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A Phenomenological Study of Adolescent Pregnancy Loss

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To the Graduate Council:

I am submitting herewith a dissertation written by Jenny Stout Webb entitled "A Phenomenological Study of Adolescent Pregnancy Loss." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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A Phenomenological Study of Adolescent Pregnancy Loss

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Degree
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Dedication

I dedicate this dissertation to my husband, Paul, and my three boys, Eli, Hall, and Landon. To Paul, thank you for your endless support and encouragement while I have been in doctoral school. I know that you understand what this work has meant to me and I hope that you realize how much I love you and appreciate your patience throughout this experience. To my boys, thank you for being understanding when I needed to work rather than play, thank you for encouraging me and reminding me to slow down and enjoy life with you. I hope that one day you read this and are inspired to help others the same way I have been. All four of you kept me going during the trying times when I wanted to give up and have loved me unconditionally. I will never be able to repay you for what you have done for me during this time.

Acknowledgments

First, I want to thank God for providing the opportunities which allowed me to reach this goal. He has loved me and provided for me and without Him I would be nothing.

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I would like to thank the University of Tennessee College of Nursing for awarding me with a scholarship that helped to fund this research study. Thank you for believing in this work and me.

Abstract

Very little is known about the experience and long-term effects of pregnancy loss during adolescence. The purpose of this existential phenomenological research study was to gain a better understanding of the meanings adolescent mothers give to their experience of pregnancy loss. For this study, four participants were interviewed using unstructured, phenomenological interviews. The participants were 17 (3) and 18(1) at the time of the loss and ranged in age from 29 to 58 years at the time of the interviews. Data analysis resulted in the development of five themes to describe the experience of pregnancy loss during adolescence: 1) "It was an emotional roller coaster," 2) My baby and I were less important to them [health care providers], 3) "It was all my fault," 4) "I will always wonder," and 5) "Everything happens for a reason." Rigor was ensured by following Thomas and Pollio's (2002) phenomenological research methods. The findings of this study offer understanding of the meaning of the experience of pregnancy loss during adolescence, which have implications for the nursing discipline.

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Chapter One: Introduction

> Perinatal loss was a term unfamiliar to me until my son Quinn was stillborn at 37 weeks on May 11, 2005. My world was forever changed in ways that I could never have imagined before that date (Forhan, 2010 p. 142).

Pregnancy loss is a uniquely painful experience. Those who have experienced such a loss during adulthood describe feelings of confusion, disbelief, denial, anger, guilt, anxiety, searching, and longing (Badenhorst & Hughes, 2007; Cacciatore, 2013; Engelhard, van den Hout, & Arntz, 2001; Farren et al., 2016; Geller, Klier, & Neugebauer, 2001; Klier, Geller, & Neugebauer, 2000; Kulathilaka, Hanwella, & de Silva, 2016; Maker & Ogden, 2003; Sefton, 2007; Vance et al., 1995; Welch & Bergen, 2000). Pregnancy loss can be especially traumatic for adolescents who are vulnerable to experiencing overwhelming grief, anxiety, and anger during bereavement because of their developmental stage (Lewis & Frydenberg, 2004). It is important for nurses to understand these young mothers' experiences and emotions in order to become more knowledgeable about helping them find their way (Bennett, Litz, Maguen, & Ehrenreich, 2008; Malacrida, 1997; Swanson-Kauffman, 1983). Gaining insight into these adolescent pregnancy loss experiences through first-person narratives is a necessary step in understanding the meanings these women give to this phenomenon. Because adolescents seldom have been asked to tell their stories of pregnancy loss, the researcher chose a phenomenological research method to explore their lived experiences.

Chapter 1 presents background on this area of inquiry. This information is followed by the study's problem statement, purpose and research question, aims, problem scope, conceptual definition of terms, philosophical framework, assumptions, limitations, and delimitations. The chapter concludes with a discussion of the study's significance to the nursing discipline.

Background

As a labor and delivery nurse working with high-risk populations, the researcher often cared for adolescents who were having a miscarriage, or delivering a severely preterm neonate or stillborn baby. While the researcher and her fellow nurses treated these young mothers the same way as the adult patients in their care, she began to wonder if their developmental stage meant they had different needs. She also was interested in exploring the long-term maternal consequences of suffering a pregnancy loss as an adolescent. An extensive literature review uncovered very little research about the phenomenon of pregnancy loss in adolescent mothers. While many researchers have examined how to care for mothers who have experienced a pregnancy loss as well as the long-term effects of pregnancy loss, none has used existential phenomenology to understand adolescents' perinatal loss experiences. Peterson, Davies, Rashotte, Salvador, and Trépanier, (2012) discovered that hospital-based perinatal nurses have indicated they need more education to improve the care of adolescent mothers in their units. Similarly, Roehrs, Masterson, Alles, Witt, and Rutt (2008) found that nurses generally are uncomfortable caring for mothers who have experienced a pregnancy loss.

Statement of the Problem

To provide high quality, customized care to this population, nurses need access to information about pregnancy loss in adolescence. Unfortunately, such information is unavailable because the needs of this population have not been sufficiently studied or described. To fill this knowledge gap, this qualitative study examined the lived experiences of mothers who have suffered a pregnancy loss during adolescence.

Purpose and Research Question

The purpose of this qualitative study was to gain a better understanding of the meanings adolescent mothers give to their experience of pregnancy loss. Using the interpretivist paradigm and existential phenomenology tenets set forth by Merleau-Ponty (1945/2012), the researcher asked participants to describe what it was like experiencing a pregnancy loss as an adolescent.

Aims

This study had the following four aims concerning the experiences of adolescent girls who have lived through the death of a fetus:

1. To address the research and knowledge gaps regarding this phenomenon;
2. To provide information that helps the nursing discipline understand the experience of this phenomenon;
3. To suggest ideas for future research studies regarding this phenomenon; and
4. To delineate practice, education, and health policy implications regarding this phenomenon.

Conceptual Definitions of Terms

Definitions of key terms used for this study are presented below. These same terms are used by the Centers for Disease Control for Vital Statistics Reporting (MacDorman & Gregory, 2015).

Fetus – The product of human conception from eight weeks after conception until full-term gestation (>37 weeks).

Fetal death – death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced pregnancy termination. The death is indicated by the fact that after such expulsion or extraction,

the fetus does not breathe or show any other evidence of life such as heartbeats, umbilical cord pulsation, or definite voluntary muscle movement. Heartbeats are to be distinguished from transient cardiac contractions, and respirations are to be distinguished from fleeting respiratory efforts or gasps.

Fetal mortality – the number of fetal deaths per 1000 births, generally divided into three periods: early (less than 20 completed weeks of gestation), intermediate (20–27 weeks of gestation), and late (28 weeks of gestation or more).

The significant terms listed below also were used throughout this study.

Adolescent – an individual between the ages of 10 and 19 (World Health Organization, 2014).

Miscarriage – lay term commonly used to describe fetal deaths prior to 20 weeks of gestation.

Stillbirth – lay term commonly used to describe fetal deaths after 20 weeks of gestation.

Pregnancy Loss – lay term commonly used to describe fetal death.

Scope of the Problem

Losing a baby at any stage of pregnancy can affect a mother profoundly, regardless of her age. Capitulo (2005) stated, "the loss of a pregnancy or death of an infant causes profound grief, yet society has long minimized or ignored this grief, which is among the most painful of bereavement experiences" (p. 389). The long-term maternal effects of perinatal loss can include anxiety, depression, and post-traumatic stress disorder (Badenhorst & Hughes, 2007; Barr, 2004; Bennett, Litz, Lee, & Maguen, 2005; Cacciatore, 2013; Engelhard et al., 2001; Farren et al., 2016; Geller et al., 2001; Kulathilaka et al., 2016). These mental health disorders can have a significant impact on an individual's quality of life and ability to contribute to society. Family relationships—such as those with future children, spouses, significant others, parents, siblings, or

extended family members—also can be disrupted by the long-term effects of the perinatal loss (Bright, 1987).

Adolescent Development

Erikson (1963) suggests that teenagers gain a sense of identity during adolescence. During this time of psychosocial growth the adolescent also begins to take on more responsibility for their behaviors, needs acceptance among their peers, and are able to understand the implications of behaviors and decisions. Piaget (1969) posits that within the cognitive realm, the adolescent becomes able to think more abstractly, enjoys independent decision making, and is concerned with their place in society. Additionally, Kohlberg (1984) conveys that adolescents develop morals based upon their contextual environment and compares their own newly developed morals to those of the society in which they are maturing.

Adolescent Bereavement

Adolescent bereavement may follow a different trajectory than adult bereavement. According to Balk (1991; 1996), bereavement during adolescence can impede advancement through developmental tasks, as the grieving experience is an additional complication added to the already complex physical, cognitive, moral, interpersonal, and psychological changes occurring during that time. Balk (1991) also emphasized the impact of bereavement on the adolescent's life including "self-concept and identity formation, interpersonal relations, schoolwork, family involvement, and overall psychological well-being" (p. 8).

Adolescents who have experienced the loss of a baby through miscarriage, stillbirth, or neonatal death can have many conflicting feelings. They may feel relieved, guilty, sad, regretful, or ashamed (Bright, 1987; Fenstermacher, 2014; Sefton, 2007; Welch & Bergen, 2000; Wheeler & Austin, 2000). Additionally, many adolescent mothers may not understand the profundity of

their loss or the depth of their trauma until later in their adult lives, often when they have other children (Bright, 1987; Sefton, 2007).

While the long-term effects of pregnancy loss on adolescent mothers likely are unique and complex, due to lack of research they are not well understood. While many studies have examined the long-term maternal sequelae of perinatal losses (Badenhorst & Hughes, 2007; Barr, 2004; Bennett et al., 2005; Cacciatore, 2013; Engelhard et al., 2001), none has looked specifically at the adolescent population. Unfortunately, there is insufficient published data to understand and generalize how the loss of a pregnancy affects this population.

Prevalence of Pregnancy Loss in Adolescence

Pregnancy loss occurs more frequently in adolescent mothers than in older mothers (MacDorman & Gregory, 2015). Fetal mortality rates are calculated per 1000 births. In 2013, the fetal mortality rate for mothers aged 24–29 was 5.34 (MacDorman & Gregory, 2015). In comparison, the most recently published information from the Centers for Disease Control and Prevention indicated that adolescents had the highest fetal mortality rates: 15.88 for mothers younger than 15, 7.03 for 15–17 year olds, and 6.52 for 18–19 year olds (MacDorman & Gregory, 2015). However, these statistics may not include fetal losses occurring prior to 20 weeks gestation, as not all states are required to report such losses (MacDorman & Gregory, 2015).

Because pregnancy loss is more common among adolescent mothers, labor and delivery nurses are likely to encounter many young women experiencing such a loss. Therefore, it would be helpful for these nurses to be familiar with the unique experiences of these patients.

Philosophical Framework of the Study

The research method of existential phenomenology is one of the approaches within the interpretive perspective, which suggests that a phenomenon must be viewed through the perspective of those who lived through the experience (Weaver & Olson, 2006; Welford, Murphy, & Casey, 2011). The origins of existentialist thought can be traced to Soren Kierkegaard, a 19th century philosopher who sought to gain a better understanding of "the difficulties of existence" (Thomas & Pollio, 2002, p. 9). Similarly, 20th century phenomenologists sought to describe the essence of experiences associated with human existence. Joining the philosophy of existentialism with the methods of phenomenology yielded a research approach that is used widely in 21st century human sciences, including nursing.

The approach used in this study is based primarily in the existential phenomenology of French philosopher Maurice Merleau-Ponty (1945/2012), who built upon the work of Kierkegaard and German philosopher Edmund Husserl (van Manen, 2014). Merleau-Ponty's views opposed Descartes' belief in mind-body duality. Descartes relied on the premise that the rational mind is the only way to establish certainty (Primozic, 2001; van Manen, 2014). In contrast, Merleau-Ponty upheld the tenets of Gestalt psychology, maintaining that the mind and body are intertwined and cannot be separated from each other (Merleau-Ponty, 1945/2012; Thomas, 2005). Furthermore, Merleau-Ponty asserted that the body creates the possibility of thinking (cited in Sohn, Thomas, Greenberg, & Pollio, 2017).

Merleau-Ponty described phenomenology as "the study of essences" and a philosophy that "puts essences back into existence" (Merleau-Ponty, 1945/2012, p. xx). Some key concepts of Merleau-Ponty's philosophy of existential phenomenology (perception, figure-ground, intentionality, and freedom) are defined below.

For Merleau-Ponty, *perception* was the avenue through which understanding about human experiences could be achieved. According to Merleau-Ponty (2004), prior philosophy did not consider the importance of perception and its role in knowledge development. He also claimed that the "role of perception is to present the perceiver with an intersubjective world of things, which have a definite character and a location in that world" (Romdenh-Romluc, 2011, p. 17). Additionally, Thomas and Pollio (2002) stated, "experience, like perception, is always a transaction between us and the world, and both aspects of the transaction are significant" (p. 14). Merleau-Ponty stated, "the perceptual 'something' is always in the middle of some other thing, it always belongs to a 'field'… [and] a truly homogenous area, offering *nothing to perceive,* cannot be given to *any perception*" (1945/2012, p. 4).

