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An exploratory study to determine the needs of the nurse and the mother of a stillborn infant.

AN EXPLORATORY STUDY TO DETERMINE THE NEEDS OF THE NURSE AND THE MOTHER OF A STILLBORN INFANT.

by

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CHAPTER I

INTRODUCTION

My office was located at the beginning of a wing on a rather busy maternity floor. It could have been considered an integral part of a happy, vibrant post-partum unit. The chatter of those gregarious mothers and the contented cry of their new born infants should hardly have been considered the ideal niche for the instructor to concentrate on formulating lesson plams, arranging new programs and advising students, - but it was. I could leave my door open and hear nothing. What an astute fellow, this architect who designed the floor so well I could visually be a part of the activity and yet not be disturbed by all those components of the phenomenon called undertone. I liked it and I certainly thought I was happy, - but I wasn't, really. I could not erase that eternally present and constantly annoying question, "why is this wing so quiet?" There was no life to this peace! It was cold and still! It was death! Only half of the people were living. What of those who lived near my office?

A cursory review of the census revealed that the majority of the mothers in this area were childless. They had lost the necessary link needed to become a member of this floor.

They were alone. Again, why? I thought the answer lay in the fact that many of these women appeared obstetrically elderly and presented a task too overwhelming for any nurse. How could she help these mothers? They were getting "old"! They had no children! They had just lost their babies and the probability of conceiving again was rather moot! Were these feelings an outgrowth of the much labored conclusion that the elderly primigravid patient presented more of an obstetrical risk in terms of abortion, congenital anomalies, and still births than the younger woman? A review of the records of one hospital for a period of one year, October 1, 1956, to September 30, 1957, revealed that the incidence of fetal wastage was slightly higher in the young mothers (15-20 years of age) than the older women (35 to 40 years of age). Could this then be the reason why these women were so alone? Why no nurse could be found visiting them just to talk and listen? What was the reason?

STATEMENT OF THE PROBLEM

A review of the records of one hospital might be considered as inadequate sampling and an unscientific basis for concluding that the age of the mother without a baby should not be an influencing factor; however, I did utilize just such a conclusion. The common denominator in all of these mothers

located in a specific wing of a particular maternity department seemed to be their childlessness. The feelings these women evoked in me were both alarming and frightening. They are the basis of this study. What could I, a nurse, do for or give to a mother who had lost her baby? How could I replace this loss so that she might look at her problem objectively? Should the mother even try to be objective? What could I say to lessen her grief? What equipment and tools might I need before I visit her? How might I help her to see the positive factors in her problem? What does she need? Do I have it? How do other nurses feel about caring for the mother who has delivered a stillborn infant? What do the mothers want from the nurse?

This investigation is concerned with the feelings nurses have in caring for the mother of a stillborn infant, how they see the needs of the mother and how the mother perceives the nursing role.

JUSTIFICATION OF THE PROBLEM

Professional nursing is constantly investigating the ways and means whereby increasingly effective patient care might be realized. As an integral component of patient-centered care, the nurse must be ready to assume her responsibility for recognizing the needs of her mothers and she

must possess the skill and ability so essential to therapeutic patient relationships. She must be able to meet, not only those emotional needs considered indigenous to the maternity cycle, but also those situations most likely to lead to mental health hazards.

Gerald Caplan[1] describes these hazards as areas involving "prematurity, -----, illegitimacy -----, birth trauma in the child and similar situations", which I have interpreted to include the mother who delivers a stillborn infant. He further states -

> "the mental hygiene work that is based on the nurse's closeness to her patient inevitably involves the nurse herself in emotional problems. The danger is that she will find herself in crisis situations because her own problems are stimulated by those of her patients. This closeness makes her vulnerable in this respect. The likelihood that her patient's problems may set up internal disequilibrium in the nurse is especially great in this field of maternal and child care, because of its significance to every woman, and especially to a woman in the child-bearing years. One unfortunate result of such a process might be the nurse might try to work out her own problems through her patients. This might show itself by -------the nurse attempting to deal with her

[1] Caplan, Gerald, Mental Health Aspects of Social Work in Public Health, p. 288.

