1993

Perinatal bereavement knowledge gain and self-reported comfort level of maternal-child health nurses

Marcene Y. Saxman
San Jose State University

Order Number 1356493

Perinatal bereavement knowledge gain and self-reported comfort level of maternal-child health nurses

Saxman, Marcene Y., M.S.

San Jose State University, 1993

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

PERINATAL BEREAVEMENT KNOWLEDGE GAIN AND SELF-REPORTED COMFORT LEVEL OF MATERNAL-CHILD HEALTH NURSES

A Thesis

Presented to

The Faculty of the School of Nursing

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Marcene Y. Saxman

December, 1993

APPROVED FOR THE SCHOOL OF NURSING

Merle Kataoka-Yahiro, Dr. PH., R.N.

Bobbye Gorenberg, D.N.Sc., R.N.

Barbara Diller, M.S., R.N.

APPROVED FOR THE UNIVERSITY

ABSTRACT

PERINATAL BEREAVEMENT KNOWLEDGE GAIN AND SELF-REPORTED COMFORT LEVEL OF MATERNAL-CHILD HEALTH NURSES

by Marcene Y. Saxman

This quasi-experimental pilot study investigated the effectiveness of a self-instructional perinatal bereavement support lesson designed to improve the knowledge and comfort levels of maternal-child health nurses. Differences between pretest and post-test knowledge scores reflected a significant increase in participants' knowledge about perinatal bereavement support. Participants reported their comfort level with perinatal bereavement support increased significantly after completion of the lesson.

The adult learning principles of Knowles and the experiential learning model of Kolb provided the conceptual framework for the lesson and the pilot study. The sample population consisted of 32 maternal-child health nurses employed by a northern California hospital. Participants completed a pretest, studied the self-instructional lesson written by the researcher, and took a post-test within a 4-week period. Participant evaluations of the lesson provided valuable formative evaluation data that will be used to improve the lesson and future lessons.

ACKNOWLEDGMENTS

To Merle Kataoka-Yahiro, Dr. PH., R.N.
for months of reading, rereading, patience, and
invaluable assistance in the preparation of this thesis.

To Bobbye Gorenberg, D.N.Sc., R.N. and
Barbara Diller, M.S., R.N.
for their efforts as readers of this thesis.

To the staff and management of the Maternal-Child
Health Department of the test site for their
participation and support.

To Eloise Blanchard for her editorial work.
To David C. Ekstrand for his computer assistance.

To my parents who instilled in me the importance of
prayer, dependence on the Lord, and perseverance.

TABLE OF CONTENTS

Chapter 1

INTRODUCTION

"Approximately 40,000 neonatal deaths occur annually in the United States. Out of every 100 pregnancies, 10 to 20 end in miscarriage before 20 weeks' gestation, and two end in stillbirth after 20 week's gestation" (Brost & Kenney, 1992, p. 457). The U. S. Department of Health and Human Services (1990) reported 49,820 deaths of babies greater than 20 week's gestation and less than 7 days of age in 1987. For the same year, the California Department of Health Services (1990) reported 2,767 neonatal deaths, and for 1988, 3,527 stillbirths.

Background

Comprehensive bereavement programs and specialized nursing policies, procedures, checklists, and protocols on perinatal loss have evolved to meet the special needs of families who experience perinatal loss. The coordinators of bereavement programs educate and assist nurses and other staff members who care for these families in crisis. Bereavement programs also benefit clergy, physicians, and funeral home operators who work with the families. The responsibility for emotional and spiritual support is shared by nurses, physicians, and clergy, who in turn, support each other. Physicians benefit from improved documentation and notification procedures initiated by nurses. Also, patients do much of their funeral planning with the nurse and that simplifies funeral directors' responsibilities.

The researcher, a bereavement counselor and program coordinator, designed, implemented, and coordinated a bereavement program at the test site. Quality assurance checks at the site revealed that the staff did not consistently meet the requirements of the established policies and procedures on perinatal loss. In response to these findings, the researcher conducted a needs assessment and identified a training need for theoretical and practical information on perinatal bereavement support. The maternal-child health nurses who completed the needs assessment indicated a willingness to test a self-instructional format for perinatal bereavement support education.

There are distinct advantages to self-instructional or self-directed continuing nursing education. Self-directed learning activities: (a) require the individual learner to take the initiative and responsibility for the learning process, (b) involve activities that are specific to the learners' needs, (c) require minimal structure, (d) allow educators more time to assist the learner on an individual basis, and (e) are an effective teaching modality.

The researcher considered the advantages and disadvantages of the suggested training methods. The schedule constraints of the staff precluded convenient and efficient scheduling of seminar or lecture presentations, and the test site had limited video resources. The flexibility, convenience, and proven effectiveness of self-instructional study favored its use.

A literature search did not reveal any existing perinatal bereavement support modules. However, researchers have tested and proven the effectiveness of this format in teaching such diverse topics as oral contraceptives, nursing care plans, and human sexuality counseling (Guimei, 1977; Ogundeyin, 1980; Santopietro, 1980).

The Problem

Although most nurses have had some exposure to theories about death and dying, many have not had recent or specialized education in grief support and counseling. Nurses must fulfill the patient care, documentation, and notification requirements of the perinatal loss policies and procedures in spite of inadequate preparation. At the same time, they must provide patient and family grief counseling and teaching.

At the test site, the policy and procedure for intrauterine fetal death was a seven page itemization of: (a) state and county regulations pursuant to fetal death, (b) infant and patient care routines, and (c) essential teaching and interventions required to establish a foundation and framework for follow-up on the grieving patient. The nurses provided physical and emotional care to the patient and family and met the legal requirements pursuant to fetal or neonatal death. Additionally, the nurses had to deal with their own feelings and responses to the death.

The complexity of the tasks and responsibilities of the nurses who provided this care was evident. The questions of how to most effectively prepare and assist the nurses in this

challenging aspect of their work arose. Sporadic lectures, memos, and one-on-one teaching of nurses had proven ineffective as the unit had grown in size and the number of employees increased. The departmental manager asked the researcher to address the problem of equipping and assisting staff to meet these job requirements with an effective, efficient, and cost-effective teaching method. After weighing the advantages and disadvantages of various teaching methods, the researcher chose a self-instructional or modular approach for perinatal bereavement education.

Purpose

The researcher searched the professional literature for modules or other self-study materials that covered the topic and found books, articles, and audio-visual materials on perinatal bereavement support. There was no comprehensive self-study presentation on the topic.

The researcher decided to design a self-instructional module on perinatal bereavement support for the test site. She divided the module into 4 lessons and pilot tested Lesson 1 of the module for this research project. The researcher chose that lesson because it covered the theories involved in perinatal bereavement support and its content was foundational to the module and the bereavement program.

The Research Questions

This pilot study investigated the effectiveness of a self-instructional perinatal bereavement support lesson to increase knowledge and comfort levels of maternal-child

health nurses. The two research questions are:

1. Is there a significant difference in knowledge gain of maternal-child health nurses after completion of a self-instructional perinatal bereavement support lesson?

2. Is there a positive change in self-reported comfort levels of maternal-child health nurses after completion of a self-instructional perinatal bereavement support lesson?

Definition of Terms

For the purpose of this study, the following definitions apply:

1. A maternal-child health nurse (MCHN) is a registered nurse or licensed vocational nurse who provides direct and indirect care to patients in the perinatal setting. The setting includes labor and delivery, postpartum, nursery, and pediatrics.

2. Perinatal loss refers to the loss of a conceptus by spontaneous abortion, intrauterine fetal death, neonatal death, or ectopic pregnancy.

3. Perinatal bereavement support is the provision of physical, emotional, spiritual, and educational assistance and resources during the acute period of grief and mourning following perinatal loss.

4. A self-instructional lesson refers to educational materials designed for independent use and includes well-defined objectives, pretest, post-test, directions, and materials for reaching the objectives of a lesson.

5. Knowledge gain is the comparison of the number and percentage of items each participant answered correctly on

the cognitive pretest and post-test.

6. Comfort level is the self-reported feeling of confidence and competence when providing care to patients and families experiencing perinatal loss.

Summary

A search of the professional literature revealed no comprehensive self-study presentation on the topic. Therefore, the researcher developed a perinatal bereavement support lesson (a) to meet the specific needs of the maternal-child health department at the test site, (b) to supplement lecture and seminar presentations of the material, (c) for use during the orientation of new employees, and (d) for employees who want to increase their knowledge on the topic. The lesson covered information on parenting tasks, bonding, death and dying, grief and mourning, and the human to human or nurse-patient interactionist model of Travelbee (Bobak, Jensen, & Zalar, 1989; Bowlby & Parkes, 1970; Klaus & Kennell, 1982; Kubler-Ross, 1969, 1975; Travelbee, 1966, 1969, 1971; Worden, 1982, 1991).

The researcher designed and pilot tested the first lesson of a self-instructional perinatal bereavement support module. This study considered whether there was a significant difference in knowledge gain and self-reported comfort levels of maternal-child health nurses after completion of the perinatal bereavement support lesson.

Chapter 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Introduction

"The quality of modern health care depends to a large degree on the knowledge, skills, and attitudes of practicing health professionals" (Brunt & Scott, 1986, p. 87). Basic professional preparation, no matter how comprehensive, is no longer sufficient for a lifetime of practice. Laws and standards of practice mandate that nurses must keep abreast of technological and theoretical advances in health care. Additionally, they must be attentive to societal change and meet the changing needs and demands of individual patients.

Although each nurse must assume responsibility for personal continuing education, continuing educators have the task of providing cost-effective, relevant, readily-applied learning opportunities. These educators must contend with the challenge of meeting the demands of individual and corporate consumers, accrediting agencies, legislators, and others who control educational funding. "Cost-effectiveness" and the "bottom line" are the popular phrases of the decade.

How continuing educators meet the challenge of providing cost-effective, well generalized, and practical learning opportunities for nurses is of great importance. Logically, they start with the basics and build. The adult learning model is the cornerstone of continuing education for nurses.

Conceptual Framework

The adult learning principles of Knowles' (1978, 1980, 1984) and Kolb's (1984) experiential learning model comprise the conceptual framework for this study. Knowles defined adult education as the art and science of helping adults learn and coined the term andragogy, derived from the Greek "aner" or "andros" meaning man or grown-up. Knowles established that adults: (a) learn best when they involve themselves with their own learning; (b) learn best when they learn about current life situations, rather than isolated subjects; (c) usually learn more readily when they voluntarily choose a learning experience; (d) have a deep need to be self-directing; (e) possess individual differences that increase with age; and (f) draw on experience as their richest resource for learning.

Knowles (1980) considered educators to be change agents or resources for self-directed learners, not just people who impart a body of knowledge. He maintained that adults learn best when actively involved with their learning, therefore educators should encourage learners to give input on differences in style, time, place, and preferred learning styles and methods.

Kolb's (1984) experiential learning model complements Knowles' principles and also applied to this study. Kolb's model, a four-stage cycle, begins with a concrete experience that leads to observations and reflection. In that model,

the learner uses these observations to form abstract concepts and generalizations, tests the concepts in new situations, reflects on new experiences, accepts or modifies present concepts, and continues the cycle. Two important aspects of the experiential learning model focused on the present or the here-and-now and used concrete experiences to validate abstract ideas.

Kolb's model represented an integration of many lines of research on cognitive development and cognitive style consistent with the stages of human growth and development. He also emphasized the vital role that experience plays in the learning process. Human growth and development and experiential learning are important aspects of biological sciences such as nursing.

The researcher believes Knowles' adult education principles and Kolb's experiential learning model to be consistent and complementary. Together they can provide a useful general adult learning model, an analogy to help the educator understand the learning process and plan instruction. The researcher used Knowles' adult learning principles in the choice of topic, the development of the lesson and related materials, and the method of conducting the pilot study. Additionally, Kolb's experiential learning model influenced the choice of topic, lesson content, and test content.

Review of Literature

Perinatal Loss

Nursing literature includes numerous resources and references pertaining to perinatal loss. Nurses, physicians, psychologists, parents, and clergy have studied parental responses to loss and nursing responses to parents who lose babies by miscarriage, ectopic pregnancy, stillbirth, or neonatal death.

According to Hutti (1988) early pregnancy losses are often the least valued by health care providers. Caregivers often assume miscarriage to be less important than stillbirth, and stillbirth less important than neonatal death. Peppers and Knapp (1980) however found no differences in the intensity of grief responses between parents who had experienced miscarriage, stillbirth, or neonatal death.

Saylor (1977) observed that the emotional trauma of stillbirth presents a unique challenge for the obstetrics nurse. Saylor, a hospital chaplain, pointed out that the nurse's role is important and potentially therapeutic in interactions with patients experiencing stillbirth. The nurse's understanding of the grief process can enable the nurse to communicate more effectively with the bereaved patient and family and promotes the concept of holistic care.

Benfield, Leib, and Vollman (1978) studied the grief response of parents to neonatal death and found that a parent's grief is "highly individualized" and may depend more

on the compassionate concern of caregivers than on any other single factor. The attitudes and behavior of family, friends, and health care providers in the hospital often adversely influenced parent grieving. While the study did not focus specifically on the role of the nurse in bereavement support, the findings relate to nurses as well as other caregivers.

Hutti (1988) also observed that the concern nurses express can make a significant impact on families after a perinatal loss. How nurses view the patient and the patient's loss determines how therapeutic their nursing interventions will be. Whether a nurse views a woman as a "vaginal bleeder" or as a mother who is losing her baby influences not only immediate nursing interventions, but also the parents' initial and subsequent grief responses as well as their responses to future pregnancies.

Reed (1990) also looked at the emotional care given to women experiencing miscarriages. The findings of that study support the idea that nurses do in fact perceive the need for emotional support for women experiencing miscarriage but may not be able to meet that need. Anecdotal responses indicated that in labor and delivery "a pregnant mother with a viable fetus will always have priority over a stable miscarriage mother. On a busy day emotional support is the first thing dropped by the wayside...That's life!" (p. 92).

Brost and Kenney (1992) summarized the recent literature

on pregnancy after perinatal loss and suggested nursing practice strategies to assist parents who experience such a pregnancy. The suggested nursing strategies revolved around communication and trust. The researchers concluded that (a) an empathetic and knowledgeable nurse may be the one stabilizing factor on whom the pregnant patient can rely, and (b) the establishment of a trusting environment and the creation of rapport with each patient provides the basis for care in a pregnancy that follows perinatal loss.

There are also many perinatal bereavement references and resources written by and for bereaved parents and their families (Hayford, 1990; Ilse & Burns, 1985; Kuenning, 1987; Page, 1987). The parents share their initial reactions to the death of their babies, their struggles through the grief process, and often use support group newsletters as a forum for their poetry and other writings that help convey the breadth and depth of their experiences. Nurses and other caregivers have used parents' reactions and suggestions in the development of bereavement policies, programs, and support groups (Limbo & Wheeler, 1986).

Kirkley-Best and Kellner (1982) and Kowalski (1980) addressed the importance of care providers educating themselves in the area of perinatal grief. Hospital education departments and maternal-child health units now offer grief-related workshops and training programs in response to a growing awareness of the need. Detailed

nursing policies, procedures, and protocols educate nurses and other health care providers to assist a grieving family.

The policies and protocols are not magical formulae for staff or patients, but are guidelines that reflect research findings and common sense approaches to perinatal loss. Leon (1992) acknowledged that dramatic improvements in the hospital management of perinatal loss have taken place over the last 20 years, but expressed concern that there has been little critical examination of current strategies of managing perinatal loss and the long-term impact of this loss. He detailed possible hazards of current hospital practice, explored some alternative approaches, and concluded that care providers must educate themselves in the area of perinatal loss and listen to and learn from their patients and their families. Leon (1986) concurred with Furman (1978) that dealing with perinatal loss inevitably results in some degree of stress for the nurse and other caregivers and can lead to burn-out.

Nursing Stress

People living in the 20th century are familiar with stress. Some stress is unavoidable and can be a positive motivator. One's ability to cope with stress can vary as can the type and degree of stress encountered. Every career and each job setting present their own unique stressors. Thus, nurses who practice within or outside the hospital face general and specific stressors. Numerous sources have

documented the necessity of dealing with the specific stressors that confront nurses (Davitz, Davitz, & Rubin, 1980; Jacobson & McGrath, 1983; Lachman, 1983). Some of the identified stressors arose from the changing role of women. Women often have to balance work and home nurturing responsibilities while they face conflicts with colleagues and increasing demands at work. The demand for cost-effectiveness in practice and the provision of quality care often conflict. These demands require nurses to do more, to take on additional responsibilities, and to understand increasingly sophisticated medical technology. Hutchinson (1987) also cited nurses' lack of control over their environment, incompetent or unsympathetic supervisors, inadequate supplies and equipment, shift rotation, problems with cost containment, and conflicting accountability as stressors.

Nurses interact with patients, their families and friends, and co-workers during life and death crises. Additionally, nurses must meet their own expectations. Nurses tend to be idealists who often find paperwork and administrative tasks frustrating. Most would rather do those activities that drew them to nursing in the first place, that is to give direct patient care and develop nurturing relationships with people (Joinson, 1992).