The *figure* and *ground* concepts of Merleau-Ponty's philosophy often are depicted by Edgar Rubin's Figure-Ground (Vase-Faces) Illustration (Figure 1.1). The figure is the being or object that stands out against the ground or environment (Thomas & Pollio, 2002). The figural element is that which the participant interprets as significant. If the person viewing the illustration focuses on the white portion as most prominent, the vase is figural and appears to rest upon a black background, which represents the concept of *ground*. Ground represents the world or background against which the figural element stands out (Thomas & Pollio, 2002). Just as the faces in Figure 1.1—viewed as the black background against which the white figural vase is depicted—are a necessary component of the illustration, a figure or being cannot exist without the ground or world in which it exists. Similarly, it is important for researchers to identify the figural elements of a participant's experience in order to reduce the experience to its essence or eidetic nature.

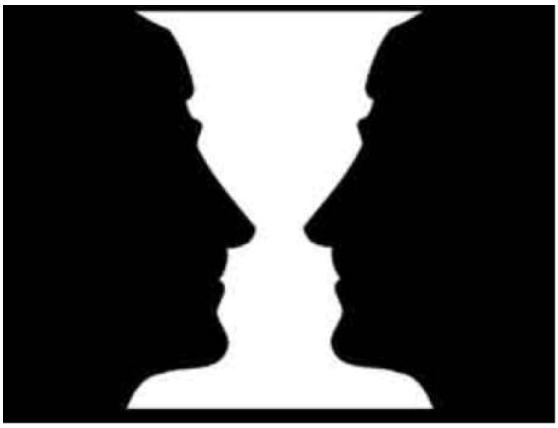

Figure 1.1 Rubin's Figure-Ground (Vase-Faces) Illustration

The concept of *intentionality* describes how people have a natural pull toward objects, events, and phenomena within the world, and illustrates the entanglement between human experiences and the world in which they exist. Merleau-Ponty spoke of intentionality when he stated "what distinguishes intentionality… is that the unity of the world, prior to being posited by knowledge through an explicit act of identification, is lived as already accomplished or as already there" (Merleau-Ponty, 1945/2012, p. xxxi). What people (or study participants) are drawn to can be helpful in understanding what they perceive as important, as Thomas and Pollio (2002) pointed out, "what I am aware of reveals what is meaningful to me" (p. 14). Additionally, when seeking to understand the relationships between ourselves and others and ourselves and the world, the principle of intentionality reveals how we connect with others and the world.

Freedom suggests participants' rights to choose their own paths and attitudes in response to their personal situations (Merleau-Ponty, 1945/2012; Thomas & Pollio, 2002). However, Merleau-Ponty stated it is "impossible to determine the 'contribution of the situation' and the 'contribution of freedom'" (Merleau-Ponty, 1945/2012, p.480). This statement means that

researchers will not be able to determine a situation's influence on the participant's choices versus their freedom to choose a particular path.

Four existential grounds of human experiences are noted in Merleau-Ponty's philosophy: body, others, time, and world. These grounds contextualize human experience. As previously stated, Merleau-Ponty rejected the concept of mind-body duality. Merleau-Ponty felt the *body* was deserving of philosophical and scientific research (Thomas & Pollio, 2002). Furthermore, Merleau-Ponty emphasized the importance of viewing the body as a form of consciousness, rejecting viewing the body as an object (Romdenh-Romluc, 2011). Merleau-Ponty developed his belief of body subjectivity through his analysis of perception and actions. Study participants may describe experiences as related to their body. They may discuss changes in their bodies, things that have happened to their bodies, or use words to describe their bodies' features.

Others refers to relationships, including aspects of relationships such as comparison and benefit. The relationships can be with significant others, friends, family, and acquaintances, or individuals with whom the participant does not have a relationship. Comparison refers to the tendency to compare oneself to someone else, finding either similarities or differences. Benefit encompasses the individual's perception of the other person's role and ability to meet the individuals' needs, including whether the other person is helpful or harmful (Thomas & Pollio, 2002). The existential ground of others also describes the participants' perceptions of their social world (Romdenh-Romluc, 2011). In order to understand the meanings of the experiences of another person, we must consider the presence of others, especially those people who stand out to the participant as figural. Study participants' discussion of others—such as their mothers, grandmothers, friends, other family members, and healthcare providers—will enable the researcher to gain a better understanding of the social aspects of their experiences.

Time represents past, present, or future. One of the essential features of time, as described by Merleau-Ponty, is that it keeps moving (Romdenh-Romluc, 2011). When discussing time, participants may refer to a specific period, a specific moment, or a lack of time. In his writings about time, Merleau-Ponty stated:

> To analyze time is not to draw out the consequences of a pre-established conception of subjectivity, but rather to gain access to its concrete structure through time… Thus, we must consider time in itself, and by following its internal dialectic we will be led to revise our idea of the subject (1945/2012, p. 433).

Merleau-Ponty's philosophy focuses on the subjective experience of time, including how the participant views and describes the meaning of time. Participants' accounts of time can "shed light on the nature of consciousness" (Romdenh-Romluc, 2011, p218).

Finally, the *world* represents the spaces and places in which human experience is lived (Thomas & Pollio, 2002). Space refers to the actual area surrounding the participant. Place refers to the participant's geographical setting. Merleau-Ponty discussed the concept of spatiality when he stated "the spatial level is, then, a certain possession of the world by my body, a certain hold my body has on the world" (1945/2012, p. 261). Romdenh-Romuluc (2011) also described Merleau-Ponty's thoughts on the phenomenal world as the worldly objects that one perceives as well as their own embodied self. The world can have a profound effect on the perception of the experience. Participants may discuss particular places that are important in their experience such as a house, clinic, school, etc. The meaning of the experience may be influenced by whether a participant remembers a place as being safe or unsafe.

Assumptions

The researcher's literature review, personal experience of pregnancy loss, personal experience caring for adolescent mothers who have suffered a pregnancy loss, and bracketing interview have led to five assumptions she holds about this area of inquiry.

1. Pregnancy loss is an emotionally painful experience.
2. Pregnancy loss may affect adolescents in a different manner than adults.
3. Adolescents have different coping mechanisms for dealing with grief, including grief from a pregnancy loss.
4. There are long-term psychological sequelae that can arise following pregnancy loss.
5. All women, irrespective of age, desire to feel supported and cared for following a pregnancy loss.

Following Thomas and Pollio's (2002) phenomenological study procedures, the researcher submitted a bracketing interview prior to speaking with study participants. This interview was audiotaped, transcribed, and analyzed with the help of University of Tennessee–Knoxville's (UTK) interdisciplinary interpretive research group (IIRG). This group consists of researchers from the fields of nursing, psychology, education, social work, philosophy, and child and family studies. Additional bracketing information is presented in Chapter 3.

Limitations

Qualitative research is not intended to be generalized to a population because participants are purposefully selected rather than chosen to represent a population. Credibility of findings is not dependent upon the number or characteristics of participants, but whether the essence of the phenomenon has been elucidated. Recruitment for this study was unusually lengthy and difficult, suggesting that many women may be unable or reluctant to talk about an adolescent miscarriage,

even years later. The women who participated wanted to tell their stories, but the experiences of those who chose not to participate remain unknown.

Delimitations

To explicate the experiences of women who have suffered a pregnancy loss that was not induced by the participant, this study excluded participants who elected to terminate a pregnancy. Accordingly, literature associated with elective pregnancy termination was not reviewed. However, there was no limitation regarding when the loss occurred during the pregnancy (i.e., 8 weeks gestation vs. 30 weeks gestation). In order to focus on the long-term effects of pregnancy loss during adolescence, the researcher included only participants over age 25 who experienced the loss between the ages of 15 and 18.

Significance of the Study

Pregnancy loss is a life-altering event that can affect adolescents in unique ways due to their developmental stage. Unfortunately, a lack of data about the experiences of these young women—who experience higher rates of pregnancy losses than women in other age groups—may prevent their nurses from caring for them as effectively as they could. It is imperative for nurses to provide supportive care to these patients to help ward off some of the long-term effects of miscarriage such as Post Traumatic Stress Disorder (PTSD), anxiety, and depression.

Summary

The experiences of adolescents suffering a pregnancy loss remain largely unknown. Using existential phenomenology and the procedures set forth by Thomas and Pollio (2002), the researcher began the process of addressing this knowledge gap and giving meaning to the experiences of adolescent pregnancy loss. Decoding this experience will provide nurses with the knowledge necessary to provide adequate care to these young, bereaved mothers.

Chapter Two: Literature Review

This chapter presents the literature review performed for this study including the literature retrieval methods followed by a critique of the literature pertinent to adolescent pregnancy loss, divided into seven key topics. Finally, a summary of what is known and unknown about adolescent pregnancy loss and how this study can build nursing knowledge in this area is presented.

Literature Search Methods

The key terms used in the literature search were miscarriage, pregnancy loss, perinatal loss, spontaneous abortion, adolescent perinatal loss, adolescent miscarriage, adolescent pregnancy loss, adolescent spontaneous abortion, adolescent bereavement, adolescent grief, perinatal grief, perinatal death, perinatal death AND adolescence, and perinatal death AND grief. The CINAHL, PubMed, and PsycINFO databases were searched and no publication date limitations were used. Non-English article were excluded from this review.

Based upon title and abstract information, 52 articles were chosen for initial review, and 20 were selected for inclusion. Publication dates ranged from 1983 to 2016. To be included, each article had to be an original work published in a peer-reviewed journal. While articles including only anecdotal evaluations and opinions were not used in the literature review, they were reviewed for background information where appropriate. The following seven themes discussed below emerged from the literature review: a description of the perinatal loss experience in adults; the psychological effects of perinatal loss; caring for patients after perinatal loss; nurses' experiences providing perinatal bereavement care; adolescent perinatal loss; adolescent coping and grief; and nursing care for adolescents suffering a perinatal loss.

Description of the Perinatal Loss Experience in Adults

For this theme, five research articles were analyzed to gain a general understanding of the experience of perinatal loss during adulthood. Abboud and Liamputtong (2003) conducted semi-structured interviews of six women and their partners to gather data for thematic analysis using a phenomenological approach. The five themes that emerged from this study were 1) shock and surprise: the news of pregnancy and miscarriage; 2) the physical and emotional experiences of pregnancy loss; 3) why me? the blame; 4) communication between couples; and 5) post miscarriage: what happened?

Abboud and Liamputtong (2003) also illustrated the women's perceptions of the partners' experiences and vice versa. The women reflected that their partners had remained strong during the experience, showing little emotion. The men reported that their partners had been much more emotionally and physically weak during the experience, adding that they felt she needed emotional support that they tried to provide. These results indicated that it is important for healthcare workers to acknowledge the physical and emotional pain of miscarriage experienced by woman. Additionally, it is just as important to acknowledge the grief felt by their partner even though they may withhold expressions of grief.

Using a descriptive phenomenological method, Kavanaugh and Hershberger (2005) examined the experience of perinatal loss in low-income, African-American parents. Twenty-three participants were interviewed following a perinatal loss. The losses occurred either at 16 weeks gestation or later or were the loss of a newborn fewer than 28 days old. Participants ranged in age from 19 to 34. Follow-up interviews were conducted with 21 of the participants to add or clarify information from the first interviews.

Four themes emerged from Kavanaugh and Herschberger's (2005) study: 1) recognizing problems and responding to the loss, 2) dealing with stressful life events, 3) creating and cherishing memories of the baby, and 4) living with the loss. The first theme detailed the reactions of the parents to the pregnancy complications and the loss. The women described feelings of hope during the medical treatment for pregnancy complications followed by intense emotions, such as shock, upon learning of the baby's death. The second theme encompassed the life events these women perceived as stressful, including financial hardships, abandonment, and unfair treatment. Theme three relayed the importance of creating positive memories surrounding the loss such as holding the baby if possible, finding family resemblances, retaining keepsakes, and holding memorial services. The final theme detailed how the parents began to move on following the loss. These parents sought diversions and support, including spirituality, to help them process the loss and begin thinking of the future, including the prospect of other pregnancies. The researchers recommended using nursing assessment to identify stressors and coping mechanisms, help parents employ coping strategies, and recommend appropriate outside referral resources following a loss. Additionally, it was recommended that nurses provide a supportive environment including showing empathy and providing keepsakes of the baby.

Swanson, Connor, Jolley, Pettinato, and Wang (2007) used secondary analysis to code inductively the descriptions of 85 women's emotional responses to miscarriage at 1, 6, 16, and 52 weeks post loss. Overall, the responses were clustered into three groups: healing, actively grieving, and overwhelmed. Those women who expressed healing used language that gave a sense of resolution and acceptance of the loss. Those actively grieving were still struggling with the loss, with their statements indicating sadness and mourning. The women who were overwhelmed expressed complex emotions including blame, loss of control, and confusion.

This study's findings suggest that the crisis period for women distressed by miscarriage occurs until about six weeks post loss (Swanson et al., 2007). The women still actively grieving at the one-year mark were made up predominantly of those who were not pregnant nor had become a new mother. Some of these women had either not been able to conceive following the loss or had experienced another pregnancy loss (Swanson et al., 2007).