> emotional upset by withdrawing from the possibility of involving herself with her patients, either by becoming insensitive to their problems or by increasing her psychological or social distance.[2]

It would seem to me that if the nurse, by the very nature of her role, is to assume such patient closeness and experience such emotional involvement, then she must be aware of her own feelings concerning the patient to whom she is giving care and the needs of the patient receiving her ministrations.

SCOPE AND LIMITATIONS.

This is an exploratory study concerned primarily with three areas of patient centered care. The first phase of this study was directed toward investigating the feelings and attitudes of twenty-five graduate nurses who had been involved in caring for the mother of a stillborn infant, and what the nurses saw as being the needs of a mother experiencing such a crisis situation. The second area of concern was the mother herself. What did she identify as her needs? Did the nurse attempt to meet her felt needs? If she did, how was such a meeting effected? Where did she feel the nurse failed her? Twenty mothers participated in this investigation. The final area of concern was not an original consideration of the study; however, in attempting to procure sufficient mothers for the

2. Ibid, p. 288.

study, five physicians were also interviewed to gain permission to visit their patients in the home setting. These physicians, all obstetrical specialists, willingly volunteered data pertinent to the problem. Therefore, the third phase of this study is concerned with the feelings and attitudes of five physicians relative to the problems of foetal wastage, the needs of the mother and the role of the nurse.

The size of the sample itself might be considered a justifiable limitation. Approximately fifty individuals participated in the study; each contributing their own feelings and needs based upon past experiences and future expectations. The total number of participants may be divided into three groupings: (1) twenty-five registered nurses, (2) twenty mothers who have experienced the crisis of an infant loss through stillbirth, and (3) five physician specialists in the field of obstetrics and gynecology. The size of the sample could justly be considered statistically invalid but the information it contains cannot be ignored.

Another limitation could be the time and depth factors, both in the duration of the study and the length of the individual interviews. The study extended for a period of seven months, from February 1, 1958, to August 30, 1958. Each interview varied in duration depending upon the needs of

the interviewed and ranged from one hour to three and one-half hours. No attempt was made to either analyze the significance of the data to the person being interviewed or the personal meaning the infant loss had to the mother or the nurse.

Several limitations occurred in the sampling of mothers selected to be interviewed since the following criteria had been established: (1) have at least one living child at home, (2) have no history of receiving psychotherapy prior or subsequent to the delivery of her stillborn infant, and (3) have delivered an infant of no less than thirty-six weeks gestation who was either stillborn or died within one hour after birth. In the initial steps of patient selection, the above limitations were suggested by one physician as a feasible means of avoiding the feelings that might be aroused due to the very nature of the study. Since there was concern expressed, these limitations were accepted and applied in the selection of all mothers.

Permission was not obtained for me to formally interview any of the mothers in a hospital setting; therefore, geography was a most imposing consideration. The data from the interviews were collected from mothers residing in Boston, Massachusetts; exurban communities within a fifty mile radius of Boston, Hartford, Connecticut, and East Manhattan, New York.

The difficulties encountered in finding mothers to inter-

view were the most real and challenging limitations to the entire study. Nurses were very co-operative and most helpful both in their contributions and their willingness to participate in the study. Nurse administrators and physicians were cordial and sincere in expressing their concern that this area of nurse-patient care most certainly needed study, but some were reluctant or unable to grant the necessary permission so that I might talk to these women.

A further consideration might be found in a rather dichotomous situation. Whenever I could interview a mother in a casual manner, not representing anything or anyone other than myself and my own concern for the mother's needs, it was comparatively easy to locate and talk to the mother. However, when permission was needed, primarily to locate a sufficient sample and to centralize the geographical placement of the mother, such permission was not easily obtained. Whenever I was not permitted to interview the mother the fear expressed was always in the realm of "what will this do to the mother?" "Will it not be too'upsetting' to 'relive" such an experience?"