This conflict can lead to burnout. Burnout results from overpowering, pervasive stress that dominates and interferes

with the nurse's ability to function. Joinson (1992) maintained that those in the helping professions seem to be particularly prone to a specific type of burnout. She named it compassion fatigue. Nurses and other professional caregivers are around people who have acute or chronic discomfort or stress. These people have often lost their ability to cope with anxiety, fear, and the lack of control that often accompanies ill health, accident, aging, dying, and death. In their need, they turn to nurses to relieve some of their burdens and to provide intimate physical, emotional, and spiritual care.

Nurses fill multiple and psychologically conflicting roles in the midst of human fear and suffering. It is not uncommon for a maternal-child health nurse to provide care to a healthy mother of a healthy infant in one room, a mother who has lost her baby and possibly her fallopian tube as a result of an ectopic pregnancy, and a mother who has just miscarried down the hall. Nurses must contend with the expressed and unexpressed feelings of their patients and their own feelings simultaneously.

Professional nursing education tends to place emphasis on maintenance of composure and control of feelings, especially in the presence of patients and their families. Eakes (1990) stated that "this professional expectation is incongruent with the need for full emotional expression associated with effective grief resolution" (p. 243). Nurses

strive to provide compassionate and comprehensive care in the face of human drama and stress but often have difficulty accomplishing that goal.

Kowalski (1980) detailed some of the reasons why professionals have difficulty functioning in a "caring human manner" during these sad situations for the following reasons: (a) many physicians and nurses are not aware of grief and bereavement theory, nor have they seen this theory applied in obstetric situations; (b) few young professionals have observed an experienced nurse or physician talking with or providing support to parents undergoing perinatal loss; and (c) many health care professionals entered the field to help or cure people. Kowalski contended that when cure is not forthcoming and the problem results in loss, the professionals feel a personal defeat and this threatens their self-image as helpers or healers. Professionals can however work through their own loss and control issues and be more responsive to patient needs if they learn the theoretical bases of loss, lower their defense mechanisms, and work through their feelings.

Murphy (1986) observed that one way to work through these feelings is by introspection and confrontation of one's own mortality and understanding that self-care and acknowledgment of one's feelings are essential if the nurse is to function effectively. Joinson (1992) suggested that the nurses should periodically reflect, assess, nurture, and

renew themselves in order to remain emotionally fit. Along the same line, Swanson-Kauffman (1988) contended that "an essential part of nursing others through difficult life events is knowing when it is time to withdraw and to practice self-care" (p. 83). That researcher also stated that only after nurses have identified and attended to their personal loss and control issues and their own mortality and self-care concerns can they focus on the caring needs of their patients.

Swanson-Kauffman's research (1983, 1986) involved caring needs associated with early pregnancy loss. She presented insights, descriptions, and interpretations of the perceived needs of women experiencing pregnancy loss through miscarriage. Swanson-Kauffman encouraged care providers to draw upon each patient's expressed needs, as well as other available clinical data, as they attempt to provide care and counter the tremendous depersonalization of health care that exists today. The ability of care providers to provide care and counter depersonalization requires knowledge and expertise. Kowalski (1980) observed that "with additional knowledge and expertise, professionals can help patients explore alternatives that create positive mental health and well-being rather than pathology" (p. 1115).

In order for nurses to help patients explore alternatives that may create positive mental health and well-being, nurses must interact with patients. These

interactions vary in depth, duration, and intensity. Travelbee's (1966, 1969, 1971) nursing model provides structure for nurse-patient interactions. Travelbee considered communication to be the key to effective nurse-patient interactions and essential to the development of positive relationships.

Death and Dying Education

For more than two decades general death and dying education was taught within the framework of health education, not nursing (Leviton, 1971; McMahon, 1973; Noland & Crosby, 1983). Dietrich (1980) noted that there was no course to help allied health students to deal with death and dying and proposed a curriculum modified from a medical education thanatology course.

Nurses have also criticized their educational programs as inadequate in preparing them to support and comfort the dying patient, and nurse educators and researchers have sought to remedy the situation by studying the effectiveness of different types of death education (Murphy, 1986). Nurses are aware that they are in a position to have a crucial and meaningful impact on those patients and families who are dealing with death. Nurse educators and researchers are also aware that nurses need to be as skilled in meeting these important psychological needs as in any other aspect of critical practice (Chodil & Dulaney, 1984).

Educators must develop methods so that basic nursing

education and continuing education can effectively assist nurses in increasing their skill in meeting these important needs. Nursing students and practicing nurses, as adult learners, bring their diverse backgrounds, experiences, learning styles, and preferences with them to each learning experience. That is especially true with death education classes or workshops. Students or practicing nurses who have had exposure to death, either from personal experience with family and friends or with patients, respond differently to death and dying than do inexperienced nurses or student nurses (Durlak, 1978; Hurtig & Stewin, 1990).

Early studies to measure the effects of death education on nursing students were descriptive and used subjective evaluation. Many of those studies reported positive results with a reduction in death anxiety among nurses involved in death education courses. However, educators could not come to a consensus as to which methods of death education were the most appropriate and effective for nurses (Drummond & Blumberg, 1962; Robinson, 1974; Watson, 1968; Wise, 1974).

Later longitudinal studies determined that the often delayed positive effects of death education resulted from experience with death rather than from education alone (Caty & Tamblyn, 1984; Laube, 1977; Murray, 1974). Martin and Collier (1975) surveyed third year baccalaureate nursing students to determine to what extent death education in their junior year affected their attitudes toward death. A

significant number of the students found a seminar on death and grief had a positive effect on their attitudes. A majority of those students suggested the seminar should be part of a death education curricula. The second most cited factor that affected their attitudes toward death was care of a dying patient and 30% recommended that type of experience as desirable in a curriculum.

Johansson and Lally (1990) recently studied the effectiveness of death education in reducing death anxiety of nursing students. They tested the attitudes of junior and senior baccalaureate nursing students to determine whether clinical experience was a necessary component of this type of education. The seniors had prior supervised clinical experience with dying patients and the juniors did not. Test results showed the program to be effective in reducing the death anxiety of some of the senior students but had the opposite effect on some of the junior students. The researchers concluded that supervised clinical experience with dying patients may be the most important component of an effective death education program.

Durlak (1978) compared experiential and didactic methods of death education in a hospital setting. The experiential workshop sought to provide participants with both a cognitive and emotional encounter with death and included role playing and exercises involving personalized death and grief awareness. The didactic program emphasized only the

cognitive component and included discussion on helping patients cope with impending death and personal feelings about death. Participants in the experiential workshop group experienced a significant reduction in their fear of death. Nurses, physicians, orderlies, laboratory technicians, and others comprised the study sample. The researcher suggested caution in interpreting the study findings because of the heterogeneity of the sample and the fact that program evaluation was confined to immediate, self-report measures of death attitudes and feelings. The durability of reported changes and their relation to subsequent behavior was not assessed.

Hurtig and Stewin (1990) also looked at the effect of different types of death education on nursing students' attitudes. That research study compared a "didactic" death education program that included lectures, films, and group discussion to an "experiential" program that focused on death awareness exercises, music, drawing, and dyadic encounters between students. The study also included a placebo program comprised of a simulation game relating to independence in the aging adult and a lecture and discussion on adult development.

Study findings indicated that the death attitudes of inexperienced students who were in the experiential program were more positive than similar students who received the didactic or placebo program. Experienced students, however,

were negatively affected by the experiential approach. The researchers suggested the use of a more cognitive, didactic approach for "death experienced" students. "At least initially, they could confront their death concerns in a less intensive way. Students with unresolved thoughts and feelings about death arising from past bereavements may be identified and referred for individualized help, if necessary" (p. 33). While acknowledging that students may require a variety of approaches, Hurtig and Stewin concluded that brief death education programs can promote personal death awareness and are a worthwhile addition to nursing curricula.

Hurtig and Stewin also pointed out that the majority of American and Canadian baccalaureate nursing programs do not include separate death education courses as part of their curricula. The programs have tried to fill the gap by integrating ideas and issues related to death and dying into other courses, although a comparison of integrated and separate death education course approaches found the latter to be more effective in reducing students' death anxiety.

Researchers studied the effect of death and dying education not only on nursing students, but on professional nurses and hospital staff as well. Murray (1974) found a reduction in death anxiety for nurses involved in a death education course, but there was no control group against which to measure and compare the significance of obtained

findings. Murphy (1986) measured the effects of a death awareness workshop on the death anxiety of 150 registered nurses and found that the workshop did decrease the nurses' death anxiety.

Interest in attitudes of nurses toward death and death education exists because of nurses' active involvement during the dying, death, and grieving processes (Eakes, 1990). Nurses provide direct and indirect care to dying patients and their families. Nurses suction, medicate, and often resuscitate the dying. They also rub backs, hold hands, sit with, and listen to the dying. Nurses often function as liaisons between patients and their physicians, patients and ancillary personnel, and patients and their families. Increasingly, they are case managers for dying patients in the hospital, hospice, or home setting. Nurses also provide care for patients whose unborn or newborn infants have died.

Most nurses are aware of their need to be knowledgeable of and skilled in dealing with death and grief. However, Murphy (1986) stated that extensive evidence has accumulated to implicate health professionals in the general tendency to cope with death and dying by avoidance and withdrawal. Nurses may respond to the anxiety produced by dying patients not only with avoidance, but also with professional detachment and control or denial of their own feelings. They may also focus on tasks, technology, or ritual instead of people.

The professional literature has recently included suggestions as to how care providers can identify and effectively deal with their feelings of grief in a variety of settings. Researchers have discussed the stress of providing care to the dying in hospice settings, oncology units, and neonatal or pediatric intensive care units. Eakes (1990) used interviews with hospice nurses to gather information on how they coped with the cumulative loss of patients. The nurses were unable to articulate their specific coping strategies, but recurring themes surfaced during the interview process. These included: (a) the importance of a collaborative relationship between the dying patient, the patient's family, and the nurse; (b) the necessity for the nurse to move away from a curative focus toward a palliative focus; (c) the necessity of open and honest airing of feelings activated by the death of a patient; (d) the importance of the maintenance and use of a solid support system by the nurse; and (e) the critical importance of the nurse achieving a sense of closure to the relationship.

Herrle and Robinson (1987) observed that while there is no lack of material concerning the terminal patient, material devoted to helping the nursing staff cope with the patient is lacking. Those researchers worked with nurses in an oncology unit who were having difficulty accepting the impending death of a patient to whom they had grown close. Group meetings held after the death of the patient allowed the nurses to

express their feelings of grief, recognize personal limitations, reduce their stress, and develop a support system among themselves.

Small, Engler, and Rushton (1991) looked at how staff in neonatal and pediatric intensive care units respond to one stressor: caring for dying patients and their families. They found that Herrle and Robinson's (1987) strategies to support caregivers applied to the perinatal setting as well as the oncology setting. Small, Engler, and Rushton also acknowledged that bereavement and loss programs and memorial services to remember the infants and children who have died were beneficial to nurses, other staff, and the families of the children. May and Mahlmeister (1990) in their recent obstetrical text, discussed perinatal loss and briefly mentioned the necessity for perinatal nurses to come to grips with their feelings of anxiety, anger, sadness, and loss.

Nursing Education and Self-instructional Learning

Adult education principles and the experiential learning model have carried over into nursing education and self-instructional learning, the focus of this study. Self-instructional learning in nursing continuing education was a natural outgrowth of the adult education models and capitalizes on the desire of busy nurses to study interesting and relevant material in a flexible format at their own pace.

The literature suggests that self-instructional modules used by nurses are as effective in increasing knowledge as

traditional methods of learning and are at the same time cost-effective (Brooks, 1985; Rufo, 1985; Schmidt & Fisher, 1992). Nursing educators have effectively used lessons in self-instructional format to cover topics such as pediatric nursing, medical-surgical nursing, health assessment skills, cardiac life support, oral contraceptives, nursing care plan development, human sexuality counseling, and management development (Blatchley, Herzog, & Russell, 1978; Chinn & Hunt, 1975; Dick, 1983; Friesen & Stotts, 1984; Guimei, 1977; Ogundeyin, 1980; Santopietro, 1980; Stetler, Garity, Macdonald, & Smith, 1980). Schmidt and Fisher (1992) acknowledged the need for nurse educators to become the resource, not the source of learning. In the face of increasing demands and decreasing resources, nurse educators must face the challenge of providing creative, effective, appropriate, and cost-effective educational programs. One effective method of extending resources and meeting this challenge is through the development and utilization of self-instructional modules (Schmidt & Fisher, 1992).

Summary

The adult learning model is the cornerstone of continuing education for nurses. The adult education principles of Knowles and the experiential learning model of Kolb provided the conceptual framework for this study.

The topic of the lesson tested in this pilot study was perinatal bereavement support. A review of the professional

literature revealed many articles on perinatal loss and a great deal of information on adult education and self-study methods. However, there were no lessons or modules that combined these principles. In response to this lack of material, the researcher designed and pilot tested a perinatal bereavement support lesson in a self-study format.

The researcher chose this flexible, self-paced, individualized learning format to provide effective use of the students' time. The lesson required minimal direct instructor involvement, was portable, and incorporated a variety of learning strategies (Mast & Van Atta, 1986).

Chapter 3

METHODOLOGY

Design

The pilot study design was quasi-experimental (Polit & Hungler, 1987, p. 130) and all participants were in one treatment group. The independent variable, a perinatal bereavement support lesson, was the treatment. The dependent variables were knowledge gain and change in self-reported comfort level.

Setting and Sample Population

The researcher recruited a convenience sample of 40 maternal-child health nurses (MCHNs) at a 250-bed community hospital in northern California. The recruited nurses were members of the maternal-child health department that included labor and delivery, postpartum, nursery, and pediatrics.

Participants (a) had at least 1 year of experience in maternal-child health nursing, (b) had not participated in a death and dying or related grief course for at least 1 year prior to the study, and (c) were not perinatal bereavement counselors. The 40 recruited MCHNs met the stated criteria, but only 32 of those recruited completed the post-test within the time allotment.

Human Subjects Approval

The researcher met with the Head Nurse Manager of the department on September 18, 1992, and outlined the purpose

and the procedures of the study, the expected duration, and the time, dates, and place of the testing. The manager consented to the research project and presented the researcher with a letter of authorization at that time (see Appendix A).

The researcher submitted a request to the Human Subjects-Institutional Review Board of San Jose State University in late November 1992. The Board granted approval on January 14, 1993 (see Appendix B).

Data Collection

Approximately one half of the MCHNs who had signed up for the study were present at a regularly scheduled staff meeting on February 11, 1993. At that meeting the researcher gave each MCHN two copies of the consent form (see Appendix C) and read the consent aloud and answered questions. Those who were willing to abide by the requirements set forth in the consent form signed the form and initialed each page. Participants retained one copy and returned the other to the researcher. The consent included the promise of a small monetary payment to those participants who completed the study within the stated time frame. The researcher intended this as an incentive for the participants to finish the project and to acknowledge the fact that their time was valued.

The researcher numbered the consents sequentially with 3 digit identification numbers that became the personal code

numbers (PCNs) for the participants. All of the materials the participants received had the same code number to facilitate collation and analysis of demographic, evaluative, and test data in a confidential manner. The use of personal code numbers allowed the participants to receive feedback on their individual test scores after completion of the study. The researcher maintained the list of personal code numbers assigned to the participants separately from the study materials, kept it in a locked file, and destroyed the list at the completion of the research project.

The majority of the participants took the pretest and completed a demographic questionnaire (see Appendix D) during the staff meeting on February 11, 1993. All the participants had been pretested individually or in small groups by February 18, 1993. Prior to administering the pretests, the researcher assured the participants that the test was specific to lesson content and that participants were not expected to know all the answers. The pretest knowledge scores provided a basis of comparison for the post-test results. Each participant completed the cognitive pretest (see Appendix E) before completing the demographic questionnaire.

After the participants completed their pretests and demographic questionnaires, the researcher read aloud the study instructions, distributed the lessons, and admonished the participants not to discuss the pretest or lesson content

among themselves. The researcher issued this caveat so that participants who received their materials after the initial distribution would not read the lesson content prior to taking the pretest. The researcher read the instructions aloud to each test group or individual participant.

Each participant completed the lesson in a place and time of their choosing. After the participants studied the lesson material and felt ready to take the post-test, they notified the researcher who administered the post-test (see Appendix E) in the Labor and Delivery conference room. Each participant completed an evaluation form after taking the post-test.

The researcher dated the post-tests to monitor the average amount of time the participants allowed themselves to study the material prior to post-testing. One participant requested the post-test after 1 week, but most of the participants completed the post-test 2 to 3 weeks after receiving the lesson. At the time of post-testing, the researcher reminded participants not to discuss the content of the lesson and tests with others.