Using a narrative approach, McCreight (2008) examined the experiences of women in Northern Ireland who have suffered a perinatal loss. After obtaining the appropriate ethical approval, 23 women, ranging from 19 to 60 years of age, consented to individual interviews, which took place in their homes. The women reflected upon their emotional responses to pregnancy loss; the medicalization of perinatal grief; and their reactions to burial arrangements. Participants expressed many emotions including grief, denial, anger, and self-blame. It also was apparent to the researcher that these women were searching for meaning and explanations surrounding their pregnancy loss. For these women, healthcare providers often provided blunt and non-empathetic responses, revealing that the emotional aspect of this experience often is overlooked by medical staff. These women expressed the importance of burial and public mourning. Several of them had been unable to hold or bury their babies, which did not allow them the social recognition of that loss, resulting in disenfranchised grief (McCreight, 2008).

Regarding the matter of support, McCreight's (2008) findings indicated participants' overwhelming appreciation for the perinatal bereavement support group and confirmed previous research showing the benefits of attending such groups following a loss. Furthermore, the researcher noted the importance of acknowledging a baby's death and how such acknowledgement helped these mothers deal with their grief (McCreight, 2008).

Gerber-Epstein, Leichtentritt, and Benyamini (2009) employed a qualitative descriptive approach to investigate the experience of miscarriage in 19 women. Participants ranged in age from 25–35 years old. Thematic analysis of the interviews revealed five central themes: 1) the greater the joy, the more painful the crash, 2) the nature and intensity of the loss, 3) sources of support, 4) life after the miscarriage, and 5) recommendations to professionals. This study's findings highlighted the complexity of the miscarriage experience and suggested the need for future research to gain a better understanding of this experience. Additionally, this study identified the need for better support and positive social interactions for women who have experienced a miscarriage (Gerber-Epstein et al., 2009).

The first theme identified by Gerber-Epstein et al. (2009) reveals the initial happiness about the pregnancy followed by the emotional downfall at its loss. The second theme described the loss experience and the women's attempts to understand it by giving descriptions of "the collapse of the dreams and fantasies" and the "helplessness, grief, and a profound pain" (p. 13). The second theme also encompassed the women's fears regarding subsequent losses or the loss of their fertility altogether. The third theme revealed the societal support these women turned to after the loss. The group that provided the most support was other women with similar experiences. The immediate families of these women encouraged them to return to normal life in order to diminish the profoundness of the loss. The fourth theme revealed how the women coped with the loss and returned to everyday life. Some of these women expressed difficulty in encountering a society full of people moving forward and other pregnant women while they were still reeling from their loss. However, some women expressed returning to normal life as "an escape from thinking and excessive brooding over the loss" (p. 20). The final theme indicated what these women wanted the public, especially other women and healthcare providers, to

understand about their pregnancy loss experience. The women recommended choosing a healthcare provider who makes you comfortable and suits your needs. They also recommended the importance of processing the experience, turning to professional counselors if needed. The last recommendation was to "be with the women in their pain, let the woman who had a miscarriage mourn at her own pace, and let each of them experience the event and relate to it in her own individual way" (Gerber-Epstein et al., 2009, p. 21).

These five articles framed the experience of perinatal loss during adulthood. From the research presented, it is known that pregnancy loss causes physical and emotional pain (Abboud & Liamputtong, 2003; Gerber-Epstein et al., 2009; Kavanaugh & Hershberger, 2005; McCreight, 2008; Swanson et al., 2007). Swanson et al. (2007) posited that the emotional crisis of miscarriage is heightened during the first six weeks following the loss. Abboud and Liamputtong (2003) and Kavanaugh and Hershberger (2005) identified the need for the women to make sense of the loss.

McCreight's (2008) findings supported the utilization of bereavement support groups as a means of healing. Similarly, Kavanaugh and Hershberger (2005) identified the need for adequate resources to help parents to cope with perinatal loss as well as the importance of recognizing additional life stressors that may interfere with coping mechanisms. Finally, Abboud and Liamputtong (2003), Kavanaugh and Hershberger (2005), and McCreight (2008) highlighted the importance of creating memories of the baby to be cherished in the coming years including providing mementos, allowing the family to hold the baby, and planning memorial or burial services that allow for public mourning and loss recognition.

The Psychological Effects of Perinatal Loss

In the reviewed literature, four studies examined how perinatal loss affected the mother's psychological health. Engelhard et al. (2001) conducted a prospective longitudinal study about the prevalence of PTSD following pregnancy loss. Using the Posttraumatic Symptom Scale, which has established validity and reliability, the researchers surveyed 113 participants at one-month post loss and 101 participants at four months post loss. The mean age for participants was 30.7 years. Results indicated that 28 (25%) of the participants met PTSD criteria at the one-month mark, and seven (7%) did so at the four month mark. Additionally, longer gestational length was significantly related to PTSD and depression at both one and four months post loss. These findings emphasized the need for assessment of patients' psychological status following a pregnancy loss, especially observing for signs of PTSD and depression (Engelhard et al., 2001).

Similarly, Farren et al. (2016) conducted a prospective survey pilot study comparing emotional distress in women who had an early pregnancy loss (128 women) to that of a control group of women with ongoing pregnancies (58 women). The survey was given to the women at 1, 3, and 9 months after the early pregnancy loss, and to the women with an ongoing pregnancy one month after confirmation of a viable pregnancy. To measure for PTSD, the researchers used the Post-Traumatic Diagnostic Scale (PDS). Anxiety and depression were measured using the Hospital Anxiety and Depression Scale. Both of these tools are well validated. Statistical analysis included the use of Fisher's exact test to compare the variables, with a p value of <0.05 being noted as statistically significant. Results were analyzed only for the one-month and three-month surveys due to a small number of responses (n=26) to the nine-month questionnaire.

At one month, 28% of the early pregnancy loss participants met the criteria for probable moderate or severe PTSD, 32% met the criteria for moderate to severe anxiety, and 16 % met the

criteria for moderate and severe depression (Farren et al., 2016). At three months, 39% of the early pregnancy loss participants met the criteria for probable moderate or severe PTSD, 20% met the criteria for moderate to severe anxiety, and 5% met the criteria for moderate to severe depression. In contrast, there were no women meeting criteria for probable moderate or severe PTSD in the control group. This study's results suggest the need to screen all women who have suffered an early pregnancy loss for PTSD, anxiety, and depression (Farren et al., 2016).

Geller et al. (2001) examined the incidence of obsessive-compulsive, panic, and phobic disorders within six months following miscarriage. Using a cohort design, the researchers studied 229 women who experienced a spontaneous abortion compared to 230 women drawn from the community. Participants' ages ranged from 18 to older than 34 years, with 53% of participants in the 25 to 34 year range.

The women were interviewed using the Diagnostic Interview Schedule (DIS), which is based on DSM-III criteria (Geller et al., 2001). Chi-square tests revealed that the variables were equally distributed between the two cohorts. Using a logistic regression model, the researchers estimated the association between miscarriage and each of the three anxiety disorders using 95% confidence intervals and unadjusted relative risks. To calculate relative risk, the researcher divided the six-month total incidence rate of the anxiety disorder in the miscarriage cohort by the community cohort. The results indicated a significant risk for obsessive-compulsive disorder in women following a miscarriage (Geller et al., 2001). However, the results did not reveal a significant relationship between miscarriage and panic disorder or phobic disorders. The researchers were somewhat cautious in reporting the significance of the relationship between miscarriage and obsessive-compulsive disorder due to the possibility that women with obsessive-

compulsive disorder may be more likely to seek medical treatment following a miscarriage, which could skew the findings (Geller et al., 2001).

In a longitudinal cohort study, Barr (2004) explored guilt and shame's relationship to grief in those who had experienced a perinatal loss. Eighty-six women (mean age 32 years) and 72 men (mean age 34.4 years) participated in the study. At one-month post loss, the participants completed the survey following a semi-structured interview that included providing a loss narrative. At 13 months post loss, the participants completed and returned the survey that was mailed to them. The survey included the Perinatal Grief Scale-33 (PGS-33), Test of Self-Conscious Affect-2 (TOSCA-2), Personal Feelings Questionnaire-2 (PFQ-2), and Interpersonal Guilt Questionnaire-67 (IGQ-67) (Barr, 2004).

Initially, a correlation matrix was developed between guilt and shame using the responses from the TOSCA-2, PFQ-2, and IGQ-67 with Pearson *r*-values ranging from 0.12 (showing a small correlation) to .60 (showing a large correlation) (Barr, 2004). Partial correlations were obtained with early (one-month) and late (13-month) grief (PGS-33) controlling for shame and guilt. Finally, hierarchical multiple regression analysis was completed. TOSCA-2 Shame and PFQ-2 Shame were entered in step one of the series hierarchical multiple regressions. TOSCA-2 Guilt, PFQ-2 Guilt, IGQ-67 Survivor Guilt, and IGQ-67 Omnipotence Guilt were entered in step two. Completing the hierarchical, multiple regression analysis in this fashion allowed guilt to be statistically controlled for shame, allowing the researcher to analyze pure guilt (Barr, 2004).

Results from Barr's (2004) hierarchical multiple regression analysis indicated that shame explained a statistically significant proportion of the variance in early grief in women and men. However, guilt did not contribute to the further variance of early grief. Additionally, shame and guilt both were statistically significant in explaining the late grief experienced by both men and

women following perinatal loss. It also was noted that early shame in men was a predictor for late grief. The findings of this study indicated the tightly woven relationship between shame, guilt, and grief (Barr, 2004) for those experiencing a perinatal loss..

These four studies illuminated the psychological impacts of pregnancy loss. Two studies offered evidence to support the relationship between pregnancy loss and PTSD, anxiety, and depression (Engelhard, 2001; Farren et al., 2016). There also is evidence that relates pregnancy loss to OCD (Geller et al, 2001). Barr (2004) provided support for links between shame, guilt, and grief.

Caring for Patients after Perinatal Loss

Four studies examining the experiences of women who had suffered a perinatal loss provided information to help nurses care for this population. Swanson-Kauffman's (1983) dissertation helped develop the science of providing nursing care for patients experiencing a perinatal loss. Using a combined qualitative methods approach (grounded theory, ethnography, and phenomenology), the Swanson-Kauffman completed two semi-structured interviews with each of 20 participants, ranging in age from 18 to 38 years, in which she asked them to discuss their miscarriage experiences. Each interview was transcribed verbatim, read for accuracy, and analyzed individually as well as within the context of the other interviews. Validity was ensured through the constant comparison of the data from the interviews with previous interviews as well as aligning the findings with previous bereavement studies. The six categories that emerged from the study (coming to know, losing and gaining, sharing the loss, going public, getting through, and trying again) guided Swanson-Kauffman's future work and led to the development of a middle-range theory of caring.

Similarly, Malacrida (1997) conducted a qualitative exploratory study employing unstructured interviews to gather information from 26 participants who ranged in age from 22 to 38 years at the time of their loss. Following Mishler's (1986) method, Malacrida conducted, audio recorded, and transcribed all of the interviews. Participants were invited to share their stories and expound upon their attitudes about parenting, birthing, family, marriage, death, spirituality, responsibility, individuality, and grieving norms. The participants also were asked to share their interactions with interdisciplinary team members including physicians, nurses, medical technicians, social workers, clergy, funeral directors, and insurance agents. Each interview lasted longer than an hour and the researcher noted participants' eagerness to tell their stories (Malacrida, 1997).

Malacrida (1997) used Glaser and Strauss' (1967) constant comparison analysis method to analyze the interview data. She also developed categories and theoretical links to help with further data analysis. Four key categories were identified: "tell me the truth," "tell me what to do," "tell me about what happened," and "tell me what's next." The use of the Glaser and Strauss' (1967) method is designed to produce a theory. However, Malacrida did not present a final theory, which is a limitation of this study. Instead, the findings were aimed at guiding practitioners in the care of those who have experienced the death of their child through miscarriage or neonatal loss (Malacrida, 1997).

DiMarco, Menke, and McNamara (2001) evaluated the effectiveness of support groups in helping with perinatal loss bereavement. Using a cross-sectional, retrospective, two-group design, the researchers studied the grief reactions of 121 participants who had experienced a perinatal loss. Of the 121 participants, 67 attended support groups and 51 did not. The mean participant age was 31.8 years for those who attended the support group, and 32.5 years for those

who did not. The Hogan Grief Reactions Checklist (HGRC) was used along with a demographic questionnaire that included two open-ended questions ("What was the most helpful?" and "What was the least helpful?"). The HGRC has established validity with Cronbach alpha coefficients for the six factors ranging from r=0.79-0.90. Answers to the open-ended questions were analyzed using content analysis (DiMarco et al., 2001).

Interestingly, there were no significant differences noted in the HGRC scores between the participants who attended support groups and those who did not (DiMarco et al., 2001). However, rich qualitative information was gleaned from the responses to the study's open-ended questions. Responses in the most helpful category included crying with the family, having someone "be there" for them, having someone listen to them, assigning meaning to the experience, and having pictures of the baby (DiMarco et al., 2001). The interventions identified as least helpful included being told not to cry, people who failed to acknowledge the experience, people making light of the experience, and being told the loss was for the best. While this study was aimed at determining the effectiveness of support groups, the results actually yielded information that nurses who care for patients who have experienced a perinatal loss can use to ensure they are being as supportive as possible during this difficult time (DiMarco et al., 2001).

