY?

You will not be paid for taking part in this study; however, a small honorarium will be provided at the end the interview in the form of a $25 spa gift card. The honorarium will be provided even if you wish to withdraw from the study.

X. WHO CAN YOU CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY?

If you have any questions or concerns about what we are asking of you, please contact the study leader or one of the study staff. The names and telephone numbers are listed at the top of the first page of this form.

XI. WHO CAN YOU CONTACT IF YOU HAVE COMPLAINTS OR CONCERSN ABOUT THIS STUDY?

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance email RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, contact the Fraser Health Research Ethics Board co-Chair by calling 604-587-4681. You may discuss these rights with one of the Fraser Health REB.

XII. PARTICIPANT CONSENT AND SIGNATURE PAGE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out at any time without giving a reason and without any negative impact on your employment at Fraser Health. Please proceed to the signature page.

THE EFFECTS OF PERINATAL LOSS ON BRITISH COLUMBIAN OBSTETRIC NURSES

CONSENT TO PARTICIPATE

Please read this checklist prior to signing

- I have read and understood the subject information and consent form and am consenting to participate in the study: Effects of Perinatal Loss on British Columbian Obstetric Nurses.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.
- I understand that I am not waving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated copy of this form.

SIGNATURES

Printed name of participant: Signature: Date:

Printed name of witness: Signature: Date:

Printed Name of

Principal investigator/

Primary contact: Signature: Date:

☐ Please check this box if you wish to receive your transcript

☐ Please check this box if you wish to receive the preliminary findings

Appendix E Interview Guide

1. Tell me about your interest in participating in this study?
2. What are your experiences over your career of caring for families who are undergoing or have undergone a perinatal loss?
    - Which particular family or experience that comes to mind?
    - Which particular story that comes to mind?
    - What about that story/experience was so meaningful for you?
    - What are some of the particularities that stand out?
    - What emotions did you feel?
    - How long did these emotions last?
    - How has the experience changed you? Has it changed you?
3. What are some of the positives or rewarding moments of caring for bereaved families?
    - What have you learnt from this experience?
4. What has it been like for you to talk about these experiences?
    - Who do you talk to about this experience?
5. How might your life experience influence your experiences of caring for families in the context of perinatal loss?
    - How might your life stage influence your experience?
6. What final thoughts before we conclude this interview?

Appendix F Demographic Table

Gender	Number of Participants
Male	0
Female	8
Age	
30-40	3
41-50	3
51-60	2
Marital Status	
Single	1
Married	6
Divorced	1
Undisclosed	0
Level of Education	
Diploma	3
BSN	5
MSN	0
Length of Employment in Nursing	
2-5 years	1
5-10 years	1
10-15 years	1
15-20 years	1
20-25 years	1
25 + years	3
Level of Employment	
Casual	0
Part-Time	7
Full-Time	1