At the end of the first week, the researcher posted signs advising participants of the approaching deadline. After the second week, the researcher extended the study deadline by 1 week. The latest acceptable post-test date for inclusion in the study was March 11, the end of the 1 week extension. The researcher decided to extend the deadline

because (a) some of the participants stated they needed more time to study the material, (b) a number of participants belatedly expressed their desire to participate and received their lessons a week after the original group, (c) the majority of the participants worked part-time and could not take the post-test within the initial time period, and (d) participant absence from the test site decreased the possible contamination of subjects that might have resulted from an extended deadline. The researcher contacted individuals who had not taken the post-test by week 3 to remind them of the final deadline.

The researcher corrected the post-tests as soon as the participants completed them and reported individual pretest and post-test scores in the letter of appreciation sent to each participant. Enclosed with the letter was the promised payment for completion of the study. The researcher did not return individual answer sheets until all the participants completed their post-tests.

Development of Study Materials and Instruments

Background

Time and study constraints precluded testing of the entire module. The researcher decided to pilot test Lesson 1, the theory lesson, because the grief and nursing theories addressed in that lesson were foundational to the module and to the bereavement program as a whole.

The researcher chose a pretest and post-test approach to

measure knowledge gain. According to Kemp (1985), pretesting can benefit both traditional group-instruction situations and self-paced or individualized learning. The use of a pretest was important to the study because it (a) determined learners' readiness for the lesson by alerting them to what they knew or did not know about the topic, (b) motivated them by arousing their curiosity and interest, (c) informed learners of the lesson content and instructor choice of testing methods, (d) provided a data base for determining learner growth in learning by comparison of pretest and post-test knowledge scores, and (e) provided valuable evaluative data of the lesson so the developer could revise it to meet the learners' needs.

The pretest and post-test were identical. The researcher designed the pretest and post-test after determining the lesson content so that the questions reflected the learning objectives (Kemp, 1985).

Another component of the study was the evaluation form. The researcher designed the form to (a) address the second research question regarding the participants' comfort with bereavement support, (b) to elicit feedback on the participants' perceived knowledge levels, and (c) to allow the participants to critique the lesson. Each participant completed the lesson evaluation after taking the post-test. The evaluation tool (see Appendix F) consisted of 10 forced-response questions.

The researcher submitted the study materials, consisting of the pretest and post-test, demographic questionnaire, and evaluation form, to a small group of colleagues for review and evaluation of content and face validity. The group consisted of a perinatal bereavement counselor, a labor and delivery charge nurse, and a former nursing instructor who worked per diem in the labor and delivery area.

The bereavement counselor was a content expert and was familiar with the bereavement program at the hospital, as was the charge nurse. The educator had extensive experience in the area of bereavement support and had experience in test writing and curriculum development and evaluation.

The small group completed the pretest, the lesson, the post-test, the demographic questionnaire, and the evaluation. The researcher asked them to evaluate the content of the lesson and the other materials and to comment on the appropriateness of the instruments for the pilot study. The small group also timed themselves as they completed the materials so that the researcher could have an idea of a realistic time requirement for the data collection period.

The group made a few suggestions, but concurred that the lesson content was interesting, informative, organized concisely, and appropriate for the target audience. They also concluded that the pretest and post-test (a) was clearly written, (b) adequately tested the objectives, and

(c) was appropriate to the experiential and educational levels of the potential sample population. The evaluators required from 3 to 10 minutes to complete each test and 17 to 20 minutes to study the lesson content.

Cognitive Pretest and Post-test

Standardized instruments are useful in that there are fewer questions about their validity and reliability and accompanying norms allow researchers to evaluate their results. The researcher, unable to find a standardized test designed to measure knowledge of perinatal bereavement support in the literature, developed a cognitive pretest and post-test from the objectives delineated in the lesson (see Appendix E). The objectives stated that upon completion of the lesson, the nurse should be able to: (a) describe perinatal loss, (b) describe the normal grief and mourning process as related to perinatal loss, (c) describe basic grief counseling principles, and (d) describe the basic concepts of Travelbee's nurse-patient interaction model. The researcher used Bloom's taxonomy as a guide to ensure that the questions reflected a level of difficulty appropriate to the corresponding objectives (Bloom, Hastings, & Madaus, 1971).

The pretest and post-test consisted of 12 objective questions. Nine questions required fill-in responses and 3 were multiple choice. Knowledge scores reflected the number of questions each participants answered correctly. The

researcher chose this scoring method to simplify data collection and computer entry and analysis.

The researcher considered questions 1, 4, 10, 11, and 12 to be experiential questions that maternal-child health nurses should answer correctly based on their experience. Theoretical content in the lesson formed the basis for the remaining questions: 2, 3, 5, 6, 7, 8, and 9.

Pretest and Post-test Experiential Questions

The researcher adopted the term experiential from Kolb's (1984) discussion of the importance of adult learners' life experiences to every learning opportunity they encounter. The researcher structured the experiential questions to (a) measure participants' knowledge, (b) help the participants recognize that they had knowledge in the topic area, and (c) stimulate participants to extrapolate their practice experiences into the theoretical framework of normal grief responses and accepted counseling principles. The questions required participants to (a) list 2 perinatal events other than death that might result in feelings of guilt, (b) list 4 manifestations of normal grief, and (c) respond to 3 patient situations that required grief support and counseling.

Pretest and Post-test Theory Questions

The theory-based questions measured participants' understanding of a variety of principles and theories. The questions referred to specific lesson content that included

parenting tasks, Bowlby and Parkes' phases of grief, Worden's mourning tasks and grief counseling principles, and the nurse-patient interaction model of Travelbee (Bobak, Jensen, & Zalar, 1989; Bowlby & Parkes, 1970; Travelbee, 1966, 1969, 1971; Worden, 1982, 1991).

The theory questions related to lesson content that pertained to identified learning needs. Parenting tasks were an important consideration because specialists in perinatal grief maintain that it is critical for parents of deceased infants to complete as many parenting tasks as they can in order to better recognize and work through their loss (Limbo & Wheeler, 1986). The lesson included the grief phases of Bowlby and Parkes (1970) because the literature and support materials given to parents as part of the perinatal loss program refer to those phases. Worden's (1982, 1991) grief counseling principles provide practical guidelines for anyone who provides perinatal or general bereavement support. The nurse-patient interaction model of Travelbee (1966, 1969, 1971) provided the framework and foundation for the perinatal loss program and can provide structure for nurse-patient interactions during perinatal bereavement support.

Comfort Level

One of the outcome variables this study considered was the change in self-reported "comfort level" on the part of the maternal-child health nurses who participated and received the lesson. The professional literature did not

include a tool that measured the comfort level of nurses who provide perinatal bereavement support. The researcher therefore designed an evaluation form that included an operational definition of comfort level and a question that asked participants to indicate their perceived comfort levels with perinatal bereavement support. The evaluation form requested participants to indicate their comfort level before and after completion of the lesson. They indicated their responses on a continuum from 1 to 10 with 1 designating uncomfortable and 10 designating comfortable.

The comfort level definition was congruent with Kolcaba and Kolcaba's (1991) work on a taxonomic structure for the term comfort. Those researchers focused on comfort as a desirable outcome of nursing care and not as a desirable feeling or experience for nurses, but they did discuss two meanings of comfort that were appropriate to this study.

Demographic Questionnaire

The researcher developed the Demographic Questionnaire (see Appendix D) completed by the participants. The questionnaire asked which bereavement policies and procedures the participants had used, whether they had experienced any difficulty in completing the procedures, and the nature of any experienced difficulty. Participants also indicated their gender, age, whether they were registered or licensed vocational nurses, how many years they had worked in nursing, how many years in the specialty area of maternal-child

health, the level of their basic nursing education, and any post-basic education.

Evaluation Form

The researcher developed an evaluation form (see Appendix F) to (a) elicit participants' reactions to each section of the lesson, (b) determine their willingness to complete additional lessons, and (c) involve them in the learning experience through the formative evaluation process. The researcher also wanted to compare participants' "perceived" knowledge level to their "measured" knowledge gain, as indicated by post-test scores. Participants indicated their perceived pre-lesson and post-lesson knowledge level on the evaluation form using a scale of 1 to 10. One designated a poor knowledge level and 10 designated an excellent knowledge level.

Self-instructional Lesson

The researcher designed the self-instructional lesson on perinatal bereavement support because there were no self-instructional lessons on the topic in the professional literature. This pilot study tested Lesson 1 (see Appendix G). The format of the lesson included directions, behavioral learning objectives, subject content, a short reference list, and an evaluation form. The lesson covered general death and dying theory, grief and mourning theory, perinatal bereavement theory, grief counseling principles, and an

application story entitled "A Story of Jane." That story exemplified the application of Travelbee's nursing model, with the use of grief counseling principles in a perinatal practice setting.

Analysis Procedures

The researcher reviewed and tabulated the completed demographic questionnaires and evaluation forms and used descriptive statistics to organize and summarize the findings. Descriptive and inferential statistics were used to analyze, summarize, and discuss the pretest and post-test knowledge scores and self-reported comfort levels.

The researcher entered the summed knowledge scores into the computer, analyzed them using StatView, and used paired *t*-tests to determine whether there was a significant knowledge gain between the pretest and post-test period. The researcher followed the same procedure with the self-reported comfort level scores. Based on Polit and Hungler (1987), the researcher selected the paired *t*-test as the most appropriate statistical technique because of the sample size, the type of data collected, and the need to compare pretest and post-test scores. The researcher used tables and narrative descriptions to summarize and present the results of this study.

Chapter 4

FINDINGS AND INTERPRETATION OF DATA

This chapter presents the analyses and interpretation of data from the pilot study of the perinatal bereavement support lesson. The background characteristics of the sample are presented first, followed by the analyses and interpretation of the research findings.

Description of the Sample

Forty maternal-child health nurses (MCHNs) were eligible to participate in the study. Of the 40 MCHNs, 32 completed the pretest and post-test within the time constraints of the study (see Appendix H).

All participants were female registered nurses who worked part time. Twenty-seven (84%) of the participants were between 31 and 50 years old. Seventeen (53%) of the participants had received their basic nursing education through associate degree programs, 11 (34%) through baccalaureate programs, and 4 (13%) through diploma programs. One participant had earned a master of science degree in nursing, 2 were certified nurse midwives, and 5 were certified in their specialty areas.

The participants' years of active practice ranged from 2 to 30 years, with 19 (59%) in the 6 to 15 year category. Five (16%) participants were in the 16 to 20 year category. The participants' years of experience in maternal-child

health nursing ranged from 1 year to 30 years. Twenty (62%) fell in the 6 to 15 year range. Five (16%) MCHNs were in the 2 to 5 year range and 5 (16%) were in the 16 to 20 year category.

Many of the nurses worked in more than a single area within the maternal-child health department. Twenty (62%) participants worked primarily in labor and delivery, 6 (19%) in postpartum, 5 (16%) in the nursery, and 1 (3%) in pediatrics.

Twenty-three (72%) of the participants had attended one or more grief related classes in the past. The participants attended those classes 1 to 20 years prior to this study.

Twenty-nine (91%) indicated that they had used 1 or more policies and procedures. Twenty-three (72%) had used the stillbirth policy; 16 (50%) had used the neonatal death policy; 15 (47%) had used the miscarriage policy; and 9 (28%) had used the ectopic pregnancy policy.

Seventeen (59%) of the 29 who had used the policies had encountered 1 or more problems with following or completing them. The most common problem reported was inadequate time to complete the requirements of the policies. Fourteen (82%) encountered that problem. Thirteen (76%) of those who experienced problems indicated that the policies or procedures were unclear, and 9 (53%) cited lack of adequate knowledge as being problematic. Four (24%) of the participants stated they had experienced difficulty due to

their lack of comfort in providing that type of nursing care. One participant stated that she did not know where to obtain the necessary forms and another stated that coordinating the paperwork, "both legal and family stuff," was difficult.

Major Findings

Knowledge Gain as Reflected by Pretest and Post-test Scores

Knowledge gain as reflected by the pretest and post-test scores was statistically significant: $t(31) = 12.613$, $p<.0001$. The pretest scores ranged from 6 to 15 points out of a possible 25 points, with a mean of 11 (44%). The range of scores on the post-test was 10 to 25 points out of the possible 25 points, with a mean of 20 (80%).

Responses to Individual Items on Pretest and Post-test

Experiential Questions - 1, 4, 10, 11, and 12

Participants did very well on each of the 5 experiential questions both on the pretest and post-test (see Appendix I). Correct responses to the experiential questions on the pretest ranged from 75% to 100%, and post-test scores on those questions ranged from 91% to 100%.

Questions 1 and 4, recall or listing questions, showed the greatest increases in knowledge gain. Those questions asked participants to (a) list 2 perinatal events other than death, that might result in feelings of loss, and (b) list 4 manifestations of normal grief. Questions 10 and 11, multiple choice questions, showed very slight decreases from pretest to post-test scores. Question 12, also a multiple

choice question, increased slightly. Question 10 asked the participants to indicate why persons who help families cope with perinatal loss need knowledge of death and grief theory. Question 11 referred to the importance of communication to ensure continuity of patient care. Question 12 addressed how the nurse can encourage patients not to make rash decisions after a perinatal loss.

Theory Questions - 2, 3, 5, 6, 7, 8 and 9

Participants increased their theory question scores from the pretest to the post-test. Increases in post-test scores on the theory questions ranged from 9% to 84% (see Appendix I). The greatest increase (85%) was on question 5 which asked for 2 of Worden's 4 tasks of mourning. Scores on questions 2 and 3, which referred parenting tasks and Bowlby and Parkes' phases of grief, increased by 69% and 53% respectively. Post-test scores on questions 6 and 7, which referred to Worden's principles of grief counseling, increased by 65% and 69%. The questions pertaining to Travelbee's nurse-patient interaction model showed the smallest increase in scores. Post-test scores on question 8, which asked participants to state the key element in each nurse-patient interaction, increased by 43%. Scores on question 9, which asked for the necessary steps in the development of nurse-patient relationships, increased by 9%.

Comfort Level

Self-reported comfort level with perinatal bereavement

support was the second outcome or dependent variable considered in this study. The difference between self-reported pre-lesson and post-lesson comfort levels was statistically significant ($t(31) = 5.351$, $p<.0001$). The mean self-reported pre-lesson comfort level was 4.75 and the mean self-reported post-lesson comfort level was 6.375, a mean difference of 1.625.

Perceived Knowledge Level

The researcher asked participants to indicate their perceived knowledge levels in order to evaluate possible relationships between this evaluative variable and knowledge gain. The difference between perceived pre-lesson and post-lesson knowledge levels was statistically significant ($t(31) = 8.206$, $p<.0001$). The mean perceived pre-lesson knowledge level was 4.25 and the mean perceived post-lesson knowledge level was 6.875, a mean difference of 2.625.

Lesson Evaluation

Each participant completed an evaluation form after taking the post-test. To ease the interpretation of participant responses the researcher chose to present the responses in two collapsed categories of "not at all to somewhat", and "moderately to a great deal" (see Appendix J).

The participants indicated that the lesson sections contributed "moderately to a great deal" to their knowledge levels as follows: (a) grief and mourning, 88%; (b) bonding and parenting, 69%; (c) death and dying, 69%; and

(d) Travelbee's model, 66%. Twenty-seven (84%) of the participants found the application section, "A Story of Jane," to be helpful for tying together the presented material. Twenty-seven (84%) participants indicated their willingness to complete additional lessons in the module.

Attribute Variables

The researcher also examined attribute variables to determine if there were any strong relationships between them and the dependent variables of knowledge gain and comfort level. To simplify attribute comparisons, the researcher compared the high scoring participants with post-test scores of ≥90% and the low scoring participants with post-test scores of ≤75%. The researcher arbitrarily defined the limits for the comparison groups on a normal curve with ≤ 75% indicating a minimally passing or low score and ≥90% indicating an above average or high score. Eleven participants were in the ≥90% range and 7 were in the ≤75% range (see Appendix K).

The researcher first considered the age range of the participants in the high scoring and low scoring post-test groups. Data indicated that although the majority of participants in both groups were in the 31 to 50 year age group, those in the high scoring post-test group tended to fall on the younger end of the spectrum.

The researcher also compared the educational levels of the high scoring and low scoring post-test participants.

The majority of the high scoring post-test group were baccalaureate nurses. There were no baccalaureate nurses in the low scoring post-test group.

The low scoring post-test group had slightly more years in nursing practice and in maternal-child health nursing than the high scoring post-test group. The researcher, in comparing the participants' primary work area within the department, found that most participants worked primarily in labor and delivery.

There was a small difference in the number of high scoring and low scoring participants who had attended grief related classes. Six of the 11 high scoring participants compared to 5 of the 7 low scoring participants had taken grief related classes in the past. One of the low scoring participants had attended a death and dying course and a perinatal loss class.

The researcher also examined the variable related to the program policies and procedures. Nine of the high scoring post-test participants had used 1 or more policy and procedure and 5 of those participants had experienced 1 or more problems with the completion of the policy requirements. All of the low scoring participants had used 1 or more policy and procedure and 6 of that group had experienced 1 or more problems with fulfilling the requirements.