Séjourné, Callahan, and Chabrol (2010) used online surveys to asked 305 women what they wanted or found helpful following a miscarriage. Ninety-one percent of the women reported wanting support following their miscarriage. Support could have been in the form of an in-depth conversation with their healthcare provider, group therapy, an informational brochure, or appointments with or referrals to a psychiatrist or psychologist. Furthermore, the women reported wanting support immediately following the miscarriage diagnosis, as well as a few days or weeks after the miscarriage. The women expressed frustration about the lack of information

concerning the psychological impacts of miscarriage, also citing fear about subsequent pregnancies as a significant complication. The women used several strategies to cope with the miscarriage, including seeking information, discussing the loss with others (partner, family members, close friends, and other women who had a miscarriage), participating in online forums, and distracting themselves. This study's findings highlight the desires of women who have experienced a miscarriage concerning the care provided to them (Séjourné et al., 2010).

The studies reviewed in this section suggest that women who experience a miscarriage want support (DiMarco et al., 2001; Séjourné et al., 2010; Swanson-Kauffman, 1983). Additionally, these women desire information about procedures, psychological impacts, support groups and counseling, and how to move forward with their lives (DiMarco et al., 2001; Malacrida, 1997; Séjourné et al., 2010; Swanson-Kauffman, 1983). This information is important to nurses because it provides insight into these women's care expectations.

Nurses' Experiences Providing Perinatal Bereavement Care

Three studies from the literature review described and documented nurses' experiences providing perinatal bereavement care to adults. Chan et al. (2008) used structured questionnaires with 334 participants who worked in five obstetrical units in Hong Kong. Convenience sampling was used to recruit participants. After obtaining appropriate permissions to conduct the study, the research team placed the questionnaires and two return boxes on each of the units. No identifying information was included on the questionnaire, which was developed by the research team and revised based on confirmatory factor analysis results prior to this study. Three factors were addressed in the questionnaire: attitudes about perinatal bereavement care, attitudes about the importance of hospital policy for bereavement care, and attitudes on the training for bereavement care. The goodness of fit indices of the three-factor model indicated that the validity of the

questionnaire was acceptable with a GFI of 0.92, AGFI of 0.84, and CFI of 0.91. The questionnaire's internal consistency also was established with Cronbach's alpha for each of the factors addressed being 0.892, 0.865, and 0.909 respectively.

Chan et al.'s (2008) study results indicated that most nurses agreed that grief counseling and parental support groups were beneficial for bereaved parents and that nurses should support parents in making care decisions. Additionally, a majority of participants believed that parents should be given time to grieve their loss. In regards to hospital policy for managing perinatal bereavement care, more than 90% of the nurses felt that a clear policy should be in place requiring that all staff be well informed about and understand how to handle such cases. Furthermore, a majority of participants felt it was imperative to have training and support to ensure proper care is given to those suffering perinatal bereavement. Overall, participants supported the provision of formal education in giving perinatal bereavement care as well as supportive care for the nurses caring for the bereaved (Chan et al., 2008).

For their qualitative descriptive study, Roehrs et al. (2008) used online surveys and follow-up interviews to survey 10 labor nurses about providing care to families experiencing perinatal loss. The survey and related interview guide included open-ended questions that had been developed, piloted, and refined by the three primary researchers. To maintain confidentiality, research assistants conducted all of the interviews and were the participants' only point of contact with the study. Only the researchers saw the transcripts during data analysis.

Content analysis of the surveys and interview transcripts yielded two categories and six themes (Roehrs et al., 2008). The two categories were coping and providing care, and influencing the context of providing care. The themes were 1) focusing on the care the patient needs, 2) finding support while providing care, 3) recovering after providing care, 4) assigning

nursing staff to provide bereavement care, 5) avoiding compromising care, and 6) becoming more comfortable and knowledgeable about the care. Once data saturation had been reached, the researchers' checked with the participants to ensure that their thoughts and feelings had been adequately captured. Similar to Chan et al.'s (2008) results, these researchers found that nurses desire formal education and support for providing perinatal bereavement care. The researchers also noted that while the nurses felt they were able to provide adequate care to patients experiencing a perinatal loss, they often felt uncomfortable doing so (Roehrs et al., 2008).

Puia, Lewis, and Beck (2013) used qualitative content analysis to explore the effects of perinatal loss on obstetrical nurses. This study was a secondary analysis from a parent study involving obstetric nurses who witnessed a traumatic birth. The parent study asked nurses to provide written responses about their experiences with traumatic birth. This secondary study involved only the written responses from the nurses involved with a perinatal loss. For the secondary study, 91 of the written experiences were analyzed using Krippendorff's (2013) method for qualitative content analysis. Using this method, the researchers closely read each of the participant responses and then grouped them into clusters of themes. The themes were reviewed by all three researchers to ensure consistency of data interpretation. Six overarching themes were identified: 1) getting through the shift, 2) symptoms of pain and loss, 3) frustrations with inadequate care, 4) showing genuine care, 5) recovering from traumatic experience, and 6) never forget. These findings emphasized the need to supply support measures for nurses who care for patients experiencing perinatal loss and the authors suggested debriefing as a beneficial tool for helping nurses cope with their experiences (Puia et al., 2013).

Adolescent Perinatal Loss

Only three studies addressing the experience of spontaneous pregnancy loss among adolescents were found. Welch and Bergen's (2000) exploratory qualitative study used the case studies of six adolescent mothers mourning the loss of their infants to stillbirth or neonatal death. Using in-depth, semi-structured interviews, the researchers sought a better understanding of the young mothers' emotions, feelings, and behaviors. All of the participants were Caucasian females ranging in age from 15 to 17 years. Four participants experienced the death of their neonate, while two experienced a third-trimester stillbirth. Five of the young women came from middle-class backgrounds, while one lived in poverty-level conditions. Each participant was interviewed privately by the primary investigator at two, four, six, and 12 months post loss. Four primary areas were addressed in the interviews: identity issues, separation from family of origin, peer relationships, and bereavement support.

Welch and Bergen's (2000) findings suggested both similarities to and differences from bereavement in adults coping with stillbirth or neonatal death. Similar to adults, the adolescents exhibited fluctuating emotions including confusion, disbelief, denial, disorganization, anger, guilt, blame, fear of "going crazy," anxiety, searching/longing, and a desire for a subsequent replacement child. Unlike adults, the adolescents all resumed sexual activity within two to three months after the loss. Also in stark contrast to adults, the adolescents did not report feeling guilty for resuming sexual activity. All participants reported feeling that their friendships changed after the death of their child. The findings indicated that the two participants with access to bereavement support groups felt uncomfortable attending them and therefore chose not to do so. Additionally, none of these young mothers received educational information following their child's death. Welch and Bergen (2000) indicated that the study uncovered the need to educate

caregivers about the implications of this traumatic event during adolescence, provide appropriate patient education, and increase the availability of support groups for bereaved adolescents.

Sefton (2007) conducted a qualitative study examining the bereavement experiences of 14 Latina women who had a miscarriage as an adolescent. Guba and Lincoln's (1981) procedure for naturalistic inquiry was used to guide the study's data collection and analysis. After obtaining IRB approval, the researchers conducted interviews in a private office or in the participants' homes. After giving demographic information, participants were asked to describe their miscarriage experience including how they felt at the time of the loss, and how they felt about it at the time of the interview. Along with questions about significant relationships, dating and sexual practices, life goals, and personal religious practices, participants also were asked if they felt the experience changed them and if they learned anything from it.

Using the Integrative Theory of Bereavement, Sefton (2007) sought to divide the responses into each of the theory's five bereavement phases: shock, awareness of loss, conservation/withdrawal, healing, and renewal. The researcher found that most of the women expressed feelings characteristic of the shock phase when the loss occurred. At the time of the interview, no participants remained in the shock phase, and all acknowledged awareness of their losses. Eight participants seemed to have gone through a withdrawal period at the time of the loss. Statements of healing were noted in most of the interviews. All participants showed signs of renewal and moving on with their lives. The responses in this study support the Integrative Theory of Bereavement as an adequate representation of responses to grief following a miscarriage. Limitations of this study include the fact that the sample included only young Latina women. The pre-selection of a theoretical framework—a practice not typical in narrative research—also can be considered a study limitation. Sefton suggested that future studies include

women who are further removed from the experience in order to gain a better understanding of the long-term sequelae.

Fenstermacher (2014) highlighted the experiences of African-American adolescents who had suffered a perinatal loss. Symbolic interactionism guided this grounded theory study, which employed the Corbin and Strauss (2008) method. After obtaining IRB approval, eight Black adolescent females (ranging in age from 18 to 21) elected to participate in the study. The researcher aimed to conduct three in-depth interviews with each of the participants. Using a semi-structured interview guide, the first interview was conducted as close to the loss as possible, the second around six to nine weeks after the loss, and the third around 12 weeks post loss. Four participants completed all interviews, three completed the first two, and one withdrew after the first interview due to illness. The audio recordings from the interviews were transcribed verbatim and read by the researcher for accuracy. Data saturation was reached in all categories. Constant comparison was used with each interview transcription. Member checking was completed with two participants to gauge how well the researcher captured and interpreted their responses and feelings.

The core category that emerged from Fenstermacher's (2014) study data was "enduring the loss." The process participants described included phases of "denying and hesitating," "getting ready for this whole new life," "suffering through the loss," "all that pain for nothing," "mixed emotions going everywhere," "reaching out for support, " "preserving the memory and maintaining relationship," "searching for meaning and asking why," and "gaining new perspective on life." These findings reaffirmed this population's need for emotional support and educational help (regarding physical changes such as lactation and fatigue). The author also

emphasized the need for future research to include adolescents of all races who have experienced perinatal loss (Fenstermacher, 2014).

These three studies began to define the experience of adolescent pregnancy loss. From these articles we understand that these mothers have an emotional response to pregnancy loss (Welch & Bergen, 2000), move through the stages of grief (Sefton, 2007), and desire support and information from care providers (Fenstermacher, 2014). Each of these studies highlights the need for more research concerning this population to increase the depth of nursing knowledge surrounding this phenomenon.

Nursing Care for Adolescents Suffering a Perinatal Loss

Only one study specifically addressed the nursing care needs of adolescents suffering a perinatal loss. Peterson et al.'s (2012) descriptive quantitative study employed key informant surveys to determine if perinatal nurses identified a need to improve the care of adolescent mothers experiencing a perinatal loss. Using purposive sampling, the researchers sought out knowledgeable informants who shed light on the organizational structures surrounding perinatal bereavement care of the adolescent. After receiving appropriate Research Ethics Board approval, research assistants administered the 25-item survey developed by the researchers. The survey had been reviewed for content validity prior to the study by an advisory committee and pretested at one of the research study sites. The survey included eight demographic, two Likert-scale, and 15 yes/no questions. The non-demographic questions were drawn from existing surveys that had been modified slightly to address this study's needs. Twenty-seven key informants from eight perinatal units in a Canadian city participated. Research assistants administered the survey, kept field notes, and quoted the key informants' explanations of their survey answers. The results of Peterson et al.'s (2012) study identified a need to educate nurses about caring for adolescents

experiencing perinatal bereavement. Peer mentoring and self-reflection were suggested by the researchers as strategies to assist with developing knowledge about caring for adolescents suffering perinatal bereavement.

Summary

Research in the current body of medical and nursing literature describes and documents how adults experience perinatal loss, the possible long-term psychological effects of the experience, and some nursing care recommendations for this population. Three studies examined the experiences of nurses who provided care for mothers who lost a fetus or infant. Only three studies—with limited generalizability—looked at the experiences of adolescents who had suffered a perinatal loss. The one study that examined nursing care for this specialized population indicated the need to build knowledge in this area. Moreover, with no phenomenological studies examining the lived experience of adolescent pregnancy loss, very little is known about how adolescents experience this kind of loss. Without access to this knowledge, nurses may struggle in caring for adolescents who have lost a child. The current study was designed to begin to fill this research and knowledge gap, shed light on the psychological impact of perinatal loss in adolescents, and help nurses care for this previously unstudied population.

Chapter Three: Methods

There is a sizeable gap in the nursing knowledge about adolescents' experiences of pregnancy loss. The researcher sought to gain insight into this phenomenon using Merleau-Ponty's existential phenomenology as her study's guiding methodology. This chapter presents the study's design and procedures including its sample, researcher protection measures, human subjects protection measures, bracketing and pilot interview information, data collection and analysis procedures, and methods for ensuring study rigor.

Design

This study employed Thomas and Pollio's (2002) interpretive methodology inspired by the work of existential phenomenologist Merleau-Ponty (1945/2012). This methodology includes specific procedures, depicted in Figure 3.1, through which the researcher completes a study in four phases: self as focus, participants as focus, text as focus, and research community as focus.

Self as Focus

To focus on *self*, the researcher participated in a bracketing interview during which she was asked two primary questions: "What about the topic was important enough for you to make it the major concern of an investigation?" and "In what ways or situations have you experienced the phenomenon?" (Thomas & Pollio, 2002, p. 44). The purpose of the bracketing interview was not to encourage objectivity but to increase the researcher's awareness of her assumptions, biases, and personal beliefs about the study topic. This vital step helped the researcher prevent her preconceptions from influencing data collection and analysis.