Finally, the role I assumed during this investigation was new and not always comfortable. A theoretical awareness and understanding of interview technique does not guarantee practicality and astuteness in the reality situation.

DEFINITION OF TERMS.

For the purposes of this study the following terms will be defined as such:

STILLBORN INFANT--any infant of thirty-six weeks gestation or more, who was either born dead or who lived for no more than one hour after birth. I have used such latitude in the definition of this term because when the mother was sufficiently alert to realize she had given birth, the infant was dead and she never saw her child. Actually some of these infants could be classified as: (1) true stillbirths where the infants were born dead, and (2) neonatal deaths where the infants expired one hour after birth.

FEELING--Webster's [3] definition of the term is applicable to this study when he described the word as a "partly mental and partly physical response that is painful or pleasurable or both in some degree."

ATTITUDE--will be considered to describe "a feeling or mood"[4] and will be used interchangeably with the word feeling.

[3] Webster's New Collegiate Dictionary, p. 304.

[4] Ibid, p.58.

NEED--will be considered as "a condition requiring supply or relief." [5]

PREVIEW OF METHODOLOGY.

Fifty individuals were interviewed for the purposes of gaining information pertinent to the study. Only the nurses were participants in a formal interview setting where I employed the use of a prepared guide and recorded the data as it was given. The mothers were interviewed informally. A prepared guide was followed but the content of the interview was not recorded until immediately after and away from the discussion scene. No guide was employed when interviewing the physicians. However, the data was recorded by recall immediately after the interview. I have included my own reactions to these interviews, the reactions of the mothers asked to participate in the study, and the ways in which the mothers related to me.

[5] Ibid, p. 562.

SEQUENCE OF PRESENTATION.

Chapter II contains a review of the literature which supports the philosophy underlying this study and a statement of the hypothesis.

Chapter III explains the methodology employed and describes the agents involved in the study.

Chapter IV contains a presentation and discussion of the findings.

Chapter V includes a summary of the findings and conclusions, together with recommendations growing out of the study.

In the Appendix will be found -

(1) guide employed for the nurse interviews

(2) guide used for the mothers' interviews

(3) seven sample interviews with nurses

(4) four sample interviews evolving from seeking permission to visit mothers of a stillborn infant

(5) five sample interviews with mothers

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Philosophy Underlying the Study

> You give but little when you give of your possessions.
> It is when you give of yourself that you truly give! [1]

Unfortunately, a study of the literature revealed little work or research pertinent or specifically applicable to the problem under investigation. However, the general literature relative to the nurse as a person, her changing role as it is emerging today, the needs of her patients and the significance of grief and loss for both, were surveyed to determine what might be considered the essential elements of an effective relationship between the nurse and her patient.

When a baby is born dead or dies soon afterwards, it is a serious and tragic experience for the parents, and it is specifically significant for the mother.

> The extent of the mother's reaction depends a good deal upon the circumstances of the baby's death and at what point she learned the baby was dead. The death is easier to take when the baby is found to have a serious abnormality because it seems better the baby does not have to live in misery.------ The disappointment and trauma are

[1] Gibran, Kahlil, The Prophet, p. 20.

> greater when the child appears to be normal and where the sex of the child is the one which was particularly desired.----- It is important when such tragedies occur to consider the age of the parents, the difficulties they had in starting the pregnancy, and whether the pregnancy was complicated by any difficulties and illness of the mother. Ordinarily the reaction is, to a great extent, oversome by the mother's feeling that she can have another child. ------- When the possibility for another pregnancy is reduced, the reaction will naturally be more serious and lasting.[2]

This article by Grinstein and Sterba was the only one I could locate in the literature that dealt specifically with the area of the mother's feelings when her baby was born dead. Though the data in my investigation does not agree with much of what they said, it does show that the authors did look at a painful problem which until now has been significantly ignored.