As was the case with the total sample, the problem the comparison groups identified most often was a lack of time to

complete the policies and procedures. Two of the high scoring post-test group and 3 of the low scoring post-test group stated that their lack of knowledge was a problem, and similar numbers identified a lack of policy clarity as being problematic. Two of the low scoring participants reported that they felt uncomfortable with this type of caregiving. Four of the total sample and none of the high scoring participants complained of that problem.

As a part of knowledge gain comparisons, the researcher compared differences in the low scoring post-test group's and high scoring post-test group's responses to theory questions versus experiential questions. As noted in the knowledge gain section, the participants did very well on the experiential questions on both the pretest and post-test. The high scoring post-test group correctly responded to 80% to 100% of those questions on the pretest. That group achieved 100% correct on the post-test. The low scoring post-test group correctly answered 70% to 100% of the experiential questions on the pretest and dropped their scores slightly to 60% to 100% correct on the post-test.

There were significant gains in the theory questions from pretest to post-test. The high scoring post-test group increased their post-test scores on the theory questions by 22% to 100%. The low scoring post-test group increased their post-test scores on the theory questions by 14% to 64%.

The last variable the researcher looked at was gain in

comfort level as self-reported by the high scoring and low scoring post-test participants. Ten (91%) of the high scoring post-test participants reported gains in comfort level. One (9%) high scoring post-test participant reported no change in comfort level. Five (71%) of the low scoring post-test participants reported increases in comfort level. One (14%) low scoring post-test participant indicated no change in comfort level, and 1 (14%) reported a decrease in comfort level. The total sample reported an average gain in comfort level of 3.54 points.

The researcher discusses the significance of these findings in Chapter 5. Chapter 5 also includes the researcher's recommendations for nursing practice, education, and research based on these findings.

Chapter 5

DISCUSSION

Summary

This chapter presents the conclusions, limitations, and recommendations from the analyses and interpretation of data presented in the previous chapter. This quasi-experimental pilot study investigated the effectiveness of a self-instructional lesson format for teaching perinatal bereavement support. The pilot study evolved from a needs assessment conducted at the test site, a community hospital in northern California. Respondents to the needs assessment acknowledged the need for education on this subject and indicated a willingness to use a self-instructional lesson format to study perinatal bereavement support.

Data collection instruments consisted of (a) a demographic questionnaire, (b) a cognitive knowledge pretest and post-test, and (c) a participant evaluation form. The treatment in this study was the testing of one lesson of a perinatal bereavement support module.

Conclusions

The findings of this study support the following conclusions: (a) staff nurses in a maternal-child health setting can gain knowledge about perinatal loss and bereavement support through the use of a self-instructional module, and (b) the use of a self-instructional module can

positively influence the self-reported comfort level of nurses who provide perinatal bereavement support. Findings also indicate that adult learning principles are applicable to self-instructional modules designed for continuing nursing education.

Discussion of Major Findings

Both of the dependent variables measured in this study, knowledge gain and increased self-reported comfort level, were significant. Knowledge pretest and post-test scores on an instrument developed by the researcher reflected knowledge gain. On the evaluation form, participants reported perceived increases in their level of comfort with perinatal bereavement support.

Adult learning principles influenced the content of the self-instructional lesson and the design and conduct of the study. The experiential learning model influenced topic choice, lesson content, and test content. Study findings demonstrated that these principles were appropriate to nursing continuing education that related to perinatal bereavement support.

Knowledge Gain

This pilot study tested Lesson 1 of the module, the theory lesson. The researcher wanted to take advantage of the opportunity to introduce the participants to the theoretical foundation of the perinatal bereavement support program, but had anticipated that they might have difficulty

learning the new and "pure theory" content that comprised the lesson. This concern arose at the time of the needs assessment.

All of the participants in this study were female registered nurses who worked part time in the maternal-child health department of the test site. The majority had been maternal-child health nurses for 6 to 20 years and had received their nursing education in associate degree programs.

The majority of the participants expressed a preference for a pragmatic, rather than a theoretical, approach to perinatal bereavement support education. This preference may have resulted from a lack of emphasis on theory when the majority of participants were in school or from the fact that a majority of the participants were associate degree nurses. According to Lutjens and Horan (1992) contemporary nursing educators and curricula developers are now emphasizing theory and research in all levels of nursing education. Because this emphasis is recent, practicing nurses might respond to theory and research differently, based on their level of nursing education and how recently they graduated. Those researchers stated that associate degree nurses should be able to appreciate nursing theory and to identify nursing as a theory-based practice and baccalaureate nurses should be able to use nursing theory and conceptualize nursing as theory-based practice. Nursing interventions at the

baccalaureate level are, as a result, theory specific and extend beyond individuals to groups such as families and communities.

The knowledge pretest and post-test consisted of questions the researcher considered to be experiential and theory-based questions that related to specific theory content presented in the lesson. The experiential questions dealt with experiences and situations generally familiar to maternal-child health nurses. All participants scored notably higher on the experiential questions on the pretest than on theory-based questions.

The researcher had anticipated high scores on the experiential questions based on the adult education principles of Knowles (1978, 1980, 1984) and the experiential learning principles of Kolb (1984). Both of those researchers maintained that adults draw on experience as their richest resource for learning.

According to Knowles (1984), as individuals mature they accumulate an expanding reservoir of experience that causes them to become increasingly rich resources for learning. At the same time, this maturity and experience provide the individual with a broader base on which to relate new learning. Knowles also maintained that adult learners learn best when learning experiences are relevant to their needs. Learners may not be ready to study a specific area of content until they confront problems related to the content.

Each of these principles applied to the participants in this pilot study. The majority of the nurses had worked in maternal-child health nursing for quite a while and therefore had a broad base of knowledge and experience to apply to the learning experience. The content of the self-instructional lesson related to the provision of perinatal bereavement support. The learning experience was relevant to a specific need because maternal-child health nurses commonly interact with patients who experience perinatal loss. The nurses who participated in the study had repeatedly requested information on the topic because they experienced ongoing problems with the perinatal bereavement policies and procedures.

Kolb's (1984) experiential learning model demonstrated that adults tend to learn by analogy, that is from a prototype model. People learn best when the material is interesting, relevant to their needs, and they can relate it to something they already know. He also found that adult learners have definite preferences in regard to learning style and instructional method. The researcher developed the self-instructional lesson to meet the identified needs of the participants and took into account the participants' expressed preference for an experiential or pragmatic approach rather than a theoretical approach.

The lesson presented several grief and mourning theories, grief counseling principles, and a nursing theory.

The researcher applied the theories and principles to a real life situation, presented in story format. "A Story of Jane," was a prototype model of effective nurse-patient interaction in a perinatal bereavement setting. The nursing interventions in the story were theory-based, but also involved practical hands-on nursing care of the patient and her baby.

Though the participants did better on experiential questions than theory questions, the majority substantially increased their scores on the theory questions. The theory questions addressed specific lesson content: a) Bowlby and Parkes' (1970) phases of mourning, (b) Worden's (1982, 1991) tasks of mourning and grief counseling principles, and (c) Travelbee's (1966) nurse-patient interaction model.

Participants increased their theory scores especially on those questions, which according to Kolb, allowed them to fit new knowledge into a framework or web of previous knowledge or experience. For example, the question on parenting tasks referred to theory routinely covered in basic undergraduate psychology courses and may have triggered the participants' memories and thereby increased retention of the material. Participants also did well on the question that referred to tasks of mourning which were similar to the stages of death and dying presented in undergraduate death and dying classes. Participants readily comprehended the concept that mourning is a process and could list Worden's grief counseling

principles, many of which they had probably used intuitively in their practice.

The smallest increases in theory-based scores were on the questions that related to the nurse-patient interaction model of Travelbee. The researcher had anticipated that participants would be able to comprehend and appreciate this theory because of its relevancy to perinatal bereavement support. The researcher attempted to present Travelbee's model in a concrete manner by including a written abstract, a pictorial representation, and a story that exemplified the application of this interactionist model to a real life situation.

The small increase in scores on the nurse-patient interaction model questions may have been a result of differences in the presentation of the grief theories and principles and the nursing model. The presentations of Bowlby and Parkes' grief theory and Worden's grief theory and counseling principles were more concrete than the presentation of Travelbee's more abstract nurse-patient interaction model.

The lesson (a) presented Bowlby and Parkes' phases of mourning in stepwise fashion, (b) included the usual time of occurrence of the phases, and (c) detailed manifestations of grief common to each phase. Worden's tasks of mourning and grief counseling principles received extensive attention in the lesson. The researcher presented each of these tasks

with a quotation from Worden and included specific examples of how the nurse might assist parents to move through these phases. The lesson also presented Worden's counseling principles in a stepwise fashion and included practical application of the principles. The lesson presented Travelbee's nurse-patient interaction model in a variety of formats, but did not identify each step, by name, in the case study.

The small increase in scores on the questions pertaining to Travelbee's model may have resulted from the abstractness of the model, or may have originated with the participants rather than the model or the lesson content. Participants (a) may have paid inadequate attention to that part of the lesson, (b) may have been resistant to learning or applying nursing theory, (c) may have lacked personal experiences that would enable them to validate an abstract model, or (d) may have been unable to comprehend the broad concepts of empathy, sympathy, and rapport presented in the model.

Comfort Level

The second dependent variable in this study involved the concept of nurses' self-reported comfort levels with perinatal bereavement support. The researcher wanted to measure the comfort level of the nurses because of numerous comments and complaints that involved the nurses' lack of comfort with this type of caregiving. A majority of the participants reported significant increases in their self-

reported comfort levels after completion of the lesson.

The researcher compared self-reported comfort levels between the low scoring and high scoring post-test participants. The pre-lesson and post-lesson self-reported comfort levels of the high scoring post-test group were higher than the comfort levels reported by the low scoring post-test group. It appears that the nurses who had a better grasp of the lesson content were more comfortable with bereavement support.

Perceived Knowledge Level

The majority of the participants reported increased perceived knowledge gain that coincided with increased knowledge gain on the post-test. The researcher used the participants' perceived knowledge gain as a way to acquaint them with the importance of self-evaluation. Knowles (1978) addressed the importance of self-evaluation or self-diagnosis in adult education. Knowles did not expect learners to sit passively by and wait for readiness to learn to develop naturally but suggested that educators could stimulate readiness by exposing learners to better models of performance and by encouraging higher levels of aspiration and self-evaluation. In this pilot study, the researcher presented a prototype model of performance, encouraged participants to aspire to higher performance, and provided an opportunity for self-evaluation.

According to Emblen and Gray (1990), individual nurses

should be able to evaluate how their perceived and measured knowledge gain compare. Resultant positive or negative correlations can act as personal and professional motivators for participants to pursue additional learning experiences.

Lesson Evaluation

The researcher sought feedback on each section of the tested lesson because this was a pilot study. This feedback or formative evaluation process allowed the researcher to make necessary changes in the content of the tested lesson and helped define forthcoming lessons. The evaluation process implemented several aspects of the adult education principles of Knowles (1984) and Kolb (1984) by increasing involvement of the participants in their learning and by emphasizing the importance of evaluation. Nursing researchers, Schmidt and Fischer (1992), considered evaluation of learning to be a critical component of any learning activity, particularly when the intent of the activity is to change behavior.

A majority of the participants in this study indicated that each section of the lesson contributed to their knowledge level, and their post-test scores increased accordingly. The participants also indicated that the application story helped them connect the presented lesson material by providing a concrete example.

The only discrepancy in participant evaluation of a section's contribution to knowledge level was the section on

Travelbee's nurse-patient interaction model. A majority of the participants indicated that Travelbee's model contributed moderately to a great deal to their knowledge about bereavement support. However, there were relatively small increases in the post-test scores on the questions that related to that nursing model.

As indicated in the discussion of knowledge gain, these incongruous findings may have resulted from weakness in the instructional plan or may have originated with study participants. The researcher believes one reason the participants had problems in comprehending this model related to the fact that the lesson section involved the attitudinal or affective domain. Nurse-patient interactions involve the affect and attitudes of both nurse and patient, and often extend to the patient's family and the community.

The researcher, as the perinatal bereavement coordinator at the test site, has received a great deal of feedback from the nurses on the program, its policies and procedures, and their comfort or lack of comfort in the provision of perinatal bereavement support. Prior to the pilot study, many participants had expressed a desire for more detailed checklists to augment the policies and procedures. The nurses stated they did not want to have to read through the policies and other materials but wanted a quick and easy recipe for meeting the requirements. Some even asked the

researcher to tell them exactly what to say in bereavement situations.

Another factor that might have contributed to the nurses' inability or unwillingness to learn about this particular nursing model is the fact that professional nursing education tends to encourage nurses to maintain composure and control their feeling, especially in the presence of patients and their families. As Eakes (1990) pointed out, this professional expectation is incongruent with the need to fully express emotions associated with positive grief resolution. Nurses who are unwilling to express their own emotions often, perhaps unconsciously, impose that stricture on their patients. As Leon (1992) observed, caregivers who provide support to families experiencing perinatal bereavement participate in a vital way in the healing process, not with a flurry of activity but by listening unhurriedly, by understanding the meaning of the loss to the bereaved family, and by helping the parents express their painful and conflicting feelings. The practice of nurses avoiding bereavement situations or responding to the situations in a task oriented manner may be amenable to change, through education.

Continuing education in nursing usually focuses on cognitive processing and psychomotor functioning. Ellis (1993) contends that it is time to incorporate the affective domain into staff development programs. Nurses can learn

that therapeutic relationships require care, self-awareness, and awareness of the emotional needs of others.

With additional knowledge and expertise, nurses can help patients explore alternatives that promote mental well-being. This pilot study attempted to do that by acquainting the participants with a nursing model that readily applies to the provision of perinatal bereavement support. Travelbee's model provides structure for the development of nurse-patient relationships that can create an atmosphere of caring, trust, self-awareness, and awareness of the emotional needs of the other person in the relationship.

Attribute Variables

The majority of participants in the high scoring post-test group and none of those in the low scoring post-test group were baccalaureate prepared. The baccalaureate prepared participants scored higher on theory-based questions on the post-test than did the associate degree nurses. Participants in the low scoring post-test group were slightly older, had more years of nursing experience, and had more years of maternal-child health nursing experience than the high scoring post-test participants. Another attribute, post-basic death and dying education, did not contribute to participants' ability to comprehend or appreciate new theory. Fewer high scoring post-test nurses had taken death education classes as compared to the total sample and the low scoring post-test group.

Exposure to death and dying classes may have made it more difficult for participants to learn new grief theory. When asked to list Bowlby and Parkes' phases of grief, some participants listed Kubler-Ross's classic stages of death and dying on the post-test. Each of the participants who listed Kubler-Ross's stages had taken death and dying courses and had 16 or more years experience in nursing.

Those participants who had a greater amount of nursing experience had been out of school longer than those participants with less experience. It apparently requires greater effort on the part of experienced nurses who have been out of school quite a while to learn new material that supplants previous knowledge or demands role changes (Bramble, 1990).

The majority of participants who had used the policies and procedures had experienced problems with using them. Slightly more of the low scoring post-test group experienced problems than did the high scoring post-test group. The most commonly encountered problem was lack of time to complete the policies. This held true for the entire sample, including both high and low scoring post-test groups.

Scope and Limitations

Sample

The participants were from one agency in a northern California city and may not be representative of other maternal-child health nurses. The researcher could not

control the threats to internal validity of history, maturation, testing, mortality, or selection, but was aware of the potential impact of these issues on study outcomes.

The researcher knew that history would be an issue if some of the participants had to deal with a perinatal loss during the study period, but none did. Participant maturation might also have affected study outcome. The researcher attempted to control for these unplanned and unrecognized changes by allowing as short a time as possible for the study thus decreasing maturational influences.

The researcher, aware that testing effects might alter the findings of this study, attempted to control for this by testing and retesting participants in as short a time as possible. This was especially important since the pretest and post-test were identical and participants may have remembered the questions from the pretest and concentrated on related aspects of the lesson. The researcher repeatedly asked the participants not to discuss lesson or test contents among themselves so that they would not know that the pretest and post-test were identical.

The mortality or attrition rate was negligible. According to Burns and Grove (1987), mortality becomes a threat when those who drop out of a study are different from those who remain in the study or when there is a difference in the type of participants who drop out of the experimental and control groups. The nurses who did not complete the

study were not strikingly different in their attribute variables from those who remained in the study. The only notable difference was that none of the nurses who started but did not complete the study were baccalaureate prepared.

A selection threat exists when there is no randomization in a study. The people who volunteered for this study may have been different from those who did not volunteer. However, participants included in a control group can also be different in an important way from those in an experimental group. The lack of a control group in this study decreased the selection threat.

The selection technique and sample size of this study do not allow generalization beyond populations with similar characteristics. A large sample is more likely to be representative of the general nursing population, resulting in a smaller sampling error (Polit & Hungler, 1987). Due to time constraints and the small sampling of participants, it was not possible to design the study to avoid the stated limitations. However, the researcher invited all the nurses in the maternal-child health department to participate in the study in order to increase both sample number and diversity.