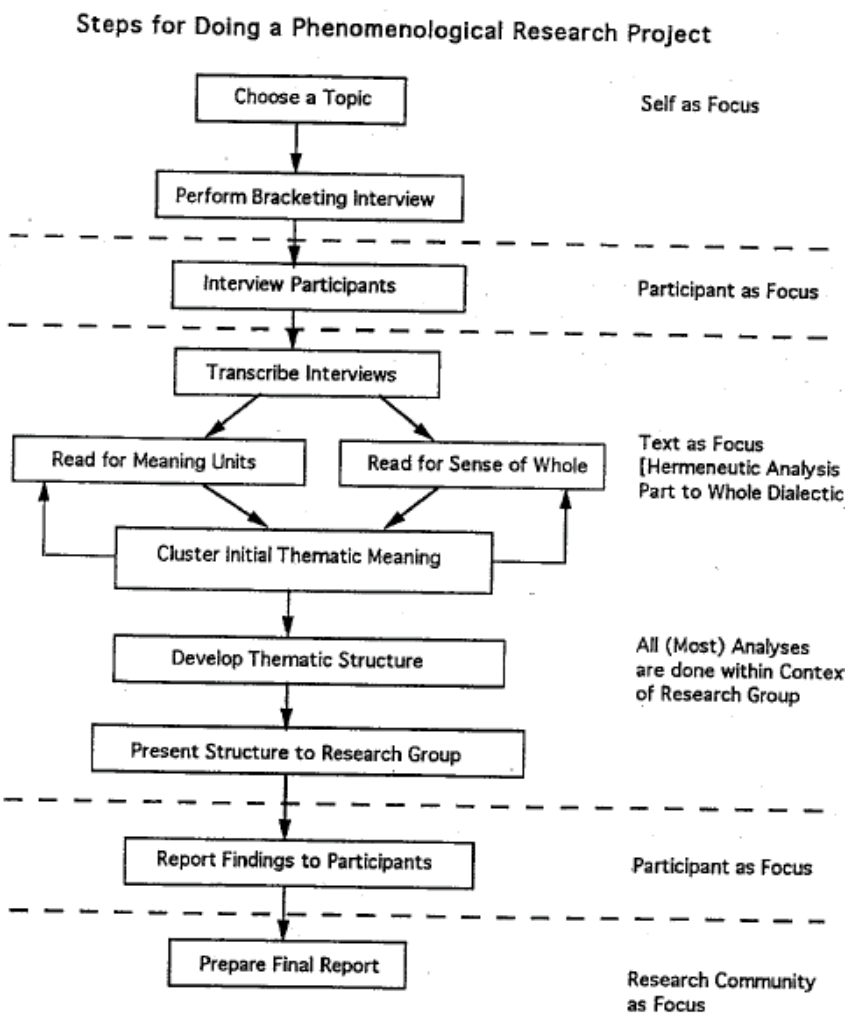

Figure 3.1 Summary of Steps for Conducting an Existential-Phenomenological Study

Note. From Thomas, S. P., & Pollio, H. R. (2002). *Listening to Patients: A Phenomenological Approach to Nursing Research and Practice*. New York, NY: Springer Publishing Company. Reprinted with permission.

Participants as Focus

Next, the study focus shifted to the *participants*. During this phase, it was essential that the researcher find ways to elicit deep, meaningful responses during her personal interviews with the participants. To receive in-depth responses that produce rich data, the researcher worked to ensure that participants felt safe and relaxed during their interviews. Furthermore, the researcher gained the participants' trust so they would feel comfortable discussing their personal feelings and intimate experiences. Lastly, the researcher co-constructed the dialogue by remaining respectful, sensitive, and open to the participants' responses while refraining from asking leading questions that could cause participants to answer the way they thought the researcher wanted them to, rather than how they truly felt.

Text as Focus

Next, the researcher focused on the *text* generated during the interviews. During this step of the interpretive process, the researcher began analyzing the verbatim interview transcripts by searching for meanings and themes presented in the participants' words. This step also included working with IIRG to identify themes from the transcripts and develop a thematic structure. The last portion of this phase included reviewing the findings, themes, and thematic structure with some of the participants to ensure the overall meanings of their experiences had been captured.

Research Community as Focus

In the final phase, the researcher focused on disseminating study results to the *research community* to contribute to the advancement of nursing science. The research report includes the research procedure, methodology (i.e., existential phenomenology), and methods (i.e., Thomas and Pollio's phenomenological procedure) (Thomas & Pollio, 2002), bracketing interview themes, significant findings, and practice implications.

Procedures

Participant Selection

The population studied for this research project was women who experienced a pregnancy loss as an adolescent. Flyers were posted at clinics and community outreach centers as well as on the Facebook social media platform (Appendix A). Additionally, participants were recruited by word of mouth and snowball sampling techniques. To be included in the study, participants must have

- been age 25 years or older;
- experienced a perinatal loss as an adolescent aged 15–18;
- no diagnosis of pre-existing mental health disorders prior to the loss;
- been able to speak, read, and write in English; and
- been willing and able to complete a one-hour, open-ended interview.

Initially, the researcher sought to interview 10–12 participants. However, due to the great difficulty experienced in participant recruitment and retention, only four interviews were conducted. Despite the small number, the researcher noted adequate convergence of themes to gain perspective concerning the studied phenomenon.

Human Subjects Protection

Prior to beginning the study, participants were informed about the risk of participation (that the interview questions might bring back painful memories of perinatal loss) and the resources available to address that risk (outpatient counseling services) (Appendix B). Three local counseling resources agreed to provide services for this study. The first resource is a facility with counselors in four rural locations spread across four counties. The second resource is a local Advanced Practice Nurse Practitioner who specializes in mental health nursing and

works under the supervision of a psychiatrist. The third resource is an independent counselor who has an office in a larger urban area. Participants were given contact information for these resources they could use if they experienced painful memories threatening their mental health. The participants also were told about the free National Crisis Hotline, which is accessed by calling 1-800-784-2433.

The researcher was the participant's sole point of contact. Participants were informed that they could withdraw from the study at any time without facing any negative repercussions. No personal information about the participants was released. Participants were given the opportunity to choose a pseudonym to be used during the interview. If no pseudonym was chosen, the interviewer assigned pseudonyms at the time of transcription (e.g., first participant Anna, second participant Barbara, etc.) and only these pseudonyms appeared on the typed transcripts reviewed by the IIRG. No oral or written references were made that could link the participants with the study. Informed consent was obtained prior to the participants beginning the interview (Appendix C) and each received a copy of their signed consent form. The signed consent forms were the only identifying information kept by the researcher. To protect participants' identities, the consent forms were kept in a locked file cabinet.

The transcriptionist signed a confidentiality form stating that she would not release any interview information. For added protection, the interview transcriptions were kept in a separate locked file cabinet and the audio recordings were stored on a password-protected computer. The researcher destroyed all audio recordings and interview transcriptions at the study's conclusion. The signed consent forms will be kept for three years in a secured location as required by the UTK IRB.

Researcher Protection

To avoid suffering mental distress from conducting interviews likely to elicit emotions such as grief, sadness, and empathy, the researcher took precautions to maintain her psychological well-being through peer debriefing sessions and journaling. Confidentiality was maintained, as the researcher did not release participants' identifying information to her peer. The peer debriefing sessions allowed the researcher to discuss her feelings about the participant interviews openly and helped reduce the psychological distress that could have arisen during data collection. The researcher also journaled as a way to express personal thoughts and feelings throughout the research process and relieve distress. The researcher ensured journal entries were kept confidential and did not identify participants.

Setting

Interviews were conducted via telephone per each participant's request. The researcher conducted the interviews in a quiet and private environment, free from outside distractions. The researcher asked that the participants also remain in a quiet environment, free from distractions, for the duration of the interview.

Bracketing Interview

An individual knowledgeable in existential phenomenological methodology conducted a bracketing interview to help the researcher identify assumptions, prior knowledge, and personal theories about the proposed phenomenon that needed to be put aside to avoid skewing the study's data interpretation. The IIRG reviewed and interpreted the interview transcript and shared the results with the researcher. This interview provided the basis for this study's assumptions.

Shortly after beginning data collection for this study, the researcher experienced a pregnancy loss of her own. After taking a few weeks to recover, she contacted her chair to determine the best way to ensure that her personal experience did not interfere with data collection and analysis. It was decided that journaling her personal experience would allow the researcher to identify her feelings surrounding the loss and effectively bracket them for data collection and analysis. The researcher does not feel that her personal experience hindered this study in any way; in fact, she believes it helped her be more empathetic to these women's situation because she had a personal understanding of the experience.

Pilot Interview

A pilot interview was conducted with the first study participant and shared with the IIRG. The group gave the researcher feedback on the richness of the interview as well as ways to improve her interview technique. This information was invaluable to the novice researcher as it helped to refine the data collection procedures used for the remaining interviews.

Data Collection

The use of open-ended interview questions allowed participants to narrate their experiences in their own way. The researcher used the same approach for each interview, allowing the flow of the conversation to guide subsequent questions to capture each individual's experience more fully. The participants were asked to speak freely about their pregnancy loss, sharing what the experience was like for them. Opening statements include "Please tell me what it was like for you to experience the loss of a pregnancy during adolescence" or "Please tell me about what stands out to you when you think back upon your experience of pregnancy loss during adolescence." Subsequent questions were posed only to elicit elaboration and clarification. The interviews ended when the participant felt she had nothing further to add. With

the participant's consent, the researcher recorded the interviews using an audio recorder. Immediately after the interview, field notes were recorded including observations of the participant's nonverbal communication, the interaction's level of ease and flow, and any unusual events that occurred. Demographic data was collected using a demographic questionnaire (Appendix D). Data collection began in November 2015. Solicitation of participants continued until August 2017. The fourth and final participant interview was conducted in April 2017. In August 2017, after determining there was a convergence of themes from the four completed interviews, the dissertation committee concurred that data collection was complete.

Data Analysis

Data analysis procedures for an existential phenomenological study are well described by Thomas and Pollio (2002) and Sohn et al. (2017). A transcriptionist who signed a confidentiality agreement transcribed interviews verbatim (Appendix E). The IIRG members assisted with transcript analysis. Each group member signed a confidentiality pledge prior to reviewing any transcripts (Appendix F).

Each transcript was read aloud, discussed, and subjected to provisional thematizing by IIRG members. During transcript analysis, the group identified meaning units (words, phrases, or metaphors participants used to describe their experiences). These meaning units were viewed individually as well as within the context of the transcription as a whole. This process yielded the initial clusters of thematic meanings that generated the thematic structure. A thematic description was completed for each interview transcript. While group feedback was important for data analysis, the ultimate authority was the text itself. Support for any proposed theme was found among the participants' words.

Using this same process, the researcher engaged in further interpretation of all transcripts. Data saturation (convergence of themes) was identified after four interviews, and data collection ceased. According to Thomas and Pollio (2002), it is not unusual for consistencies in descriptions of a phenomenon to become evident after three to five interviews. Upon completion of transcript thematization, the proposed themes and supportive text sections were presented to the IIRG. The group helped the researcher make final themes determination after their examination of the supportive evidence. Lastly, the researcher developed the final thematic structure and presented it to the IIRG for their consideration. A diagram of the thematic structure was developed to enhance the study findings.

Ensuring Rigor

To ensure this study's scientific rigor, the researcher followed the existential phenomenological method outlined by Thomas and Pollio (2002) and Sohn et al. (2017). Using the IIRG helped the researcher ensure her personal biases and assumptions did not skew her data interpretation. This sentiment is supported by a statement from van Wijngaarden, Meide, and Dahlberg (2017), "it is indispensable to engage in ongoing dialogue with other researchers as this helps to reduce blind spots, and challenges us to see the phenomenon and one's evolving understandings 'with new eyes'" (p. 1741). Furthermore, employing the collaborative knowledge and expertise of IIRG members helped relieve the overwhelming feelings often associated with interpreting large amounts of qualitative data. Using the IIRG helped the researcher ensure that she accurately captured the essences of the participants' experiences and developed a plausible thematic structure.

Care was taken to allow the participant responses to guide the interviewer's questions. This method helped the researcher avoid steering the conversation, which could have caused her

to miss key experiences that participants share when they guide their own interviews. Furthermore, the researcher obtained data dependability and confirmability through meticulous note taking and constant comparison of the interview transcriptions.

A perceived weakness associated with the phenomenological approach is the lack of replication. Brink (1998) stated, "No single researcher can return to the same participants, ask the same questions, and receive the same answers" (p. 318). However, if another study is conducted on the same phenomenon using the same population as the initial sample, the results of the second study likely will support and extend or broaden the previous study's findings (Thomas & Pollio, 2002). This study's findings were confirmed with some of the participants. This member checking process allowed the participants to confirm that the meanings of their experiences were correctly interpreted. Through member checking and comparing the current findings to those of previous studies, researchers can strengthen their study's validity (Creswell, 2013).

Qualitative studies often are cited as lacking generalizability. Conversely, Thomas and Pollio (2002) stated that "…when and if a description rings true, each specific reader who derives insight from the results of a phenomenological study may be thought to extend its generalizability… unlike other research methods, in which the researcher establishes generalizability based on statistical and experimental procedures, phenomenological research is 'validated' by its readers" (p. 42). Furthermore, van Wijngaarden et al. (2017) praised the generalizability of phenomenological research based upon the method's quest to understand the essence of meanings, citing this as the method's core strength.