Many articles have been published and much of our energy directed toward understanding the maternal emotions indigenous to, and an integral part of, any pregnancy cycle. Betsy Wooten[3] feels that:

> The treatment of the ------- pregnant woman whose fears, anxieties, and hostilities

[2] Grinstein, Alexander, Sterba, Editha, Understanding Your Family, pp. 82-84.

[3] Wooten, Betsy, A Psychosomatic Approach to Maternity Care, p. 6.

> may be strong enough to influence the course of her pregnancy is based first on the recognition that these factors exist.------- The Utopia of maternity care, however, as I see it, is a program in which nurses and obstetricians will ---- use their naturally sensitive and sympathetic abilities to identify with the patient. In addition to eliciting such historical information as the date of the last menstrual period or the state of the bowels, they will inquire about her reactions to her first menstrual period as a girl, about her relationship to her mother, ------ and about her mother's obstetrical experience. They will concern themselves with her pregnant feelings as well as her pregnant body. They will let her talk, they will listen carefully and with interest to what she has to say. They will not lecture her. They will gently re-educate and reassure her about her superficial anxieties and conflicts. They will recognize and respect the deep unconscious tensions which she may be battling in bringing this new life into the world.

Henrietta Klein[4] further confirms our feelings that fear and anxiety are an unshakable part of any pregnancy when she states:

[4] Klein, Henrietta, Anxiety in Pregnancy and Childbirth, p. 32.

> No patient, irrespective of whether the baby was wanted or unwanted, was without anxiety at some time during her pregnancy.------Some patients explained their reticence to mention anxieties on the basis that to express or admit anxiety was to make it operative. Although the degree of anxiety varies, depending upon the emotional makeup and upon the specific meaning the pregnancy has with its concomitant external factors, all patients experience anxiety some time during the pregnancy period. Even in those who give no conspicuous evidence of anxiety, specific evidence of its presence was found when attitudes, dreams, plans or fears were carefully scrutinized. Anxiety is not usually expressed as a complaint but in indirect ways. Whether the concern is related to the woman herself or to the unborn child, these anxieties are always interrelated and frequently one is substituted for the other. It is common for the woman to describe feelings of relief upon perceiving foetal movement, since this is regarded generally as an index in the baby's well being. But im addition to this, most are alert as to whether or not these movements are continuous and feel alarm if they are not present for a day or so. They equate any diminution of foetal movement with the foetus dying in utero.

If we are willing to accept the hypothesis that normal pregnancy is im itself a complex biological process and relate this to our understanding that every woman brings to this experience a galaxy of preconceived feelings, anxieties, phantasies and expectations which are all extremely threatening to her own image of the good mother, are we not then obliged to look one step deeper? If pregnancy is fraught with such emotional overtones and a healthy baby is the desired goal, what becomes of the woman who bears a lifeless child? What are her needs as defined by her? Is the nurse

prepared to meet this challenge. How does she feel toward the childless mother in her care? The current literature could neither lend support to my belief that both the mother and the nurse have specific needs in this area nor could it help identify these needs. If the dead infant is the woman's confirmed proof to herself of her unworthiness of motherhood; if he is symbolic of repressed guilt; if he is identifiable with her repressed marital hostility, then of what significance is he to the nurse? What concepts or images does she form of herself and her responsibility to her patient? Again, nothing is found in the literature to help identify the nursing role in this dilemma.

Latham and Bennett[5] have stated:

> "There is no data on the emotions nurses experience when they care for a mother whose baby has died --------." "It would be sad indeed, if nursing were to fail the public, and if Maternal and Child Health nursing programs failed to develop or remained static because nurses did not have the understanding, knowledge and experience that are needed to insure their progress."

[5] Latham, Helen, and Bennett, Elizabeth, "Should Students Have Their First Clinical Experience in Obstetrics", p. 456.