The researcher was not able to determine whether the promise of a small monetary payment to those participants who completed the study affected the outcome. Half of the participants returned the compensation to the researcher.

That would seem to indicate that the compensation was not a prime motivation for participation in the study.

Environment

The majority of participants completed the pretest and post-test during their work day, and this lack of control over environmental influences and often hurried test taking may have influenced the results. The researcher attempted to control for this by having participants take the tests individually or in small groups in a conference room away from the work stations, during their break time, or after they had given report and were free to go home.

The lesson, designed to be self-paced, had a deadline for completion because of the time constraints of the study. This may have been a limiting factor. Although the researcher could not allow unlimited time for study of the lesson, participants did have equal time to study the lesson and complete the post-test. To allow for this, the researcher extended the deadline by 1 week for those who received the lesson after the start date.

Validity

Standardized instruments are useful because there are fewer questions about their validity and reliability and accompanying norms allow researchers to evaluate their results. The researcher discovered no instruments designed to measure the dependent variables investigated in this study and therefore constructed operative definitions based

discussions and definitions from the professional literature. A group of colleagues reviewed all of the materials for content validity.

Recommendations

Research

Future studies should expand the sample population to include a larger number of participants. Researchers could recruit maternal-child health nurses from other community hospitals with perinatal bereavement programs to test the lesson. A larger sample size is more likely to be representative of the target population of maternal-child health nurses and might allow greater generalization of the research findings.

In future testing, all participants should take the pretest and post-test at the same time and in the same environment to reduce extraneous influences that can affect participant performance. Participants should complete the tests at group meetings outside work hours. Because self-instructional lessons are generally self-paced, the researcher recommends that the amount of time for completion be extended in future studies.

On the basis of the study findings, the researcher would like to make several specific recommendations regarding instrumentation validity, to include: (a) the submission of the lesson and testing instruments to additional content experts for evaluation of content

reliability and validity, and (b) further evaluation of the abstract concept of comfort level for construct validity. Researchers might add additional comfort related questions to the existing instrument or adapt instruments used by other researchers to test related concepts. Another alternative would be to replace the term comfort with a more commonly used and accepted term such as self-efficacy, competency, or self-confidence.

Time, site, and resource constraints of this study precluded the use of an experimental design. The researcher suggests the use of a control group in future testing of the lesson or other lessons in the module to compare and measure the significance of obtained findings. The use of a longitudinal study to determine the extent to which participants implement the lesson content in practice and to determine whether there is a significant loss in retention of self-studied material might also produce some interesting data. Additionally, if the lesson proves to be valid and reliable, continuing education credit should be available for nurses who complete the lesson as part of their departmental orientation.

Because this was a pilot study, the researcher concentrated on the evaluative component. Lesson evaluation included formative and summative evaluation. Formative evaluation allowed for the identification and elimination of weaknesses in the lesson. The resultant improvement of the

lesson content, learning sequence, and pace of instruction will optimize learning outcomes during full-scale use of the lesson. Summative evaluation indicated that the lesson met its outcome criteria of increasing the participants' knowledge gain and comfort level.

To further strengthen the evaluative component of the study, the researcher suggests revision and expansion of the evaluation tool. The existing evaluation form asks participants to comment on how much each section of the lesson contributed to their knowledge level. A revised evaluation form should allow for participant comments on the presentation of the content and suggestions for how the researcher could better present the lesson content to meet participant needs and learning style preferences. The researcher could then take specific learner preferences into account when revising this lesson and when completing additional lessons in the module. Participants should evaluate the case study presentation carefully to determine if reported acceptance and appreciation of that format applies to this particular group of learners.

The present evaluation form requires participants to comment on pre-lesson and post-lesson attitudes by indicating perceived knowledge level and self-reported comfort level. In order to obtain spontaneous responses, not influenced by the lesson, pre-lesson questions on comfort level and perceived knowledge level should be on the demographic

questionnaire. The evaluation form should include the post-lesson attitudinal questions.

The researcher suggests that the cognitive test used in the pilot study be revised. The cognitive test in this pilot study consisted of a combination of what Bloom's taxonomy of learning (Bloom, Hastings, & Madaus, 1971) refers to as low level and mid level questions. The listing questions were low level because they tested knowledge and comprehension, but not utilization of the material. The multiple choice questions were mid level because they tested understanding and application of the material.

The researcher used primarily low level and a few mid level questions on the cognitive test. The researcher chose these levels of questions on the basis of (a) the attribute characteristics of the sample, (b) the researcher's observation of participant response to other educational experiences at the test site, and (c) comments made by participants prior to the pilot study. The majority of the participants had completed their basic nursing education 6 to 15 years ago and had attended associate degree programs. A number of the participants had expressed a dislike and fear of test taking and stated that they did not like essay questions but preferred fill-in or multiple choice questions.

The researcher intended the test to be a positive reinforcement for the participants. Success on the test, especially on the experiential questions, should have

increased the participants' judgment of self-confidence and efficacy. In order to ensure greater success on the test, the researcher designed it to be relatively easy and easily completed.

However, the researcher suggests future testing of this lesson should include more mid level questions that participants cannot answer simply from memory or perception. Mid level questions provide a more accurate evaluation of knowledge, judgment, and application. The revised test might also include some higher level questions to provide the learners with an opportunity to practice higher order thinking. Because this group of learners has expressed a dislike of essay questions, the researcher suggests the use of a multiple choice format for the mid or high level questions. Patient care situations could form the basis for the test items.

Clinical Practice

A high percentage of participants identified inadequate time as being a problem. This affirms the importance of streamlined policies and procedures that assist the nurses with their work rather than hindering them, a team approach to the provision of perinatal loss support, and the use of bereavement counselors to assist the nurses.

The second most common complaint identified by participants was that the departmental policies and procedures were unclear. This complaint emphasizes that

ongoing evaluation, revision, and updating of policies and procedures is critical. To assure that policies and procedures reflect the needs of patients and staff, quality assurance monitors that target the perinatal loss program should be routine. Involvement of the nurses who use the policies and procedures in the evaluation process should decrease staff resistance to change (Smith, 1991). Ongoing evaluation will also provide information on the clinical application of the lesson content.

A small number of participants indicated they had encountered problems with the policies and procedures because of inadequate knowledge of and lack of comfort with perinatal bereavement support. One participant did not know where to find the forms and another had difficulty coordinating all the paperwork. Education or training programs specific to the topic can address each of these problems.

The researcher has already acted on the formative evaluation data that indicated the policies and procedures were unclear. After completing the pilot study, the researcher conducted several inservices and went through the policies and procedures with the nurses. The researcher updated and revised the policies and procedures based on feedback from the nurses.

Education

As the adult education model points out, adults learn best when the content that they are learning is directly and

immediately applicable to the work setting. Participant complaints about the perinatal bereavement policies and procedures they utilize at the test site motivated the researcher to develop this lesson and the forthcoming lessons that will comprise the perinatal bereavement support module.

Pilot study participants evidenced greater difficulty with theory-based test questions than with experiential questions and had particular difficulty comprehending Travelbee's nursing model. The researcher believes that an expanded case study approach might enhance the nurses' appreciation of the presented nursing model and enable nurses to generalize the studied principles to their practices.

The researcher's belief that a case study approach can be helpful in the presentation of theory arose from knowledge of adult education and experiential learning principles. A variety of academic disciplines, including nursing, have found the use of case studies to be a helpful and informative way to present clinical findings and materials relevant to patient care (Angelini & Knapp, 1992).

Evaluations revealed that the nurses found the case study, or application story, to be helpful to them in tying together the presented material. That story presented a real life situation that exemplified the application of Travelbee's interaction model. The scenario included references to nursing interventions, materials, and resources used at the test site.

The researcher suggests an expansion of the case study in the lesson to include specific references to Travelbee's nurse-patient interaction model as the story unfolds. A case study that demonstrates a less than ideal interaction might be helpful in conveying the idea that although each nurse-patient interaction may not be ideal, nurses can use lesson content in every situation. The situational application of Worden's grief counseling principles might form the basis for an additional case study.

The scenario presented in the lesson was a prototype model of ideal nurse-patient interaction. In addition to using words to present prototype models to learners, the researcher believes that educators and expert nurses can model what they are trying to convey to their students or co-workers. They can be living audiovisual examples. According to Mager (1968) modeling behavior is exceedingly important in the achievement of attitude objectives and changed behavior.

The researcher recommends adding a lesson objective requiring participants to apply lesson content in a patient care situation. To better equip participants to do this, the researcher suggests exposure to role modeling of the desired interactions. The researcher has used role modeling in the past by providing bereavement support while the primary nurse provided hands-on care of the patient and could expand the role modeling to include specific references to lesson

content. After modeling bereavement support, the researcher could discuss the theories and principles with the nurse.

The researcher also suggests that strategies that help nurses to recognize and understand their feelings, anxieties, strengths, and weaknesses in the provision of perinatal support are also necessary. Although numerous study participants indicated to the researcher that they did not like "emotionally draining seminars with panels of crying parents" they did indicate a willingness to view videos on perinatal bereavement support.

Although the researcher previously made videos on the topic available to the nurses at the test site, none of the nurses have requested to view them. The videos refer to grief counseling principles, demonstrate positive nurse-patient interactions, and include patient reactions to the support they have received. The nurses could view and discuss the videos in an inservice setting. That could provide a springboard to discussion and reinforcement of the principles and theories presented in the lesson.

This pilot study involved the necessity of meeting the educational needs of a diverse population of practicing nurses. Because many of the participants in this study had been practicing for many years, they may not have had recent exposure to nursing or adult education theories. The researcher suggests that staff development departments adopt the adult education model for their education programs

because these departments consistently deal with learners with varied backgrounds and levels of experience. They could teach not only the skills required for practice, but the underlying nursing and educational theory as well. This might help bridge the gap between baccalaureate prepared nurses with a more theoretical content in their program and associate degree nurses with a more practical content in their program. Inservices and workshops should also include reference to nursing research that has helped to bridge the theory-practice gap. Nursing research has demonstrated that nurses' knowledge, skill, and self-awareness can directly effect their practice by reducing stress and increasing self-confidence (King, 1984; Spickerman, 1988).

According to adult learning principles, learners should involve themselves with the planning, implementation, and evaluation of their learning experiences. This active participation in learning may establish patterns for lifelong learning. The researcher hopes that this study will inspire community hospital nurses to (a) involve themselves with the planning, implementation, and evaluation of their learning experiences; (b) challenge their existing practice and create new theory-based approaches to practice; and (c) through theory-based practice achieve full potential as individuals and as members of the discipline of nursing (Lutjens & Horan, 1992).

REFERENCES

References

Angelini, D., & Knapp, C. (1992). Case studies in perinatal nursing. Gaithersburg, MD: Aspen.

Benfield, D. G., Leib, S. A., & Vollman, J. H. (1978). Grief response of parents to neonatal death and parent participation in deciding care. Pediatrics, 62(2), 171-177.

Blatchley, M. E., Herzog, P. M., & Russell, J. D. (1978). Effects of self-study on achievement in a medical-surgical nursing course. Nursing Outlook, 7, 444-447.

Bloom, B., Hastings, J., & Madaus, G. (1971). Handbook of formative and summative evaluation of student learning. New York: McGraw-Hill.

Bobak, I., Jensen, M., & Zalar, M. (1989). Maternity and gynecologic care. St. Louis, MO: Mosby.

Bowlby, J., & Parkes, C. (1970) Separation and loss within the family. In E. J. Anthony & C. Houpernick (EDs.), The child in his family (pp. 197-216). New York: Wiley.

Bramble, K. (1990). Cooperative pedagogy in graduate nursing education. Journal of Nursing Education, 29(8), 373-374.

Brooks, B. (1985). Self-learning: An approach to cost-effective staff development. The Journal of Continuing Education in Nursing, 16(5), 165-166.

Brost, L., & Kenney, J. W. (1992). Pregnancy after perinatal loss: Parental reactions and nursing interventions. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 21(6), 457-463.

Brunt, B., & Scott, A. L. (1986). Factors to consider in the development of self-instructional materials. Journal of Continuing Education in Nursing, 17(3), 87-92.

Burns, N., & Grove, S. (1987). The practice of nursing research: Conduct, critique and utilization. Philadelphia, PA: Saunders.

Caty, S., & Tamblyn, D. (1984). Positive effects of education on nursing students' attitudes towards death and dying. Nursing Papers, 16(4), 41-53.

Chinn, P. L., & Hunt, V. O. (1975). Modules in child nursing instruction. Nursing Outlook, 23(10), 650-653.

Chodil, J. J., & Dulaney, P. E. (1984). Continuing education on dying and death. Journal of Continuing Education in Nursing, 15(11), 5-8.

Davitz, L. L., Davitz, J. R., & Rubin, C. F. (1980). Nurses' responses to patient suffering. New York: Springer.

Department of Health and Human Services. (1990). Vital Statistics of the United States, 1987, Vol. II Mortality. Hyattsville, MD: National Center for Health Services.

Department of Health Services. (1990). Vital Statistics of California, 1988. Sacramento, CA: Health and Welfare Agency.

Dick, D. J. (1983). Teaching health assessment skills: A self-instructional approach. Journal of Nursing Education, 22(8), 355-356.

Dietrich, M. C. (1980). A proposed curriculum on death and dying for the allied health student. Journal of Allied Health, 2, 25-32.

Drummond, E., & Blumberg, J. (1962). Death and the curriculum. Journal of Nursing Education, 1(2), 21-28.

Durlak, J. (1978). Comparison between experiential and didactic methods of death education. Omega, 9(1), 57-66.

Eakes, G. (1990). Grief resolution in hospice nurses. An exploration of effective methods. Nursing & Health Care, 11(5), 243-248.

Ellis, C. (1993). Incorporating the affective domain into staff development programs. Journal of Nursing Staff Development, 9(3), 127-130.

Emblen, J. D., & Gray, G. T. (1990). Comparison of nurses' self-directed learning activities. Journal of Continuing Education in Nursing, 21(2), 56-61.

Friesen, L., & Stotts, N. A. (1984). Retention of basic cardiac life support content: The effect of two teaching methods. Journal of Nursing Education, 23(5), 184-191.

Furman, E. (1978). The death of the newborn: Care of the parents. Birth and The Family Journal, 5, 214-218.

Guimei, M. K. (1977). Effectiveness of a programmed instruction module on oral contraceptives. Nursing Research, 26(6), 452-455.

Hayford, J. (1990). I'll hold you in heaven. Ventura, CA: Regal.

Herrle, S. M., & Robinson, B. (1987). Helping staff cope with grief. Nursing Management, 18(9), 33-34.

Hurtig, W. A., & Stewin, L. (1990). The effects of death education and experience on nursing students' attitude towards death. Journal of Advanced Nursing, 15, 29-34.

Hutchinson, S. (1987). Self-care and job stress. IMAGE: Journal of Nursing Scholarship, 19(4), 192-196.

Hutti, M. (1988). Perinatal loss: Assisting parents to cope. Journal of Emergency Nursing, 14(6), 338-341.

Ilse, S., & Burns, L. H. (1985). Miscarriage...A shattered dream. Long Lake, MN: Wintergreen.

Jacobson, S. F., & McGrath, H. M. (Eds.). (1983). Nurses under stress. New York: Wiley.

Johansson, N., & Lally, T. (1990). Effectiveness of a death-education program in reducing death anxiety of nursing students. Omega, 22(1), 25-33.

Joinson, C. (1992). Coping with compassion fatigue. Nursing, 22(4), 116-121.

Kemp, J. (1985). The instructional design process. New York: Harper & Row.

King, E. (1984). Affective education in nursing: A guide to teaching and assessment. Rockville, MD: Aspen.

Kirkley-Best, E., & Kenney, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52, 420-429.

Klaus, M. H., & Kennell, J. H. (1982). Parent-infant bonding. New York: Mosby.

Knowles, M. (1978). The adult learner: A neglected species (2nd ed.). Houston, TX: Gulf.

Knowles, M. (1980). The modern practice of adult education: From pedagogy to andragogy. New York: Association Press.

Knowles, M. (1984). The adult learner: A neglected species (3rd ed.). Houston, TX: Gulf.

Kolb, D. (1984). Experiential learning. Englewood Cliffs, NJ: Prentice-Hall.

Kolcaba, K. Y., & Kolcaba, R. J. (1991). An analysis of the concept of comfort. Journal of Advanced Nursing, 16, 1301-1310.

Kowalski, K. (1980). Managing perinatal loss. Clinical Obstetrics and Gynecology, 23(4), 1113-1123.

Kubler-Ross, E. (1969). On death and dying. New York: Macmillan.

Kubler-Ross, E. (1975). Death-the final stage of growth. Englewood Cliffs, NJ: Prentice-Hall.

Kuenning, D. (1987). Helping people through grief. Minneapolis, MN: Bethany House.

Lachman, V. D. (1983). Stress management: A manual for nurses. New York: Grune & Stratton.

Laube, J. (1977). Death and dying workshop for nurses: Its effect on their death anxiety level. International Journal of Nursing Studies, 14(3), 110-120.