Summary

Practicing nurses who interact with women who have experienced pregnancy loss in adolescence may view the study findings as transferable to their clients and useful in counseling them. This study's rigorous process was chosen to achieve results that describe the studied phenomenon. However, as is the case with all research, an apodictic certainty is not achievable.

Chapter Four: Findings

The purpose of this study was to describe the lived experiences of adolescents who had experienced a pregnancy loss. This chapter presents the thematic structure that emerged from the participants' interviews. Participants' demographic data also is presented. The existential grounds for pregnancy loss during adolescence are discussed along figural themes.

Four study interviews were completed between November 19, 2015 and April 25, 2017. Participants were Caucasian and ranged in age from 29 to 58 years old at the time of the interview. Participants were 17 (3) and 18 (1) at the time of their pregnancy loss and reported gestational ages of the pregnancies at the time of the losses between nine and 16 weeks. All four participants have since had children, with only one having a second pregnancy loss. None of the participants had electively terminated a pregnancy or was pregnant at the time of the interviews. Additionally, all four participants were in loving relationships with the father of their baby at the time of the pregnancy and loss with three of the participants going on to marry their partner.

Existential Grounds

Utilization of Merleau Ponty's philosophy requires that human experiences be contextualized within the four existential grounds of *time*, *body*, *world*, and *others*. These existential grounds were presented in detail in Chapter 1. In this chapter, the existential grounds that contextualize the experience of pregnancy loss during adolescence, are presented followed by discussion of the figural themes of the experience.

Time is a nonlinear, subjective experience (Merleau-Ponty, 1945/2012). During participant interviews, it was evident that time had not dulled their memories. The past was still vivid as these women told their pregnancy loss stories. Participants speculated about the timing of the loss, whether "it was just not my time" or "not God's time." For some participants this loss

was a turning point in their lives after which they "grew up really fast." Participants expressed that it "took time" to process the loss. Even with the passage of time, participants expressed that they still think about the baby. All participants described this as a difficult time in their lives.

References to the body occurred throughout the interviews as participants discussed what happened to their physical bodies as well as the psychological impacts of the loss. Participants described the physical pain, cramping, and bleeding associated with pregnancy loss. In addition, they described having their bodies examined during this experience. Internal feelings were described with statements such as "my heart was broken."

The participants described the world in which this experience happened to them. Within their lifeworld, they did not fit in with societal expectations. Participants discussed that they had "sinned" by having sex out of wedlock. This discussion of sin gives context to the world these participants lived in and its societal norms. For these participants the world of adolescent pregnancy loss was judgmental ("people shunned you"). Participants' felt "overlooked" and thereby unimportant and undeserving of proper care by a cold healthcare system.

The existential ground of others included healthcare professionals, family members, the baby, friends, and subsequent children. However, with all of these others being present in their stories, each of these women also depicted their loneliness, stating that they were "always alone" during the miscarriage experience and "didn't cry in front of anybody." In these interviews, healthcare providers, particularly physicians, were presented as having a "cold" and "callous" manner and "no compassion." The babies that were lost also were discussed, a subject which will be elaborated in the figural themes discussion. In the following section of the chapter, themes are described using the participants' in vivo language as much as possible, in accordance with

Thomas and Pollio's method (2002). Verbatim quotations from the transcripts provide support for each theme. Names of participants are pseudonyms to preserve participant confidentiality.

Figural Themes

Theme One: "It was an emotional roller coaster"

The researcher would be remiss not to mention that finding out you are pregnant as a teenager is typically a distressing situation in itself. This event often begins the emotional rollercoaster these young women will be on while going through this experience. Emotions described by the participants include feeling stressed, overwhelmed, terrified, excited, sad, guilty, and confused.

Shortly after finding out she was pregnant at 17, Beatrice and her boyfriend were married. At approximately 12 weeks gestation, Beatrice found out her pregnancy was a hydatiform mole or molar pregnancy, a rare, non-viable form of pregnancy. After this discovery, she had a dilation and curettage of her uterus to remove the products of conception, thus ending her pregnancy. In describing her loss, Beatrice stated:

> It, it was, it was definitely um, you know an emotional roller coaster for sure. You know um, cause it's finding out you're pregnant and then finally coming to terms with it going "Ok, so you know I'm 17, but I'm gonna have a baby," then I, I'd, by the time I had to come to terms with that, then it was "Ok, you're no longer pregnant"… Um, ah, for one, I was scared to death. That was the first emotion that I went, went through. I was, you know, I was a junior in high school... scared was definitely the first, first emotion and then um, with that pregnancy, you know my, with my belly growing really fast, it was, it was, that was exciting, but come to find out it was probably growing so fast because of

the fact that it was a molar pregnancy. Um, it wa, it was a lot of the emotion to it, was just ah, really shock, not really a feeling to wrap my head around it.

Diane also found herself pregnant at the age of 17 after a round of antibiotics caused her oral contraceptives to be ineffective. For Diane, the loss relieved her of the need to tell her parents that she was pregnant and it took her "a couple of years" to process the loss. At the time of the loss, she recalled being "terrified" because she did not know for sure what was happening. She and her boyfriend hid the loss and she did not seek medical care for quite some time. Diane grew up in a very strict, religious home and she knew her parents would be disappointed in her for becoming pregnant. She eventually told her mother about her miscarriage about two years after the loss, but she never told her father. Of her pregnancy loss, she said:

> I think for the first, I don't know probably several months to a year, I was more so relieved um, kind of scared all the same time 'cause I still didn't really know what was going on or how it could have happened, you know that I was on birth control and ya', it failed me at some point and I didn't know why because I knew I always took it um, and then after like I said about that year, I was just, I was upset. You know I felt I, I could be here with a baby. I love babies that I was working at a daycare at the time, um, you know and I thought "I could have done this easily," however, I did not know then, what I know now and ah, there's no way now that I think I could have done the best job at the time.

Feelings of confusion also were present throughout the transcripts. Both Alice and Caroline were confused by the medical terminology (spontaneous abortion) the healthcare providers used. Both mentioned being very unsettled by the use of the word *abortion* as they thought it meant that they had chosen to get rid of their babies. Alice stated that this was an

emotionally “difficult” and “traumatizing” time because she wanted and was excited about her baby and she “couldn’t figure out why this was happening.”

Similarly when Caroline experienced a miscarriage she was scared and unsure of what was going on and recalled “screaming” frantically for her sister to help her get to the hospital when she started cramping and bleeding. In addition to her fear at the time of the loss, Diane expressed that she still fears that “... it could happen again...”

This theme describes the emotional roller coaster of pregnancy loss, which encompasses the emotions at the time of the loss as well as those preceding and following it. The highs and lows of human emotions are experienced during a pregnancy and the subsequent pregnancy loss. The description of these emotions gives meaning to the pregnancy loss by showing the wide array of emotions that may be felt by these participants during a very short time period.

Theme Two: My baby and I were less important to them [health care providers]

This theme highlights the emotions these women faced when interacting with healthcare providers. These emotions included feelings of being overlooked and unimportant based upon their socioeconomic standing and the prevailing societal norms regarding the unacceptability of unwed teenage pregnancy.

Caroline, who became pregnant at 17, realized something was wrong when she began having painful cramping and bleeding. Her 15-year-old sister drove her to a small rural hospital where she encountered an ER physician whom she perceived as “cold” and “callous.” She recalls this event vividly:

> the doctor came back there and my mom, the first thing my mom said was “Is she ok to go to the larger hospital?” and I don’t know if it made him feel like you know we didn’t trust him, which I really didn’t but ah, you know he just kind of lifted up my gown and

looked between my legs. Didn't even touch me, just lifted up my gown and looked between my legs and said, "Yeah, she's ok to go," and didn't send me by ambulance, [but] had my mom drive me to the hospital in another town…"

Caroline also described the insensitivity she encountered when she arrived at the larger hospital as she was placed on the maternity ward in a room next to a new mother and baby. She described this agonizing situation by stating, "I could hear the babies crying and of course that night, I didn't get much sleep. I just kept crying. I just remember crying all the time. It was just awful hearing those babies when I had just lost mine."

Alice found herself pregnant at 17. She described herself as being "poor" and felt judged by the physician she went to immediately following the loss. Her miscarriage occurred at home, her mother retrieved the baby from the toilet and placed it in a jar to take to the clinic. She stated that the obstetrician she encountered had

"no compassion," stating "for him, it was "this is the best thing you [could've] had," you know I had no right having a baby anyway at this age um, and he had that jar and he kind of, you know shook that baby around in the jar…"

Her perception was that this physician might have thought she had aborted this baby deliberately. She felt like this doctor treated her like "something less than a person." Additionally, Alice recalled feeling overlooked when she returned to that clinic years later:

I mean years later when I went back to that um, same obstetrician later in life, one of the um, one of obstetricians looked at my chart and said "Oh, still marri," or no, "divorced?" and I said "No, still married to the same man," but see that was the attitude they had that I was just a loose and that I, you know I was on Medicaid and I was gonna have this baby and that kind of thing. And my baby was less important. You see what I mean, my baby

was less important than someone whose baby, who, who is married and who um, you know who was older and who had insurance and could afford a baby and do you see? I mean that's kind of the way is my baby had no importance. It was a good thing that my baby was gone, 'cause well, it was good thing I wasn't having a baby at this point.

Beatrice expressed that, based upon the rarity of her condition and that many healthcare providers she encountered had never actually cared for a patient with a molar pregnancy, the providers were more inquisitive about her particular experience, but not necessarily empathetic. She felt like the nurses interacted with her more out of curiosity than because they cared about her situation.

This theme describes the interactions these women had with healthcare providers and illustrates their perceptions of others judging them and being generally unsupportive and not empathetic towards their plight. The participants give strong meaning to their experience by showing that they did not feel that they received the care they deserved.

Theme Three: "It was all my fault"

In an attempt to understand what went wrong, the participants often blamed themselves for the loss, immediately thinking of anything in their lives that might have caused them to lose their baby. Caroline recalled working outside and overexerting herself the day before her miscarriage:

I just felt that it was all my fault if I had, if I had, you know just taken better care of myself. If I hadn't tried to do too much. Um, and I, it even went so far as like I dated a lot of guys and I thought well maybe if I hadn't, you know just been not really boy crazy, but you know if I had just waited until I got married, then maybe I wouldn't have lost the baby.

Thoughts of being punished for previous "sins" or misconduct also were evident throughout these transcripts. To begin, Alice stated "... I felt very guilty about it maybe because um, maybe God was punishing me because I had been, you know I, I was pregnant without being married and that kind of stuff…" Alice, who felt judged for being pregnant as a teenager in her small hometown, also went on to say:

> you know you've done something that isn't socially acceptable. I guess, you know I know that people were angry. I knew that lots of people didn't think that me having a baby when I was 17 years old was good thing. Um, I knew all of that and I knew that, you know ah, according to society, according to Biblically that um, you know I had committed a sin, you know I had sex before I was married and, and um, and of course at that point, I thought I was the only one you know in the whole world um, that outside of my family and um, so I thought that because I wasn't worthy, because I had done something wrong, that God had punished me by taking this baby...

Diane, who grew up in a very strict, religious household expressed she felt she was being punished:

> Well first for having sex out of wedlock and at 17 years old, um for being kind of wild, presumptuous um, we drank alcohol at the time and you know there were just a lot of things that we did that we should not have been doing um with our lives and I think some of that um, ah, I mean that could have, I was on antibiotics around the time that I think that I would have conceived um, but as I said, we also um, we also drank under age, so that could have played a factor in it as well.

It was essential for each of these women to come to terms with the fact that they did not intentionally cause their pregnancy loss. This theme illustrates the sense of blame and

guilt these women felt at the time of their loss. They needed someone to support them and tell them that this loss was not their fault and while they all stated that they did come to be at peace with the loss, getting there took time and truly understanding they did nothing wrong. Diane and her partner sought pastoral counseling to come to terms with the loss, stating "Um, so we sought forgiveness for our sins but realized that we didn't do anything to you know ultimately cause the miscarriage though."

Theme Four: "I will always wonder"

For these women, this loss leaves many unresolved questions about who the baby would have become. Throughout the transcripts, there is evidence of mourning that life that never came to be. During her interview, Caroline said, "I mean, I still think about the baby that I lost, but you know what he or she might have been, you know they could have been the President and I will always wonder about that…" Alice also expressed this sentiment by stating:

> Well, even though I was only just four months along, you know I had dreams for this baby. I mean I wa, I was a kid and they and, and I agree there were probably childish dreams, but I dreamed about names and I dreamed about what they'd look like and what I would buy it and you know I just as, as childish as it may have been, you know some of my dreams may have been about this child, it was still my child and um, and all the things that you know others saw as a stumbling block, um you know like not being married and all this stuff, well I was too young and naïve to realize that those were stumbling blocks. Do you? You know I mean that's kind of the way I was, I, I um, I just ah, I loved that baby and now as, you know as an adult, I realize that you know sometimes things like that happen…

Diane also echoed this feeling by stating "...We were just too young um, and we finally became at peace with it, but not a day goes by 11 years later that I don't still think about it…" and "I was just wondering what that child would be like, what my life would be like... I feel like I have unanswered questions."