"Each party in a two way relationship has conceptions about what the other is like and these preconceptions begin to operate before they come to know one another."[6] How often we read of advice given to nurses on how to behave in relation to their patients. "However, until the actual needs of the nurse are met or identified so that she is aware of what they are and how they function as barriers to the patient's goals, she does not have the needed controls to carry out all the 'shoulds' and 'musts' indicated in the nursing literature."[7] Hildegarde Peplau[8] describes these "shoulds" and "musts" as those components in nursing education that:

> --- make it more difficult for nurses to reveal to themselves and to others what they actually feel in a situation. Yet, identifying what is actually felt is a sound guarantee of the development of persons in nursing who will want to nurse patients and who will be able to take on the task of self nuture in the future. It provides a basis for developing nursing practices that can be carried out willingly, intelligently, and with satisfaction by a nurse who knows what she observes, understands its meanings and can base her actions upon observation and understanding.

[6] Peplau, Hildegarde, Interpersonal Relations in Nursing, p. 139.

[7] Ibid, p. 139.

[8] Ibid, p. 140

Norman Brill[9] identified the nursing role even further when he said:

> The popular concept of the nurse has, in part, developed from the idealized picture of Florence Nightingale --- the devoted, self-sacrificing, and generous person, who caters to the ill with no thought of herself. ------The word nurse refers to a member of a profession--to an individual who has completed a certain course of training, and not to a kind of person. This fact is frequently forgotten not only by patients and doctors, but also by the nurses themselves. ------ Nurses vary in their liking to be with other people. ------ Some nurses are interested in why persons (including themselves) behave the way they do, and others are not. While some nurses understand that the state of a person's health has a definite connection with his feelings, others think only in terms of what is physically wrong ----to them, treating a patient is something tangible, like putting on a dressing or giving a medication.--------each patient is responsive to the personalities of those who are caring for him. The recovery of patients who are extremely responsive may depend more on <u>how</u> something is done than on <u>what</u> is done. Thus the nurse who is alert to these differences in her patient's responses, who is flexible in her approach, will be more successful than the one whose rigid personality happens only by chance to meet the needs of the patient. One of the best ways to achieve this flexibility is through self-understanding. The person who doesn't understand himself cannot understand others. The nurse who can't face reality herself is unable to help her patients do so. People tend to be impatient with, and

[9] Brill, Norman, "Understand Yourself", pp. 1325-1326.

> intolerant of, undesirable characteristics in others which they themselves have; this a way of denying the presence of these characteristics in themselves.

In the dynamic study of Lesser and Keane[10] one of the most salient observations noted was the apparent dichotomy existing in the nursing role as seen by the patient and the nurse in the normal maternity setting. It is my feeling that this is not the only area where the mother and the nurse view the concept of patient centered care from opposite poles in the continuum.

> The medical scientist bore the chief responsibility for initiating current obstetrical practices that have resulted in the safe maternity care that we have today. Perhaps it is the nurse----functioning today as a professional person---who can now contribute her share to practices that will provide patients with the personal interest, emotional support, and information which represent their primary unmet needs of today.[11]

HYPOTHESIS

The methods employed by the nurse to support the mother of a stillborn infant are not felt, by the mother, to be satisfactory.

[10] Lesser, Marion and Keane, Vera, Nurse-Patient Relationships in a Hospital Maternity Service, p.224.

[11] Ibid, p. 224.

CHAPTER III

METHODOLOGY

Selection and Description of the Study Group

The nature of the problem under investigation imposed certain limitations upon the variety of agencies available for study; therefore, only one official agency was utilized. Approximately twenty-five registered nurses participated in the study and, of these, thirteen were selected from the maternity area of a large metropolitan hospital. The nursing director of this hospital provided an interviewing office away from the hustle of the nursing scene. In this way I was able to talk to each graduate without either of us feeling the pressures inherent in any working situation. In addition, she reviewed with me the work experience of each of her graduate nurses, so that I might be able to obtain a more accurate sampling of the feelings and attitudes expressed by nurses representing a broad spectre of maternity experiences. However, I did have the freedom of the entire hospital and was actually able to select any graduate nurse interested and willing to participate in the study. It is interesting to note that the interviewing room was utilized primarily by me for the purpose of record writing. Each graduate selected the

area where she wanted her interview to take place. The remaining twelve graduate nurses came from various geographical and experiencial sources, namely, four were public health nurses in Hartford, Connecticut, who presented a symposium directed toward the problem of stillbirths; six were maternity staff nurses working in the obstetrical area of a large New York medical center, and two were maternity nurse educators teaching in Boston.