Leon, I. G. (1986). Perinatal loss: A critique of current hospital practices. Clinical Pediatrics, 31(6), 366-374.

Leon, I. G. (1992). Perinatal loss: A critique of current hospital practices. Clinical Pediatrics, 6, 366-374.

Leviton, D. (1971). A course on death education and suicide prevention: Implications for health education. Journal of The American College Health Association, 4, 217-220.

Limbo, R., & Wheeler, S. (1986). Resolve Through Sharing counselor's certification manual (2nd ed.). La Crosse, WI: Lutheran Hospital.

Limbo, R., & Wheeler, S. (1986). When a baby dies: A handbook for healing and helping. La Crosse, WI: Lutheran Hospital.

Lutjens, L., & Horan, M. (1992). Nursing theory in nursing education: An educational imperative. Journal of Professional Nursing, 8(5), 276-281.

Mager, R. F. (1968). Developing attitude toward learning. Palo Alto, CA: Fearon.

Martin, L. B., & Collier, P. A. (1975). Attitudes toward death: A survey of nursing students. Journal of Nursing Education, 14(1), 28-35.

Mast, M. E., & Van Atta, M. J. (1986). Applying adult learning principles in instructional module design. Nurse Educator, 11(1), 35-39.

May, K. A., & Mahlmeister, L. R. (1990). Comprehensive maternity nursing. Philadelphia, PA: Lippincott.

McMahon, J. D. (1973). A unit for independent study in death education. School Health Review, 4, 27-34.

Murray, P. (1974). Death education and its effect on the death anxiety level of nurses. Psychological Reports, 35, 1250-1255.

Murphy, P. A. (1986). Reduction in nurses' death anxiety following a death awareness workshop. Journal of Continuing Education in Nursing, 17(4), 115-118.

Noland, M. P., & Crosby, R. A. (1983). The link between health education and death education. Health Education, 1, 34-37.

Ogundeyin, W. M. (1980). Effectiveness of self-instructional units in post-basic nursing education: With special reference to the use of nursing care plans unit. Journal of Advanced Nursing, 5, 169-178.

Page, C. G. (1987). Misty, our momentary child. Westchester, IL: Crossway.

Peppers, L. G., & Knapp, R. J. (1980). Maternal reactions to involuntary fetal/infant death. Psychiatry, 43, 155-159.

Polit, D. F., & Hungler, B. P. (1987). Nursing research principles and methods (3rd ed.). PA: Lippincott.

Reed, K. (1990). Influence of age and parity on the emotional care given to women experiencing miscarriages. IMAGE: Journal of Nursing Scholarship, 22(2), 89-92.

Robinson, L. (1974). We have no dying patients. Nursing Outlook, 22(10), 651-653.

Rufo, K. L. (1985). Effectiveness of self-instructional packages in staff development activities. Journal of Continuing Education in Nursing, 16(3), 80-84.

Santopietro, M. C. (1980). Effectiveness of a self-instructional module in human sexuality counseling. Nursing Research, 29(1), 14-18.

Saylor, D. (1977). Nursing response to mothers of stillborn infants. JOGN Nursing, 4, 39-42.

Schmidt, K. L., & Fisher, J. C. (1992). Effective development and utilization of self-learning modules. Journal of Continuing Education in Nursing, 23(2), 54-59.

Small, M., Engler, A. J., & Rushton, C. H. (1991). Saying goodbye in the intensive care unit: Helping caregivers grieve. Pediatric Nursing, 17(1), 103-105.

Smith, M. (1991). Evaluating nursing theory-based practice. Nursing Science Quarterly, 4(3), 98-99.

Spickerman, S. (1988). Enhancing the socialization of the nursing process. Nurse Educator, 13(6), 10-13.

Stetler, C., Garity, J., Macdonald, M., & Smith, S. (1980). A modular approach to management development. The Journal of Nursing Administration, 12, 19-24.

Swanson-Kauffman, K. (1983). The unborn one: A profile of the human experience of miscarriage. (Doctoral dissertation, University of Colorado, 1983, 317 p). Dissertations Abstracts International, 1984 Author Index Supplement, 406. (University Microfilms No. 8404456).

Swanson-Kauffman, K. (1986). Caring in the instance of unexpected early pregnancy loss. Topics in Clinical Nursing, 8(2) 37-46.

Swanson-Kauffman, K. (1988). There should have been two: Nursing care of parents experiencing the perinatal death of a twin. Journal of Perinatal & Neonatal Nursing, 2(2), 83.

Travelbee, J. (1966). Interpersonal aspects of nursing. Philadelphia, PA: Davis.

Travelbee, J. (1969). Intervention in psychiatric nursing. Philadelphia, PA: Davis.

Travelbee, J. (1971). Interpersonal aspects of nursing (2nd ed.). Philadelphia, PA: Davis.

Watson, M. (1968). Death--A necessary concern for nurses. Nursing Outlook, 16(2), 47-48.

Wise, D. (1974). Learning about dying. Nursing Outlook, 22(1), 42-44.

Worden, J. W. (1982). Grief counseling and grief therapy. New York: Springer.

Worden, J. W. (1991). Grief counseling and grief therapy (2nd ed.). New York: Springer.

APPENDIX A

Institutional Consent

San Jose State University
Department of Nursing
and Graduate Studies

September 18,1992

To Whom it may concern,

I have read and understand the proposal that Marcene Saxman submitted to me on August 1, 1992. Given that it does not involve patient contact, she is hereby granted approval to conduct the nursing research project she proposed, using the Hospital facilities and MCH Staff.

If you have any questions or concerns please feel free to contact me at

Sincerely,

Perinatal Pediatric
Department Manager

APPENDIX B

Human Subjects Consent

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

Office of the Academic Vice President • *Associate Academic Vice President* • *Graduate Studies and Research*
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Marcene Saxman
459 Tuttle Ave.
Watsonville, CA 95076

From: Serena W. Stanford Serena W. Stanford
AAVP, Graduate Studies and Research

Date: January 14, 1993

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

> "A Comparison of the Knowledge Gain and Comfort Level of Maternal-Child Health Nurses Before and After Completion of a Self-Instructional Perinatal Bereavement Support Lesson"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

APPENDIX C

Participant Consent Form

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of Applied Arts and Sciences • Department of Nursing • Graduate Program
One Washington Square • San Jose, California 95192-0057 • 408/924-3134

Agreement to Participate in Research

Responsible investigator(s): Marcene Y. Saxman, RN, NP, BSN

Title of Protocol: A Comparison of the Knowledge Gain and Comfort Level of Maternal-Child Health Nurses Before and After Completion of A Self-Instructional Perinatal Bereavement Support Lesson.

1. I have been asked to participate in a research study conducted by Marcene Y. Saxman, RN to investigate the effectiveness of a self-study module to teach perinatal bereavement support to maternal-child health nurses.

2. I will be asked to complete a pretest, the lesson, a posttest, an evaluation, and a demographic questionnaire provided by the researcher, within a 3 week period. Maternal-child health nurses will be recruited from _____ _____ Hospital to participate in the study in February 1993.

3. The completion of the lesson, and answering of demographic and evaluative questions, does not involve any anticipated risk. I will be free to discontinue participation in the study at any time if I feel uncomfortable with the lesson, or questions asked. If I feel uncomfortable with participation in the study I should discuss this with the investigator listed below.

4. It is anticipated that participants in the module lesson will receive an overview and introduction to bereavement support, and increase their knowledge in regard to the presented subject matter.

5. No service of any kind to which I may be entitled will be lost or jeopardized if I choose to "not participate" in the study. My decision whether or not to participate in the study will not prejudice my future relations with San Jose State University or _____ Hospital.

6. My decision to participate in this study is completely voluntary and I am free to withdraw my consent at any time.

7. Each participant will be assigned a Personal Code Number (PCN). The number will facilitate comparisons of knowledge and comfort level differences on the individual's test and evaluation forms. I understand that the key for the PCNs will be maintained separately from any other study related materials and will be destroyed at the completion of the study.

8. Results of this study may be published, but no information that could identify the subjects will be included.

9. Participants in the study will receive $10 at the completion of the study. This modest compensation is intended to convey the investigator's appreciation of the time investment of the participants.

10. Any questions about the research may be addressed to Marcene Y. Saxman, at (408) 426-7549 or (408) 462-7678. Concerns in regard to the research may be presented to Dr. Bobbye Gorenberg, Graduate Coordinator, SJSU Department of Nursing, at (408) 924-3134. Questions about research, subjects' rights, or research-related injury may be presented to Serena Stanford, Ph.D., Associate Vice President of Graduate Studies and Research, SJSU, at (408) 924-2480.

11. My signature indicates that (a) I have decided to participate, after having read the above information, and (b) I have received a signed and dated copy of the consent form.

_____

Subject's Signature Date

_____

Investigator's Signature Date

*The signature of a subject on this document indicates agreement to participate in the study.

*The signature of a researcher on this document indicates agreement to include the above named subject in the research and attestation that the subject has been fully informed of his or her rights.

APPENDIX D

Demographic Questionnaire

Code - - -

Demographic Questionnaire

Directions:
Please fill in designated blanks and/or check (√) responses as indicated.

13. Age, in years:
____20-30
____31-40
____41-50
____51-60
____61-70

14. Gender:
____Female
____Male

15. What level of nurse are you?
____RN
____LVN
____NA

16. How long have you worked in nursing? (in years)
____ 0-1
____ 2-5
____ 6-10
____11-15
____16-20
____21-25
____26-30
____31 or more

17. How long have you been involved with Maternal-Child Health Nursing? (in years)
____ 0-1
____ 2-5
____ 6-10
____11-15
____16-20
____21-25
____26-30
____31 or more

Code - - -

Demographic Questionnaire, continued

Directions:
Please fill in designated blanks and/or check (√) responses as indicated.

18. In what area(s) of MCH nursing do you now work?
___L&D
___Postpartum
___Nursery
___Peds

19. What was your basic nursing education?
___LVN
___ADN
___BSN
___DIPLOMA
___Other_____

20. Have you completed any advanced nursing degrees, certifications, or licensures?
___BSN
___MSN
___PhD
___Nurse Practitioner
___Certified Nurse Midwife
___RNC
___Other_____

21. Have you ever taken a course in any of the following? (Please Check (√) response(s) and include approximate date on the line following choice(s).)

___Death and Dying_____ [approximate date]
___Perinatal Loss_____ [approximate date]
___Hospice Nursing_____ [approximate date]
___Other, related topic_____ [approximate date]

22. Have you utilized any of the following Policies and Procedures related to perinatal loss at DSCH? (Please Check (√) the ones that apply.)
___Stillbirth (intrauterine fetal demise)
___Live Birth with Neonatal Death
___Miscarriage (spontaneous abortion)
___Ectopic Pregnancy

Code - - -

Demographic Questionnaire, continued

Directions:
Please fill in designated blanks and/or check (√) responses as indicated.

23. If you used any of the above listed Policies and Procedures, did you encounter any difficulty in completing them?

___ Yes
___ No

24. If you indicated YES on question 23, what was the nature of the difficulty?

___ I lacked adequate knowledge on the subject.
___ The policy or procedure was unclear.
___ I did not have enough time to complete the requirements.
___ I was not comfortable with this type of caregiving.
___ Other (specify) _____
_____
_____

APPENDIX E

Cognitive Test

Code - - -

Cognitive Test for Perinatal Bereavement Module Lesson 1

These Questions Are To Be Answered On The Test Form.
There are 25 possible points, and the points for each question are given in parentheses.

Directions:
Fill in your answers on the provided lines, or circle choices as indicated.

1. List 2 perinatal events, other than death, that may result in feelings of loss. (2 points)

a._____

b._____

2. List 2 parenting tasks. (2 points)

a._____

b._____

3. List the 4 phases of grief.[Bowlby & Parkes] (4 points)

a._____

b._____

c._____

d._____

4. List 4 manifestations (emotional or physical) of normal grief. (4 points)

a._____

b._____

c._____

d._____

Code - - -

Cognitive Test, (Continued)

Directions:

Fill in your answers on the provided lines, or circle choices as indicated.

5. List 2 of Worden's 4 Tasks of Mourning. (2 points)

a._____

b._____

6. Worden considers mourning to be a _____ which occurs after a loss, while grief refers to the personal experience of the loss. (1 point)

7. List 2 of Worden's principles of grief counseling. (2 points)

a._____

_____

b._____

_____

8. State the key element in each nurse-patient interaction. (1 point)

_____

9. List the 4 steps of nurse-patient interactions necessary for the development of rapport/relationship according to Travelbee.(4 points)

a._____

b._____

c._____

d._____

Code - - -

Cognitive Test, (Continued)

Directions:
Circle one best response for each statement, 10 through 12.
(1 point each)

10. Helping families cope with perinatal loss requires knowledge of death and dying and grief theory so that the nurse

a. can give a detailed description of each theory to every bereaved patient/family.
b. can give each patient/family the information needed to cope with their loss during hospitalization and after discharge.
c. provide comprehensive grief therapy for the patient/family.

11. If the patient is physically or emotionally unable to listen to teaching in regard to grief/mourning, during her/his shift, the nurse

a. has no further responsibility except to give written information to her or her support person/people.
b. must request the next shift to continue with the care plan and provide information and teaching as the patient allows.
c. should refer the patient to social services for possible psychiatric follow-up.

12. If a bereaved patient tells the nurse that she plans to return to work immediately, to forget about the baby, and get on with her life, the nurse

a. should encourage her to do so, because she should keep busy so that she does not dwell on the loss.
b. should suggest a lengthy vacation before returning to work so she can get over the loss before facing her co-workers.
c. should encourage the patient to consider how she has dealt with stress and loss in the past and suggest she take time to decide on a course of action.

APPENDIX F

Evaluation

Code - - -

Lesson Evaluation of Perinatal Bereavement Support Module
Lesson 1

In this part, you are asked about your feelings and opinions in regard to the lesson on Perinatal Bereavement Support. This section is not a test, so there are no correct answers.

Directions:
For questions 1 through 4, read each statement carefully, and circle the response that most closely conveys your opinion or feelings.

Circle 1 to indicate the section contributed not at all to your knowledge.
Circle 2 to indicate the section contributed very little to your knowledge.
Circle 3 to indicate the section contributed somewhat to your knowledge.
Circle 4 to indicate the section contributed moderately to your knowledge.
Circle 5 to indicate the section contributed a great deal to your knowledge.

1. Section 1: Parenting/Bonding
To what extent did this section of the lesson contribute to your knowledge of perinatal bereavement support?
1=the section contributed not at all to your knowledge.
2=the section contributed very little to your knowledge.
3=the section contributed somewhat to your knowledge.
4=the section contributed moderately to your knowledge.
5=the section contributed a great deal to your knowledge.

Lesson Evaluation of Perinatal Bereavement Support Module
Lesson 1

Circle your response to questions 2 through 4.

2. Section 2: Death and Dying
To what extent did this section of the lesson contribute to your knowledge of perinatal bereavement support?
1=the section contributed not at all to your knowledge.
2=the section contributed very little to your knowledge.
3=the section contributed somewhat to your knowledge.
4=the section contributed moderately to your knowledge.
5=the section contributed a great deal to your knowledge.

3. Section 3: Grief and Mourning
To what extent did this section of the lesson contribute to your knowledge of perinatal bereavement support?
1=the section contributed not at all to your knowledge.
2=the section contributed very little to your knowledge.
3=the section contributed somewhat to your knowledge.
4=the section contributed moderately to your knowledge.
5=the section contributed a great deal to your knowledge.

4. Section 4: Nurse-patient Interaction Theory
To what extent did this section of the lesson contribute to your knowledge of perinatal bereavement support?
1=the section contributed not at all to your knowledge.
2=the section contributed very little to your knowledge.
3=the section contributed somewhat to your knowledge.
4=the section contributed moderately to your knowledge.
5=the section contributed a great deal to your knowledge.

Code - - -

Lesson Evaluation of Perinatal Bereavement Support Module
Lesson 1

Directions: Please place a check (√) beside your response to Questions 5 and 6.

5. Did you find the application story, A Story of Jane, helpful for tying together the presented material?

___YES
___NO
___Uncertain

6. What are your feelings in regard to completing additional lessons in the Perinatal Bereavement Support Module?

___I want to complete the other lessons.
___I do not want to complete the other lessons
___I am undecided about completing the other lessons.

Directions:
Using the operative definitions provided, circle the number in the scale that indicates your response to questions 7 through 10.

Operative Definition:
Knowledge level is the self-reported level of familiarity with, and ability to apply and teach, theory or information on perinatal bereavement in the patient care setting.

7. Prior to completing lesson 1 of the perinatal bereavement support module, how would you describe your knowledge level on the subject?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10
POOR EXCELLENT

Code - - -

Lesson Evaluation of Perinatal Bereavement Support Module
Lesson 1
Directions:
Using the operative definitions provided, circle the number in the scale that indicates your response to questions 7 through 10.

8. After completing lesson 1 of the perinatal bereavement support module, how would you describe your knowledge level on the subject?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10
POOR EXCELLENT

Operative Definition:
Comfort Level is the self-reported feeling of confidence and competence to provide care to patients and families experiencing perinatal loss.