This theme highlights the desire that these women have to know what that lost baby would have been like. This adds richness and depth to the meaning of their adolescent experience because it shows that no matter how long it has been since the loss, this baby is still remembered and wondered about, illustrating the long-term impact of pregnancy loss during adolescence.

Theme Five: "Everything happens for a reason"

In an attempt to reframe their experience and justify the loss, the participants made statements alluding to the age-old adage that "everything happens for a reason." Beatrice expressed doubts about her parenting abilities as a teenager by stating: "I've always thought everything happens for a reason. Looking back, you know I don't think I would have been able to ah, be a good enough mother at 17 um, a selfless mother at 17."

Beatrice also gave meaning to the experience by showing how the loss has helped her to be more open with her children now.

> It definitely um, as a parent, has made me you know be more um, open with my kids and you know ah um, he knows that I got pregnant at 17 and how it, you know dramatically changed my life path for sure…so hopefully as a parent, it, it helped, hopefully it's helped me um guide my kids in the right direction.

Likewise, Caroline was happy with how things worked out because had she not experienced a pregnancy loss during her first pregnancy, she would not have had her oldest son:

> If I hadn't lost that child, I wouldn't have my oldest child that I have now ah, and he is, he's brilliant. I mean I ca, I can't even describe how smart and funny and wonderful he is, but I had to have another child to appreciate, I mean I had to have my oldest child to appreciate that if I had not lost the first one, I wouldn't have him…but I wouldn't have had Clay if I would have the first one so overall, I'm, I'm happy with the way things worked out.

Diane, who went on to become a nurse, marry someone else, and have a daughter, reflected on her loss stating, "It helps me appreciate my daughter more." She also expresses how the loss has helped her to achieve goals that would have otherwise been delayed:

> I do think that things happened for a reason and that God knew what He was doing and it, definitely let me be where I am today with school and following my dreams and my career um, that I don't think that I would have had the opportunity to do otherwise if I had a small child at 17.

She also feels that this experience helps her in her professional role as a Labor and Delivery nurse by stating

> It helps me empathize with them a little easier because I've been there before um, granted, you know like I said I was still early in my pregnancy. I was young, um, but I still think that it helps me empathize with them a little easier.

Diane gives meaning to her experience of loss by showing how it has helped her to help others in a similar situation. Even though she did not have a negative encounter with a healthcare provider during her loss, she understands the importance of being caring and supportive of someone experiencing a pregnancy loss.

This theme brings to light that these women have accepted their loss. The understanding that "everything happens for a reason" follows the thoughts of the loss being their fault. Once they are able to recognize that the loss was not their fault, they begin to understand that sometimes "things just happen." This theme also gives meaning to the loss experience by explaining that without this loss occurring, these women's lives would have been different. They would have forever been on a different life trajectory than the life they have presently lived. They have integrated this experience into their definition of self and who they are.

Thematic Structure

The themes, "it was an emotional roller coaster," my baby and I were less important to them [health care providers], "it was all my fault," "I will always wonder," and "everything happens for a reason" are shown in the diagram of the thematic structure below. The emotional roller coaster is directly related to the blame and guilt felt the participants when they thought they caused the loss. The emotional roller coaster also is related to the anger participants experienced when they felt that they and their babies were not important to the health care providers. Upon becoming at peace with the loss, the participants expressed understanding that sometimes pregnancy loss is no one's fault. Therefore, there is a direct relationship between participants' self-blame and the peace that followed once they realized they did not cause the loss. However, even with accepting that everything happens for a reason, the participants expressed that they will always wonder about the baby that was lost. The thematic structure developed from this study is shown in figure 4.1.

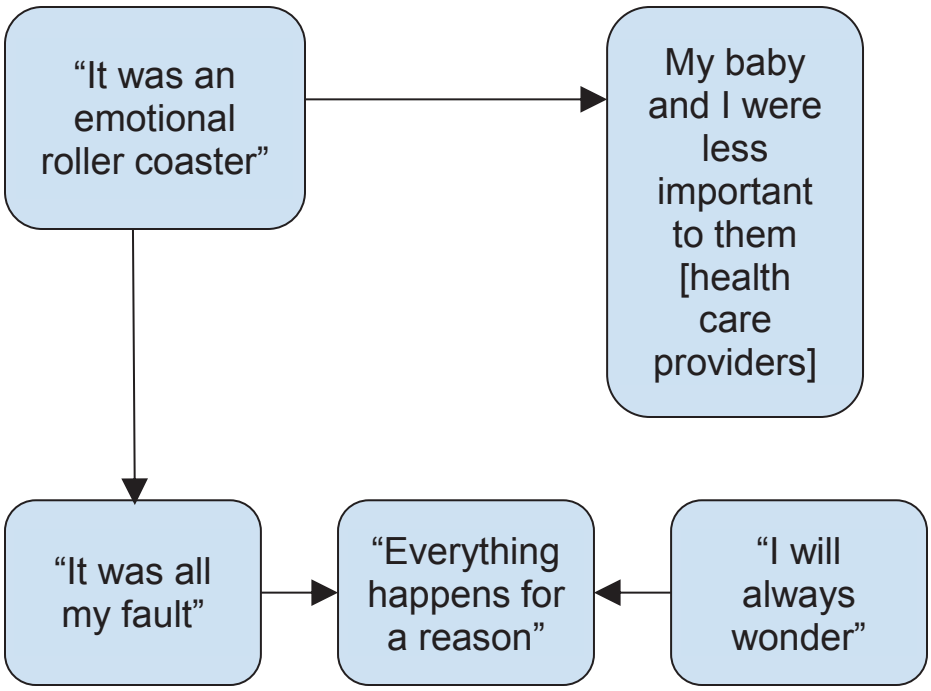

Figure 4.1 Thematic Structure of Adolescent Pregnancy Loss

Summary

The five themes that emerged from these four interviews are contextualized within a judgmental world full of societal rules and expectations. The participants experienced a wide array of emotions from excitement and acceptance of the pregnancy, to relief because they did not think they were ready to be a parent, to sadness and guilt over the life that was lost. Upon experience of the loss, these women felt that they were overlooked by and less important to the healthcare providers. The participants even blamed themselves for the loss going as far as believing they were being punished for previous misconduct. These women mourned the loss of the possibilities for who that baby would have been. Upon acceptance of the loss, these women felt that the loss was out of their control and happened for a reason at which point they became at peace with it. This process was lengthy one, sometimes taking years.

A common way of presenting thematic structure of a phenomenological study is to write a paragraph that blends the themes together in a first-person narrative (Sohn et al., 2017). From these four transcripts, the essence of an adolescent's experience of pregnancy loss is described in the following paragraph.

Oh no, I am pregnant. How am I going to be able to do this? How will I tell my parents? I can do this. Things are going to be fine. I am excited about this baby. I want this baby. Now my baby is gone. Will this happen again in the future? To health care providers, I am not important and my baby does not matter to them. Did this happen because of something I did? Did I work too much? Did this happen because I had sex before I got married? Am I being punished? I will never forget this baby. I will always wonder who he or she would have become. I wonder what my life would have been like with that baby. I do know now that I did nothing intentional to cause that pregnancy loss. I feel like everything worked out how it should have and I am at peace with how things ended up.

In the next chapter, findings of this study will be compared to previous research, noting areas of commonality and uniqueness. Implications for future research and nursing practice will be presented.

Chapter Five: Discussion

The purpose of this existential phenomenological study was to gain understanding of the experience of pregnancy loss during adolescence. Each of the participants willingly shared their experiences, providing insight into pregnancy loss during adolescence, a phenomenon that remains largely unstudied. This chapter reviews the thematic structure for pregnancy loss during adolescence and discusses how the findings relate to nursing literature. Implications for nursing practice, nursing education, and health policy are presented as well as recommendations for future research. Finally, strengths and limitations of this study are discussed.

Study Findings Related to Literature

Current nursing literature does not fully describe the meaning of pregnancy loss during adolescence. The thematic findings of this study did however relate to current nursing literature, thereby adding to the body of research and beginning to fill a gap in the nursing knowledge surrounding this phenomenon. While the emotional distress initially felt by these participants has decreased over time, this experience is something that has stayed with them. Because these women were able to move past the initial shock of the loss and come to terms with it, they were able to share their stories. However, those who may not have processed this loss are among the voices that we did not hear.

Theme One: "It was an emotional roller coaster"

This theme identifies the emotions experienced by these participants before, during, and after the pregnancy loss. Welch and Bergen (2000) supported the "fluctuations of emotions" (p. 435) experienced by adolescents who have suffered a pregnancy loss. Previous literature and the this study's findings support the emotions experienced—shock, acceptance, and excitement—when these women found out they were pregnant (Abboud & Liamputtong, 2003;

Fenstermacher, 2014; Gerber-Epstein et al., 2009; Sefton, 2007). At the time of the loss, these feelings of excitement give way to feelings of fear and helplessness (Abboud & Liamputtong, 2003; Fenstermacher, 2014; Gerber-Epstein et al., 2009; Swanson et al., 2007). In the time following the loss, the women in this study experienced emotions echoed in other studies including being sad, full of grief, and angry about the loss (Abboud & Liamputtong, 2003; Fenstermacher, 2014; Gerber-Epstein et al., 2009; Kavanaugh & Hershberger, 2005; Malacrida, 1997; McCreight, 2008; Sefton, 2007; Swanson et al., 2007). Balk (1991) suggested that bereavement during adolescence may impede advancement through developmental tasks, however, the findings of this study suggest that the bereavement described by the participants actually thrust them forward into adulthood and maturity beyond their years.

Confusion also is a theme common in this study and the literature (Fenstermacher, 2014). Additionally, the use of medical terms, such as spontaneous abortion, caused confusion and fear among women who did not understand them (McCreight, 2008). Another commonality from this study to current literature is the fear about future losses and being able to have children (Gerber-Epstein et al., 2009; Kavanaugh & Hershberger, 2005; Séjourné et al., 2010; Swanson et al., 2007). The findings presented in this theme support those of existing literature concerning pregnancy loss. However, these findings are within the context of the adolescent pregnancy loss experience, showing that adolescents experience the same emotional roller coaster during pregnancy loss as that experienced by adults.

Theme Two: My baby and I were less important to them.

While the current body of literature (Gerber-Epstein et al., 2009; Kavanaugh & Hershberger, 2005; Malacrida, 1997; McCreight, 2008) does indicate that women feel that their miscarriage experiences, especially the emotional aspects, are overlooked by insensitive

healthcare workers, this study's findings show the same perception among adolescent mothers experiencing a miscarriage who perceived that their age and unwed status contributed to the coldness of the treatment. Additionally, these teenage mothers wanted support following their loss just as the women in the studies by Malacrida (1997) and Séjourné et al. (2010). This study highlights the fact that these women feel that they and their babies are overlooked based on socioeconomic status and their age at the time of their loss. They perceived that they were less important as unwed mothers because according to societal standards "it was a good thing I wasn't having a baby at this point" [Alice, line 112].This theme outlines the importance of providing adequate care to these young women. It is essential they feel that they and their baby matter to healthcare professionals.

Theme Three: "It was all my fault"

The feelings of guilt and self-blame which emerged from this study also were evident in the literature reviewed for this study (Barr, 2004; McCreight, 2008; Sefton, 2007; Welch & Bergen, 2000). The perception of the women in this study that they were being punished is echoed in the literature with various studies showing women asking why the loss is happening to them or why they are being punished (Abboud & Liamputtong, 2003; Fenstermacher, 2014; Sefton, 2007; Swanson et al., 2007). While this is a common theme in the literature, it is just as important that adolescents understand that they did not cause the loss. Older women may have a better understanding of this because of their life experiences whereas the adolescents may not.

Theme Four: "I will always wonder"

Statements about remembering the baby that was lost, the path in life that was not taken, and the hopes and dreams these mothers had for their babies also is found in the literature. The mothers in Abboud and Liamputtong's (2003) study stated that they could not forget their babies.

Similarly, the mothers in the studies by Gerber-Epstein et al. (2009) and Swanson et al. (2007) reported thinking about what might have been, and the loss of sharing a life with their babies. Participants in the studies by Fenstermacher (2014), Kavanaugh and Hershberger (2005,) and McCreight (2008) also wondered what could have been, the loss of a future, and the loss of dreams. It is important to note that the passage of time did not lessen these women's desires to assign meaning to what their lives would have been like had these children survived.

Theme Five: "Everything happens for a reason"

In coming to terms with the loss and accepting it as part of their lives, participants in the present study later engaged in reframing, comforting themselves that everything happens for a reason. These participants had various ways of describing this theme, with some feeling they could not have been a good mother at 17. Some expressed that the loss helped them to be a better mother to their children or that they appreciate their children more because of the loss. One participant acknowledged that had she had a baby at 17, she could not have completed college without great difficulty. These threads of acceptance also are found in the literature. The participants in Swanson et al.'s (2007) study demonstrated their healing through statements of acceptance. Likewise, Abboud and Liamputtong's (2003) participants felt they had come to terms with the loss. Participants in Welch and Bergen's (2000) study believed that the loss made them who they are. Similarly, the participants in Sefton's (2007) and Fenstermacher's (2014) studies felt that their pregnancy was not meant to be, with the participants in the latter study also stating that everything happens for a reason. It is important to note that feeling that everything happens for a reason is a healthy way of coping with the loss but achieving this understanding often took years.

Nursing Implications

Practice

The findings of this study have various practice implications. First, it is imperative that healthcare providers are empathetic and supportive of women of any age experiencing a miscarriage. The focus of the care provided seems to be aimed at stabilizing the acute situation—bleeding and physical pain—and not on the psychological and emotional aspects of pregnancy loss. However, just as in previous studies, these women suffered immensely under the emotional weight of the loss. Nurses can provide emotional support to these women by talking with them about what to expect following the loss (Malacrida, 1997). Nurses can ask adolescents what this loss means to them. While listening to the adolescents, the nurses can explore further what the meaning of the pregnancy and subsequent loss was to them. The experience of pregnancy loss in the adolescent who never wanted to be pregnant could be very different from the participants in this study who were in loving relationships when they became pregnant.

Another way to provide emotional support is ensuring that the families have access to bereavement counseling, hospital clergy, and pregnancy loss support groups. However, as discussed by Welch & Bergen (2000) adolescents who had access to support groups were not comfortable attending them. Perhaps having a trusted friend or family member accompany the adolescent to the support group, or having a support group attendee reach out to the newly bereaved adolescent (with the adolescent's permission to release contact information) would encourage attendance. Additionally, the use of online support groups through social media platforms might be more appealing to the adolescent because they could remain relatively anonymous and engage as much or as little as they wished.

Nurses can directly affect patient care by taking time to explain procedures and terminology that might be frightening to the patients. Chan et al. (2008) contended that nurses' positive attitudes towards patients who have experienced a pregnancy loss can influence how these patients cope with the immediate grief following the loss. Malacrida (1997) suggested holding a post-loss debriefing session with the families to help them understand the loss so that they can begin to cope and process the experience.

It also is important for nurses to understand that adolescents experiencing a pregnancy loss are reeling from the same emotional turmoil as other women experiencing such a loss. They are feeling the same sadness, guilt, fear, and emotional pain and they should not be overlooked. While the findings of this study did not show that the nurses were uncaring towards these mothers, the nurses were never mentioned in a supportive or empathetic manner either.

Education

Nurses are central to providing care for adolescents experiencing a perinatal loss. Giving nurses education that can help them care for this unique patient population is crucial. Roehrs et al. (2008) posited that some nurses strive to become experts in providing bereavement care to individuals who have suffered a perinatal loss, while other nurses may find it difficult to provide quality care to their patients in this situation based upon the patient's emotional reaction.

It is necessary that nurses be educated about this population's special needs. In fact, Peterson et al. (2012) found that nurses desired further education about caring for adolescent mothers. This study can help form the foundation for education about adolescent pregnancy loss. From this study, we see that healthcare providers need to be educated on the use of terminology such as spontaneous abortion because the word abortion can have such a negative connotation. Nurses also need to be educated on how to provide emotional support to these young women

while explaining to them that they did nothing wrong to cause the loss. This alone can help to ameliorate some of the guilt and fear associated with pregnancy loss while showing the mothers that they and their babies are important to the healthcare team.

Malacrida's (1997) study revealed that nursing students want more education about providing emotional support during pregnancy loss. These students noted that, while they felt capable handling the physical aspects of the loss, they did not feel comfortable with the emotional aspect because it had not been discussed with them. Providing education to nursing students regarding the emotional support necessary following a pregnancy loss is much needed. Additionally, including topics such as pregnancy loss in specialized populations in the nursing curriculum will at minimum give these students exposure to this population and their coping mechanisms and emotional support needs.

Health Policy

One health policy implication from this study is the need for further education of current nursing staff. Policies should be adopted to ensure that nursing staff have adequate information about caring for specialized populations. Additionally, staffing policies could allow at least one specially trained nurse to be present for each shift to help provide care to women and adolescents experiencing a pregnancy loss. Another health policy implication comes from the emotional support needed by these women. Policies and procedures should be developed to assist nurses in the provision of emotional support. These could include providing in-hospital support via clergy or counselors; having nurses provide one-on-one care for pregnancy loss patients, which gives them more time to listen to patients' needs; and establishing procedures for creating memory boxes or other items holding sentimental value for mothers and families. In addition, policies should be developed for the provision of long-term emotional support should it be warranted.

Recommendations for Future Research

With the limited amount of research available concerning adolescent pregnancy loss, there is a need for further exploration of this phenomenon in order to gain a better understanding of it. Additionally, further comparisons can be made between the experience of pregnancy loss during adolescence and adulthood. There is a need to determine if there are changes that should be made in the care provided to these young mothers following a pregnancy loss. This study was a retrospective look at adolescent pregnancy loss. Therefore, another recommendation from this study is to interview adolescents at the time of the pregnancy loss to gain perspective into their experiences as they express them immediately following the loss. Conducting such interviews was the original intent of this study, however, after many months, the researcher was unable to recruit adolescent participants at the time of their pregnancy loss. There are no current studies which view adolescent pregnancy loss through the lens of developmental theorists such as Piaget, Erikson, and Kohlberg which yields another recommendation for future research.

Strengths and Limitations

Many strengths can be attributed to this study. The use of Thomas and Pollio's (2002) method derived from the tenets of Merleau Ponty's existential phenomenology to explore this topic is a study strength. Since so little is known about this area of inquiry, using non-structured qualitative interviews allowed the researcher to gain a true perspective of the experience through the participants' voices. The richness of the interview data helped the researcher to depict the essence of the meanings associated with this loss experience.

Adherence to the procedural guidelines set forth by Thomas and Pollio's (2002) method is a study strength. In accordance with this method, the researcher completed a bracketing interview help avoid bias. Additionally, ensuring convergence of themes was present prior to

cessation of data collection is a study strength. Enlisting assistance from the IIRG bolstered this study's findings. As stated previously, this group helped with initial thematization of each transcript as well as critiqued the researcher's interview techniques to improve the richness of the interview data elicited. Three of the four participants from this study responded to the researcher concerning the figural themes developed during this study. The researcher could not reach the fourth participant via the provided contact information. However, the three responding participants supported the figural themes that had been developed and verified that the researcher had captured the essence of their experiences, which is a strength of this study.

There are several limitations in this study as identified by the researcher. The first limitation is the homogeneity of the sample. All four participants were Caucasian women living in the Southeastern United States. Women from different ethnic backgrounds might respond to this loss experience in a different way. All participants had subsequent successful pregnancies that could change their perspective about the loss experience. Had they never been able to have children following the loss as an adolescent, they may have perceived this loss differently. Additionally, all participants were in loving relationships with their partners at the time of the pregnancy and subsequent loss. Had these women become pregnant as a teenager as a result of casual sex, forced sex, or incest their stories may have been very different. Although the sample size was small for this study, the researcher does not perceive this as a limitation since convergence of themes occurred and findings from this study were in line with previous studies' findings.

Summary

The findings of this study are supportive of current literature concerning pregnancy loss as well as the small amount of literature concerning pregnancy loss during adolescence. It has

been noted that this population feels overlooked by the healthcare team. This study's results overwhelmingly indicate the need for women to receive adequate emotional support following a pregnancy loss. It is imperative that nurses understand the needs of these women and recognize that this loss event is just as traumatic to an adolescent as it is to an older woman. Support interventions should be tailored to the adolescent's developmental level with special care being given to explain terminology and what they can expect following the loss. The purpose of this study was to gain a better understanding of adolescent pregnancy loss. Viewed within Merleau Ponty's (1945/2002) existential grounds of time, body, world, and others for analysis, five themes emerged: 1) "It was an emotional roller coaster," 2) My baby and I were less important to them [health care providers], 3) "It was all my fault," 4) "I will always wonder," and 5)"Everything happens for a reason." This study gives much needed insight into the experience of pregnancy loss during adolescence. The implications of this study will help to improve nursing knowledge and care concerning adolescent patients who have experienced a pregnancy loss.

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Appendices

Appendix A

Research Study Flyer

"The Lived Experience of Perinatal Loss During Adolescence"

For this study, you will share your story about your miscarriage to help nurses better understand your experience.

Who is Eligible?

- Women over the age of 25 who experienced a pregnancy loss between the ages 15 and 18 years old.
- Participation is voluntary and confidential

What will you do?

- Complete a 45 minute to 1 hour long interview during which you will talk about your miscarriage experience

If you have any questions or are interested in participating, please contact:

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Appendix B

Participant Mental Health Resources

Cathy Jordan, Licensed Professional Counselor 731-298-6388

Carey Counseling Center 731-855-2871

Yvette Barton, APN (specializing in Mental Health) 731-644-2271

National Crisis Hotline 1-800-744-2433

Appendix C

Informed Consent Form

You are being asked to participate in a study titled "The Lived Experience of the Adolescent Mother Suffering a Perinatal Loss." This study will involve you sharing your story about the death of your baby while you were an adolescent. The purpose of this consent form is to describe to you what you can expect during the research process and to inform you of potential risks involved with this study. Your participation in this study is voluntary and you can withdraw from the study at any time.

The purpose of this study is to gain a better understanding of the meaning of the experiences of the adolescent mother who suffered a perinatal loss. While there are no direct benefits to you for participating in this study, you may find it comforting to be able to share your story. Also, your story and the stories of the other participants in this study will help nurses to better understand how to provide care for adolescents when they do experience the death of a baby.

This study is being conducted by Jenny Webb, MSN, RN to meet dissertation requirements for a PhD in Nursing to be awarded by the University of Tennessee at Knoxville.

You are being asked to participate in this study based upon your previous experience of suffering a miscarriage as an adolescent.

If you choose to participate in this study, you will be asked to share this experience with the researcher in an audio-recorded interview.

The interview will last approximately 45 minutes to an hour (or longer, depending on how much you choose to share). You may take a break at any time during the interview, or you may stop the interview at any time if you choose without suffering any negative consequences.

The interview will take place in a private location which we will both agree upon.

The interview will be audio recorded to ensure accuracy.

Potential risks from this study involve psychological and emotional distress related to the reliving of the experience. Should you feel the need to seek professional help due to participation in this study, outpatient counseling services contact information will be given to you.

Personal information will be kept confidential. Any identifying information will be changed. The researcher will be the only person who has access to any personal/identification information. This information will be kept in a locked file cabinet in a secure location. The transcriptionist who will listen to the recordings and transcribe them for the researcher will sign a confidentiality form and will not be given your name or identifying information.

Findings from this study will be shared with external sources, however, all identifying information will be changed.

No personal information will be released at any time without your explicit consent.

This study has been approved by the University of Tennessee at Knoxville, Institutional Review Board. The UTK IRB can be contacted with questions about informed consent, participant rights, or complaints about the way in which you were treated during this study at research@utk.edu or 865-974-3466.

Should you have questions or concerns, the researcher (Jenny Webb) can be reached at 731-514-2657 (cell) or jstout4@utk.edu (email). Dr. Sandra Thomas, the researcher's supervisor, can be contacted at 865-974-7581 or sthomas@utk.edu.

By signing this form you acknowledge that you have been informed about the study and the potential risks and benefits for participating in the study; that you enter this study freely and without coercion; that you have been given the opportunity to ask questions; that you have not received any compensation for participating in this study; that you have received a copy of this form; that you consent for audio recording during the interview.

Participant's Name:_____

Participant's Signature:_____

Date:_____

Researcher's Name:_____

Researcher's Signature:_____

Date:_____

Appendix D

Demographic Questionnaire

Name:_____ Current Age:_____

Age at time of Miscarriage/Death of Baby:_____

How far along in the pregnancy were you? _____

Have you had any other miscarriages or children who have died?_____

Have you ever had an abortion/terminated a pregnancy? _____

Race:
_____Caucasian
_____African American
_____Hispanic
_____Other_____

Income:
_____ Cannot make ends meet
_____ Just getting by
_____ I have what I need
_____I have plenty

Education:
_____High School Graduate
_____GED
_____Some college
_____Associate's Degree
_____Bachelor's Degree
_____Master's Degree
_____Doctoral Degree
_____Other_____

Appendix E

Transcriptionist Confidentiality Form

I understand that all audio recordings submitted to me are confidential and pertain to private experiences described by research participants. I will use pseudonyms to describe all participants and will not discuss any of the recordings with anyone other than the primary researcher.

_____
Signature

_____
Date

Appendix F

Interdisciplinary Research Group Confidentiality Form

I understand that all transcripts submitted to me are confidential and pertain to private experiences described by research participants. I not discuss any of the transcripts with anyone outside of the interdisciplinary research group meeting.

_____
Signature

_____
Date

Vita

Jenny Beth Stout Webb was born July 10, 1984 to Tony and Lorre Stout of Greenfield, Tennessee. She attended Greenfield High School, graduating fourth in her class in 2002. She completed her Bachelor of Science in Nursing from The University of Tennessee at Martin in 2007. She began her nursing career as a staff nurse and charge nurse on a medical/surgical unit in West Tennessee. She relocated to a women's hospital in Memphis, Tennessee in 2008 where she worked as a labor and delivery staff nurse in a high-risk labor and delivery unit. In 2010, she moved to Jackson, Tennessee and began working as a staff nurse on the postpartum unit and in the well-baby nursery. She completed her Master's of Science in Nursing degree with a focus in nursing education from Union University in 2010. In 2010, she became a full-time faculty member at Bethel University. She completed her Doctorate of Philosophy at the University of Tennessee in December 2017.