9. Prior to completing lesson 1 of the perinatal bereavement support module, how would you describe your comfort level on the subject?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10
UNCOMFORTABLE COMFORTABLE

10. After completing lesson 1 of the perinatal bereavement support module, how would you describe your comfort level on the subject?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10
UNCOMFORTABLE COMFORTABLE

APPENDIX G

Perinatal Bereavement Support Lesson

PERINATAL BEREAVEMENT MODULE

PURPOSE

The Perinatal Bereavement Module consists of 4 lessons. For the purpose of testing the module's effectiveness, you will only complete 1 lesson at this time. Before starting the module you will need to complete a closed-book pretest.

The module progresses from the presentation of parenting and bonding theory, and basic grief and mourning theory, to the application of those concepts to specific perinatal loss situations. The Nurse-Patient or Human-to-Human Interaction Model of Joyce Travelbee will be introduced briefly. It is the organizing framework for the module and the perinatal bereavement support program.

The module is intended as a supplement to the written policies and procedures that govern the nursing care performed for parents and families experiencing perinatal loss. The module developer hopes that the information, guidelines, and practical applications included herein, will help to equip, empower, and enable the individual maternal-child health nurse to provide superlative care for these families in crisis.

"Care is the essence and the central, unifying, and dominant domain to characterize nursing." M. M. Leininger

Lesson 1: Perinatal Loss, Parenting and Bonding, Grief and Mourning Theory, Nurse-Patient Interaction Model

DIRECTIONS

After you complete the pretest, you may begin the first lesson of the module. This section of the module will provide you with a review of perinatal loss events, parenting and bonding, and basic death and dying theory. Grief and mourning theory will be related to perinatal loss. Much of this information should be familiar to you.

Objectives

Upon completion of the lesson, the nurse should be able:

1. To describe perinatal loss.
2. To describe the normal grief and mourning process as it relates to perinatal loss.
3. To describe basic grief counseling principles.
4. To describe the basic concepts of Joyce Travelbee's Nurse-Patient Relationship Model.

Introduction

There are many losses involved in women's health care. These losses may go unrecognized by both lay people and professionals who associate labor and delivery, and postpartum, with all happy events. The losses may be small- such as a less than perfect labor and delivery experience, the chosen doctor not being on call, failure of the camera to function properly, a newborn who does not look like a Gerber baby, or is not the desired sex. The loss may be greater- a small imperfection or abnormality may be noted, ranging from birth marks, to extra digits, or to 'real' and serious conditions such as prematurity, fetal alcohol syndrome, drug addiction, Trisomy disorders, stillbirth, miscarriage, ectopic pregnancy, newborn death, or SIDS. The list is endless.

Regardless of the degree of loss, the parent(s) and families experience mild to severe grief, and the role of the nurse is to help them begin the mourning process. One may never get over a loss, but he or she should get through it. Ideally, individuals and families grow from the experience.

A sound theoretical base is essential in all areas of nursing practice, especially in areas geared toward psychosocial interventions. We will start with a review of familiar theories, and then introduce some concepts that may be new to you. Although, this lesson focuses on the losses most often encountered in labor and delivery, the mourning

process is similar for parents of malformed, sick, or premature infants.

****

Definitions:

Miscarriage is the lay term for spontaneous abortion, which is the spontaneous termination of a pregnancy before 20 weeks of gestational age and/or with a fetal weight of less than 400 grams (weight parameters vary by state).

Ectopic Pregnancy is the term used to designate a pregnancy wherein the blastocyst does not implant in the endometrium. More than 95% involve the fallopian tube.

Intrauterine Fetal Demise (Stillbirth) is death prior to the complete expulsion or extraction from its mother of a product of conception.

Live Birth with Neonatal Death: A live birth is the complete expulsion or extraction from its mother of a product of conception that, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the cord, definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. A neonatal death is the death of a liveborn infant before completing four weeks (28 days) of life.

***You do not need to memorize these, they are given as reminders.

Parenting and Bonding

Here is a quick review of parenting tasks.

Four Basic Parental Tasks:

1. The parent needs to reconcile the actual child with the fantasy child.
2. The parent needs to establish the newborn as a being separate from herself or himself.
3. The parent needs to become adept in the care of the infant.
4. The parent needs to establish reasonable evaluative criteria she/he will use in assessing the success or failure of the care given to the infant.

****

Klaus and Kennell list the following events that are important to the formation of a mother's bond to her infant:

Before pregnancy:	Planning the pregnancy
During pregnancy:	Confirming the pregnancy
	Accepting the pregnancy
	Becoming aware of fetal movement
Labor and Birth:	Actual processes of labor and birth
After birth:	Seeing the baby
	Touching the baby
	Giving care to the baby
	Accepting the infant as a separate individual

Note the tasks listed for after birth. Obviously, the birth of a compromised infant who is whisked away to an intensive care nursery, or the birth of a stillborn or dying infant, interrupts these bonding and parenting tasks. If a baby lives, the parents work through the tasks eventually, as they are able to assume care of their baby. If, however, the baby dies-these tasks are usually not completed.

The nurse and/or bereavement counselor can facilitate the completion of these bonding tasks even if the baby dies. The parent(s) may not want to see and hold the baby immediately, but may need time to adjust and prepare. The nurse might need to explain what the baby looks like, how it feels, what it smells like, the possibility of drainage from its nose and mouth, and so forth. Information about any abnormality is imperative, but one needs to remember that the parents generally see the baby through eyes of love and that their imaginations may be worse than reality.

Encourage the family to provide necessary care for the baby. Even if the family is initially reluctant to see, hold, and dress the baby, offer the opportunity for involvement. If the nurse or counselor is bathing, photographing, and footprinting the baby in the mother's room, the parents might gradually assume some of the responsibility, or offer photo props, suggest poses, select clothes, and the like. Seeing someone else respond to the baby as a human being may give them permission to do the

same. This is especially true if the baby has any birth defects, a deformity, or has been dead for some time. Naming of the baby is widely encouraged. Recognizing the infant as a separate individual is an important task. If they have a name chosen, they may want to use it (some people "save" the chosen name for a subsequent baby), or a nickname, or a unisex name if the baby's gender is not obvious. The caregiver can use her or his imagination to stimulate the parents' creativity.

The parents, especially the mother, should be asked if there is something special they have dreamed of doing for the baby. This is crucial if the baby is liveborn, but will die soon. Activities might include diapering, bathing, holding the naked baby on their own chests, rocking and singing lullabies to the baby, a generational picture including grandparents, and so forth. Accommodate their desires. Provide a rocking chair, a private room or corner of the nursery, or whatever else you can do to help fulfill their wishes. This may be their only chance to establish memories of this baby.

You may also have an opportunity to help the family plan a funeral or memorial service. If there is to be a funeral, the mother might want her own rocking chair and cradle taken to the funeral home. Additional photographs can be taken at the funeral, but gently remind the parents that the baby's

color will usually darken and features may become less distinct with time.

Death and Dying and Grief Theory

All nurses have undoubtedly heard of Elizabeth Kubler-Ross and her Death and Dying work. As you know, she is the mother of modern grief work. However, there are other grief theories and theorists. Some of the newer theories are more workable and more applicable to perinatal loss, but first, let us briefly review Kubler-Ross.

Labor and Delivery staff move quickly through these stages when they encounter an undiagnosed stillborn. In denial, we usually say "Maybe someone else can find the fetal heartbeat," and get another nurse. In anger, we demand "Why doesn't someone fix this stupid machine," and get another monitor. We bargain by thinking "Maybe if we change the mother's position, or readjust the monitor." We try that. Then, after confirming the demise on ultrasound, we are depressed and say, "We can't do anymore. It is hopeless." Then, in acceptance, we say "OK, the baby is dead, but the parents need our help," and we move on with our care.

****

You need to familiarize yourself with Bowlby and Parkes' work because much of the literature and support material we use in the bereavement program is based on their approach.

Four Phases of Grief:

1. Shock and numbness (first 2 weeks)
    a. there is resistance to stimuli
    b. judgment making is difficult
    c. functioning is impeded
    d. emotional outbursts are common
    e. stunned feelings prevail
2. Searching and yearning (first 4 months)
    a. the bereaved is very sensitive to stimuli
    b. anger/guilt are common
    c. the person is restless/impatient
    d. ambiguous feelings occur
    e. testing what is real is common
3. Disorientation (fifth through ninth months)
    a. the bereaved are disorganized
    b. depression is common
    c. guilt occurs or recurs
    d. weight gain or loss is noticeable
    e. they may find themselves wondering if they are normal or are going crazy
4. Reorganization (near end of the second year)
    a. there is a sense of release
    b. the bereaved experiences renewed energy

c. the person makes judgments better

d. stable eating and sleeping habits resume

***Do not become fixated on the timing of the phases, these are offered only to give you a general idea of what to expect in normal grief.

****

You may find Worden's grief counseling principles to be helpful. The term mourning is used to indicate the process that occurs after a loss, while grief refers to the personal experience of the loss. Since mourning is a process, many people use the concept of stages, but people do not pass through stages in seriatim (in a series). An alternative is to view mourning as a process of phases. This gives an impression of flow and less rigidity. To Worden, phase implies passivity, while task requires actions and thus shows that mourning can be influenced by intervention from the outside.

Worden's Four Tasks of Mourning

1. To accept the reality of the loss.
2. To experience the pain of grief.
3. To adjust to an environment in which the deceased is missing.
4. To emotionally relocate the decreased and move on with life.

Although the perinatal nurse may only interact with the bereaved parent during a short hospital stay, it might be helpful to look at these tasks in a little more detail. Each task will be presented with a brief quote from Worden and an application of the principle to fetal or newborn loss.

Task I: To Accept the Reality of the Loss

"When someone dies, even if the death was expected, there is always a sense that it hasn't happened. The first task of grieving is to come full face with the reality that the person is dead, that the person is gone and will not return" (Worden, 1991, p 10).

The mother might insist she still feels her baby moving even after ultrasound shows no heartbeat. It is common after delivery of a diagnosed stillborn for the parents to ask if the baby is alive or is okay.

Once home, the parents may put off dismantling the nursery or at least putting away those things that were laid out in readiness for the new baby. If this went on for years it might be abnormal, but initially it might be an effective coping mechanism.

Worden also points out that another way of protecting oneself is to deny the meaning of the loss. Friends and family often do this when an preborn or newborn baby dies. They may tell the parents "well at least you did not bring the baby home" or "you can always have another." The

parent(s) may do the same thing. This invalidates or denies the loss.

Worden goes on to say, fully completing this task takes time, but the rituals we have established help us in beginning this process. Funeral or memorial services can help validate the reality of the loss. With perinatal loss, it is often critical that the parents see and touch the baby. They have no memories of a living child, just their dreams and hopes, and perhaps some ultrasound photos. Photographs and mementos help them to share the reality of the dead baby with others, and remind themselves it was not just a bad dream--the baby really did die.

Task II: To Work Through the Pain of Grief

"Not everyone experiences the same intensity of pain or feels it in the same way, but it is impossible to lose someone you have been deeply attached to without experiencing some level of pain" (Worden , 1991, p 13).

Failure to recognize and work through the pain may result in individuals who deaden their feelings with drugs or alcohol, change geographic locations to avoid memories, get out of marriages or other relationships, or who turn their anger and other feelings inward in the form of depression. The parents may need "permission" to grieve. You can help facilitate this process by validating the loss and by assisting friends and family members to see specific ways they can help. You may also need to provide the grandparents

with support since they grieve not only for the lost grandchild, but have to see their own children suffer.

Support groups or follow-up on a one to one basis can assist in completion of this task. The mother may need reassurance that she is not going crazy when she imagines she still feels fetal movement, or when she gets up at night to answer the cry of her baby who is no more. She needs to know it is okay to feel jealousy and anger when she sees mothers with healthy infants, and runs out of the store leaving a full grocery cart.

The father may also need specific information on different ways of grieving, a reminder that his needs are important, and that he does not have to be strong or stoic. He may not have felt as connected to the baby as the woman, especially if it was an early loss. The use of ultrasounds, however, has increased awareness of the fetus as a thinking, feeling, reactive individual, so more and more men are experiencing early attachment to their preborn babies. Specific information on grief of fathers is available, and support groups can often connect a bereaved father with someone who has experienced a similar loss. Try to get a male chaplain or other male caregiver to spend time with the father.

Task III: To Adjust to an Environment in Which the Deceased is Missing

"The bereaved person searches for meaning in the loss and its attendant life changes in order to make sense of it and to regain some control of his or her life" (Worden, 1991, p 16).

This task will take time to complete and may involve a great deal of work. Worden notes that "loss through death can challenge one's fundamental life values and philosophical beliefs--beliefs that are influenced by our families, peers, education, and religion as well as life experiences." Again, supportive people who are willing to listen, can help the bereaved work through this task. They may need help to recognize their changed circumstances and redefine their goals. Just talking about their concerns in regard to the job they quit in anticipation of the baby, or the maternity leave that is scheduled, or the new house they bought, may help.

They may need extensive help and counseling by trained clergy or psychologists. Each individual has individualized needs and coping responses.

Task IV: To Emotionally Relocate the Deceased and Move on With Life

"If we think of relocation, then the task for the bereaved parent is to evolve some ongoing relationship with the thoughts and memories that they associate with their child, but to do this in a way that would allow them to continue on with their lives after such a loss" (Worden, 1991, p 17).

Worden acknowledges that this is a very difficult task for many people. They often get stuck at this point and may become bitter, isolated, and full of remorse when they realize they have shut themselves off from love.

It may take a conscious decision on the part of the bereaved to put thoughts and memories of their lost child "away" so that they can get on with life. It may be an unconscious process of letting go, which frees them to react, interact, respond, look to the future, and to love others. There may always be sadness when they think of the loved one, but they need to eventually arrive at the place where they can think of the deceased without pain. This might be the signal that they have not just gotten through grief, but have grown through the experience.

Worden lists some of the manifestations of normal grief. You need to know what is normal so you can recognize pathology.

Feelings associated with grief: sadness, anger, guilt & self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning or pining, emancipation, relief, numbness.

Physical sensations experienced: hollowness in the stomach, tightness in the chest or throat, oversensitivity to noise, breathlessness, muscle weakness, lack of energy.

Cognitions and/or behaviors encountered: disbelief, confusion, preoccupation, hallucinations, sleep disturbances, appetite disturbances, absent-minded behavior, sighing, restlessness, crying.

***You, as a health care professional are expected to provide grief counseling--not therapy, but counseling, at least on an informal basis.

****

***Maybe you should stop for a cup of tea or something and rest a few minutes before reading on. Too much theory can make you neurotic.

****

Worden's Counseling Principles

Principle One: Help the Survivor Actualize the Loss

a. the survivor must get beyond the sense of unreality

b. help the survivor talk about the loss; ask questions to help them talk specifically about the loss

Principle Two: Help Survivor to Identify and Express Feelings

a. anger - at the person for dying, at self, at others

b. guilt - very common

c. anxiety and helplessness

d. sadness - may need permission to cry

Principle Three: Assist Living Without the Deceased

a. facilitate independent decision making (as with loss of a spouse)

b. avoid life-changing decisions too soon

Principle Four: Facilitate Emotional Relocation of the Deceased

a. help find a new place in their life for deceased--a place that will allow survivor to move forward with life and form new relationships

b. not looking for replacement, but okay to fill void with new relationship

Principle Five: Provide Time to Grieve

a. takes time; don't rush

b. contact at critical points, e.g. 3 months, special dates

Principle Six: Interpret "Normal" Behavior

a. fear of going crazy is common; reassure, give examples

b. hallucination, a heightened sense of distractibility, or a preoccupation with the deceased are normal

Principle Seven: Allow for Individual Differences

a. everyone is different

b. may need to help family understand differences

Principle Eight: Provide Continuing Support

a. unlike grief therapy which is focused on a specific time period, counseling requires continuing support

b. group support is often the key

Principle Nine: Examine Defenses and Coping Styles

a. requires trust relationship

b. may need to explore other possible coping avenues

Principle Ten: Identify Pathology and Refer

a. complicated grief reaction manifested as prolonged grief; usually the person self-refers because they feel grieving has gone on too long

b. grief reaction manifests itself through some masked somatic or behavioral symptom, such as difficulty breathing or lack of appetite months after loss

c. reaction manifested by exaggerated grief response--difficult to define because of normal variations; usually excessive depression, excessive anger, and so on.

***Granted, these principles are quite detailed, and take time to implement. You are not expected to whip through each of them whenever you provide support to a bereaved person. They are intended as background information.

****

Grieving: Special Types of Losses - Miscarriage, Stillbirth, Neonatal Death

1. Doctors tend to focus on statistics and probability of future events; nurses can help both the physician and the patient to focus on the present situation, the here and now.
2. The family needs to deal with this loss before considering pregnancy; share that idea.
3. Self-blame is a major concern; give clear information and refer to the physician and/or a genetic counselor if indicated.
4. Poor communication and different expectations for father and mother cause confusion and often result in the father feeling helpless. Give information to the couple together, and encourage the physician to do the same. Encourage the couple to have an advocate at interviews or conferences.
5. The patient and family need to talk about the baby's birth, death, and the surrounding events. They may not initially recognize the event as the loss of a baby. They may need "permission" to grieve.

6. They may need help telling other children; provide specific ideas.

7. Handouts on how family and friends can help are available.

8. The absence of a definite cause for the baby's death may frustrate and confuse the parents and family. Explain the availability of autopsy, with the proviso that it may fail to reveal a cause of death.

9. Statistically, there is a high break-up rate in these families. Facilitate communication between the parents. Provide information on differences in grief responses between individuals.

10. Perinatal loss support groups can provide practical help and information at the time of the loss, and can provide a sounding board during the process of mourning. When family and friends tire of hearing the parents' story, or hint that they should get on with their lives, a support group may be the only outlet available to the grieving parent.

****

The importance of talking about loss was recognized by Shakespeare, who, through Macbeth admonished, "Give Sorrow words; the grief that does not speak knits up the o'erwrought heart and bids it break".

****

The following abstract is intended to explain the schematic interpretation of the nursing theory on the subsequent page.

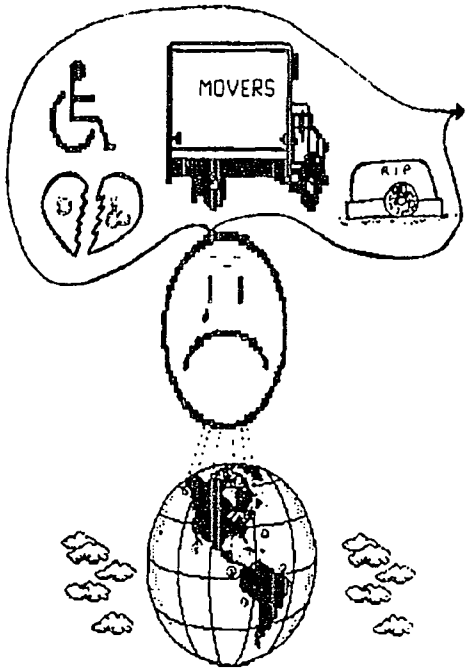
THE NURSE-PATIENT RELATIONSHIP THEORY OF JOYCE TRAVELBEE

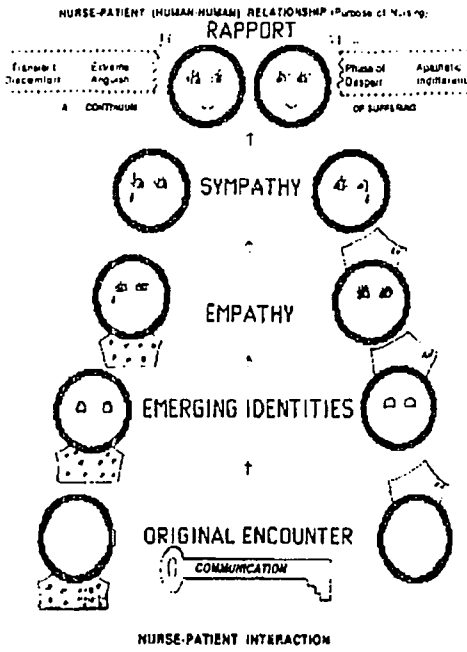
The interactionist nursing theory of Joyce Travelbee evolved from her work in psychiatric nursing. She considered the definition, role, and function of nursing to be the systematic development of a nurse-patient relationship. This nursing theory is applicable to bereavement situations, hospice, and other long term settings.

The LEFT PANEL depicts the universality of suffering. While every human being suffers because he is a human being, suffering is individual, varying in causation, intensity, duration, and depth.

The CENTER PANEL shows how suffering can lead into a continuum of suffering ranging from transient discomfort to apathetic indifference. Effective nurse-patient interactions can disrupt this continuum. Planned interactions, based on ongoing communication, should lead to the desired terminus of rapport or relationship. The development of a relationship may well prevent the patient and family from entering into despair and apathetic indifference. This enables them, not only to cope with the experience(s), but to find meaning in and to grow from them.

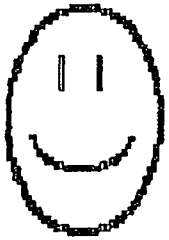
The RIGHT PANEL depicts the desired outcome.





NURSE-PATIENT INTERACTION

Patient Able To Cope With And Find Meaning In Illness and/or Suffering



APPLICATION

The immediate and long-term needs of the perinatal loss patient, and her significant others, must be addressed from admission, throughout hospitalization, and during follow-up. Communication is the cornerstone of the interactions that lead to relationship and rapport. The following scenario exemplifies the application of Travelbee's nursing model, using basic counseling and support, in a practice setting.

****

A Story of Jane

Unconsciously, and perhaps intuitively, the author has employed Travelbee's model in her ongoing labor and delivery practice, as well as in her special interest area of perinatal bereavement. In seeking to apply Travelbee's model retrospectively, several couples who experienced perinatal losses, and with whom the author developed nurse-patient relationships, come to mind. However, the relationship with Jane really stands out.

Jane had been admitted to labor and delivery at 1000 for prostaglandin induction for a diagnosed fetal demise. Review of her history, revealed that during a routine prenatal visit at 24 weeks gestation, no fetal heart tones were heard. A subsequent ultrasound revealed lack of fetal heart activity, and the attending physician suggested prostaglandin induction of labor.

The couple contacted their childbirth educator for advice because they were new to the area and had few friends and no family, nearby. The educator provided them with a book, *When Hello Means Goodbye*, which specifically addressed the needs, concerns, and options facing families whose baby dies before, or shortly after, birth. With this information, the couple opted to delay induction for two days. During that period, they contacted family and friends, made funeral plans, arranged time off, and began their grief work.

Jane was in desultory labor when the author assumed her care at 1500. Progress was slow, so there was time to get to know the couple. Jane worked in the medical field and was comfortable with hospital routine. She took an active role in explaining what was happening to her husband.

In addition to this commonality, the nurse and the couple had a shared faith, which increased their comfort level. Also, the booklet the childbirth educator had given them was mutually familiar, and provided a starting point for going over their plans to commemorate the birth and death of the baby. Because of their pre-planning, essential paperwork and forms were completed long before the baby's birth, and Jane could concentrate on getting through the labor and delivery.

During this time, one of the hospital Chaplains came in to meet the family and offer support. Family and friends came in for short visits, as did their pastor. There were

even some times of laughter in this special room--a room filled with love, support, caring, and sharing.

After a third prostin suppository was administered at 2100, Jane gradually dilated, and delivered a stillborn male at 2311. The author and the night nurse executed the delivery of the infant and the placenta, prior to the arrival of the on-call physician. The night nurse followed through with the plans the couple had made for the care of their baby, and their interaction with it. There was a lot to do. This was a time--the only time--for creating memories to last a lifetime. Jane and her husband spent the night in her labor room and went home the following morning.

The author, a bereavement counselor, called Jane a few days later, and they had a pleasant chat. Jane could not stop singing the praises of the nursing staff, and of the personal attention she received.

****

***Unfortunately, this scenario is the exception rather than the rule, but it demonstrates the growth of a relationship between nurse and patient. It shows how time, effort, a desire to help, and a working knowledge of bereavement support paid off. Working with couples experiencing perinatal loss is a nursing challenge and should not be viewed as a burden. You just need knowledge, preparation, a bit of expertise, and a willingness to apply them.

Bibliography For Lesson 1

Berezin, N. (1982). After a loss in pregnancy. New York: Simon & Schuster.

Borg, S., & Lasker, J.(1981). When pregnancy fails. Boston, MA: Beacon Press.

Bowlby, J., & Parkes, C. (1970). Separation and loss within the family. In E. J. Anthony & C. Houpernick (EDs.), The child in his family. New York: Wiley.

Davidson, G. W. (1984). Understanding mourning. Minneapolis, MN: Augsburg.

Ilse, S. (1982). Empty arms: coping with miscarriage, stillbirth and infant death. Long Lake, MN: Wintergreen Press.

Ilse, S., & Burns, L. (1985). Miscarriage...A shattered dream. Long Lake, MN: Wintergreen Press.

Klaus, M. H., & Kennell, J. H. (1983). Bonding-The beginnings of parent-infant attachment. New York: Mosby.

Kubler-Ross, E. (1969). On death and dying. New York: Macmillan.

Kuenning, D. (1987). Helping people through grief. Minneapolis, MN: Bethany.

Limbo, R. K., & Wheeler, S. R. (1986). When a baby dies: A handbook for healing and helping. La Crosse, WI: Resolve Through Sharing.

Marriner-Tomey, A. (1989). Nursing theorists and their work. St. Louis, MO: Mosby.

Bibliography (Continued)

Savage, J. A. (1989). Mourning unlived lives. A psychological study of childbearing loss. Wilmette, IL: Chiron.

Schwiebert, P., & Kirk, P. (1985). When hello means goodbye. Portland, OR: University of Oregon.

Swanson-Kauffman, K. M. (1986). Caring in the instance of unexpected early pregnancy loss. Clinics in Clinical Nursing, 8(2), 37-46.

Travelbee, J. (1966). Interpersonal aspects of nursing. Philadelphia, PA: Davis.

Travelbee, J. (1971). Interpersonal aspects of nursing. Philadelphia, PA: Davis.

Worden, J. W. (1991). Grief counseling and grief therapy. New York: Springer.

Many of these resources are available from the researcher.

S. Spickerman quote on front cover is from Enhancing the Socialization Process. (1988). Nurse Educator, 13(6), p13.

APPENDIX H

Characteristics of Sample Population

Appendix H

Characteristics of Sample Population (N = 32)

Characteristic	Number	Percentage
Gender		
Female	32	100
Level of Nurse		
Registered	32	100
Full-time or Part-time		
Part-time	32	100
Age in years		
20 to 30 years	2	6
31 to 40 years	19	59
41 to 50 years	8	25
51 to 60 years	3	9
Basic Education		
Diploma	4	13
Associate Degree	17	53
Baccalaureate	11	34
Advanced Education		
Master's Degree	1	3
Certified Nurse	5	15
Certified Nurse Midwife (CNM)	2	6

Appendix H (Continued)

Characteristics of Sample Population (N=32)

Characteristic	Number	Percentage
Years in active practice		
0 to 1	0	0
2 to 5	3	9
6 to 10	10	31
11 to 15	9	28
16 to 20	5	16
21 to 25	3	9
26 to 30	2	6
Years in Maternal-Child Health Nursing		
0 to 1	1	3
2 to 5	5	16
6 to 10	12	37
11 to 15	8	25
16 to 20	5	16
21 to 25	0	0
26 to 30	1	3
Primary Work Area		
Labor & Delivery	20	62
Postpartum	6	19
Nursery	5	16
Pediatrics	1	3

Appendix H (Continued)

Characteristics of Sample Population (N=32)

Characteristic	Number	Percentage
Grief Course or Class Attended[a]		
Death & Dying	16	50
Other	7	22
Bereavement Policies & Procedures Utilized by Participants[b]		
Stillbirth	23	79
Neonatal Death	16	55
Spontaneous Abortion	15	52
Ectopic Pregnancy	9	31
If you used any of the above listed Policies & Procedures, did you encounter any difficulty in completing them?[c]		
Yes	17	59
No	12	41
If you indicated YES on the preceding question, what was the nature of the difficulty?[d]		
Inadequate time to complete P&Ps	14	82
Policy or procedure unclear	13	76
Lack of adequate knowledge	9	53
Uncomfortable with this type of caregiving	4	24
Other	2	12

Appendix H (Continued)

Characteristics of Sample Population (N=32)

[a]Participants attended grief related classes or courses 1 year or more prior to the study. [b]Twenty-nine (91%) participants had used 1 or more policies and procedures. [c]Not all of the participants had used the policies and procedures. [d]Seventeen participants responded to this question and may have indicated more than one problem.

APPENDIX I

Responses to Individual Pretest and Post-test Items

Appendix I

Responses to Individual Pretest and Post-test Items (N = 32)

Question	Pretest Correct n (%)	Post-test Correct n (%)
1. List 2 perinatal events, other than death, that may result in feelings of loss.	28(87)	32(100)
2. List 2 parenting tasks.	2(6)	24(75)
3. List the 4 phases of grief. (Bowlby and Parkes)	0(0)	17(53)
4. List 4 manifestations, emotional or physical, of normal grief.	24(75)	29(91)
5. List 2 of Worden's 4 Tasks of Mourning.	2(6)	29(91)
6. Worden considers mourning to be a(an) ___ which occurs after a loss, while grief refers to the personal experience of the loss.	5(16)	26(81)

Appendix I (Continued)

Responses to Individual Pretest and Post-test Items (N = 32)

Question	Pretest Correct n (%)	Post-test Correct n (%)
7. List 2 of Worden's principles of grief counseling.	8(25)	30(94)
8. State the key element in each nurse-patient interaction.	6(19)	20(62)
9. List the 4 steps of nurse-patient interaction necessary for the development of relationship according to Travelbee.	0(0)	3(9)
10. Helping families cope with perinatal loss requires knowledge of death and dying and grief theory so that the nurse:	31(97)	30(94)
b. can give each patient/family the information needed to cope with their loss during hospitalization and after discharge.		

Appendix I (Continued)

Responses to Individual Pretest and Post-test Items (N = 32)

Question	Pretest Correct n (%)	Post-test Correct n (%)
11. If the patient is physically or emotionally unable to listen to teaching in regard to grief and mourning, during her shift, the nurse:	32(100)	31(97)
b. must request the next shift to continue with the care plan and provide information and teaching as the patient allows.		
12. If a bereaved patient tells the nurse that she plans to return to work immediately, to forget about the baby, and get on with her life, the nurse:	31(97)	32(100)
c. should encourage the patient to consider how she has dealt with stress and loss in the past and suggest she take time to decide on a course of action.		

APPENDIX J

Participant Evaluation of Lesson Sections

Appendix J

Participant Evaluation of Lesson Sections

Degree of Contribution to Knowledge Level (N = 32)

Lesson Section Contributed:	Not at All to Somewhat n (%)	Moderately to A Great Deal n (%)
Grief and Mourning	4 (12)	28 (88)
Bonding and Parenting	10 (31)	22 (69)
Death and Dying	10 (31)	22 (69)
Travelbee's Model	11 (34)	21 (66)
I found the "Story of Jane" helpful for tying together the presented material.		
Yes	27 (84)	
No	3 (10)	
Uncertain	2 (6)	
I want to complete additional lessons in the Perinatal Bereavement Support Module.		
Yes	27 (84)	
No	1 (3)	
Uncertain	4 (13)	

APPENDIX K

Characteristics of Participants with Post-test Scores of ≥90% and ≤75%

Appendix K

Characteristics of Participants with Post-test Scores of ≥90% and ≤75% (N=18)

Characteristic	High Scoring (>90%) (n=11)	Low Scoring (≤75%) (n=7)
Age in years		
20 to 30 years	2	0
31 to 40 years	6	2
41 to 50 years	2	3
51 to 60 years	1	2
Basic Education		
Diploma	1	2
Associate Degree	4	5
Baccalaureate	6	0
Years in active practice		
2 to 5	2	0
6 to 10	3	1
11 to 15	4	1
16 to 20	1	3
21 to 25	1	2

Appendix K (Continued)

Characteristics of Participants with Post-test Scores of ≥90% and ≤75% (N=18)

Characteristic	High Scoring (>90%) (n=11)	Low Scoring (≤75%) (n=7)
Years in Maternal-Child Health Nursing		
2 to 5	2	0
6 to 10	4	1
11 to 15	4	1
16 to 20	1	3
21 to 25	0	2
Primary Work Area		
Labor & Delivery	8	6
Postpartum	2	0
Nursery	0	1
Pediatrics	1	0
Grief Course or Class Attended[a]		
Death & Dying	6	5
Other	0	1
Bereavement Policies & Procedures Utilized by Participants[b]		
Stillbirth	5	7
Neonatal Death	3	3
Spontaneous Abortion	5	3
Ectopic Pregnancy	5	2

Appendix K (Continued)

Characteristics of Participants with Post-test Scores of ≥90% and ≤75% (N=18)

Characteristic	High Scoring (>90%) (n=11)	Low Scoring (≤75%) (n=7)
If you used any of the above listed Policies & Procedures, did you encounter any difficulty in completing them?[c]		
Yes	5	6
No	4	1
If you indicated YES on the preceding question, what was the nature of the difficulty?[d]		
Lack of adequate knowledge	2	3
Policy or procedure unclear	3	2
Inadequate time to complete	3	4
Uncomfortable with this type of caregiving	0	2
Other	0	1

Note. Percentages are not reported due to the small number of participants in the comparison groups.

[a]Participants attended grief related classes or courses 1 year or more prior to the study. [b]Nine of the high scoring participants and 7 of the low scoring participants had used more than one policy and procedure. [c]Not all of the

Appendix K (Continued)

participants had used the policies and procedures.

[d]Participants may have indicated more than 1 problem.