No provisions had been made in the original study to include the mother of the stillborn infant. It was only after I had interviewed the nurses and explored with them many of their feelings concerning these women that I began to wonder if the mother really had such needs. Did she see herself as the nurse did? Did she receive the nursing comforts that she desired, or were nursing needs imposed upon her? These questions could not be answered until the study group was expanded to include the mother, and I was not sure that I wanted to be the one who did this. Caring for the mother who had delivered or given birth to a dead baby was an area I had always tended to avoid. I was not sure I was ready to listen to her evaluation of my "good" care. Although I was uncomfortable in the role I had created for myself, it just didn't "pinch" enough to motivate a sincere desire to investigate the possibility that my frame of reference concerning the mother's nursing

needs might be diametrically opposed to her expectations. I was unable to move until I had received much reassurance and encouragement from a psychiatric nursing specialist that such an investigation would not prove disastrous. Not at all convinced that interviewing these mothers might even be therapeutic to them as well as enlightening for me, I requested permission to visit the hospitalized mothers of two large urban maternity areas. In both instances feelings were expressed that such a study might be too "anxiety provoking" and too "research oriented" to be of any value to me or any help to the mother. If I did anything at all, it would probably be "just to upset the mother". "What else could I possibly hope to gain by asking the mothers what kind of care did they expect from the nurses? After all they were in such a state of shock they wouldn't really know what they wanted." One nursing director suggested I interview mothers in their own home, particularly mothers who had since delivered a healthy living infant. If this method did not seem too traumatizing to the mother then I could again seek permission, through the chief of staff, to interview mothers from the resident service. I did not attempt to formally introduce this study in any other hospital maternity units.

In an attempt to locate this suggested group of mothers, I requested appointments with five obstetrical specialists whom I knew personally. I thought I had selected the most susceptible physician for my first interview. However, he asked me to convince him I was "prepared to assume the consequences of my visit with the mother in whom (1) reactivated unresolved guilt feelings and anxiety directly related to the loss of her baby, and possibly resulting in her requiring psychiatric treatment." Although the interview continued through a delightful dinner evening, he was not moved and I did not visit any of his mothers. The remaining four physicians decided the risk involved, if one existed, was worth hazarding so they might also know how the mother saw her needs during this grief crisis; therefore, five mothers were interviewed in the home setting. In addition, the physicians requested that their own opinions be included in the study. This investigation was again expanded to include the feelings and attitudes of five obstetricians in caring for the mother who experiences an infant loss.

Five mothers did not seem to be a sufficient sampling to afford any validity to this area of the study so that the feelings of fifteen mothers were surreptitiously incorporated into the investigation. Such a statement might possibly demand a more detailed explanation. I was fortunate in having two

remaining approaches still unexplored. The first was in the form of my maternity nursing field practice, an integral part of my graduate educational experience. This experience was offered in a large eastern medical center and was enriched through the opportunities given to me to care for the mothers of stillborn infants. In this way I was able to work with an additional four mothers. The second entrance was realized when I was employed as a maternity supervisor in a Boston hospital for summer vacation relief. In such a role it only seemed logical that the supervisor would visit her patients prior to their discharge day to determine how the mother perceived the nursing care she received and to investigate what she might consider were her unmet needs. Eleven such mothers were visited.

In summary, fifty individuals participated in this study. The three groups involved were: (1) twenty-five graduate nurses (fifteen from Boston, four from Hartford and six from New York); (2) five physicians and (3) twenty mothers, (five were seen in their homes and fifteen in the hospital setting). The study covered a period of seven months from February 1, 1958, to August 30, 1958.

Tools Used to Collect Data

The personal interview was the primary tool employed in this study. Noted observations of individual reactions to the discussion subject was also a meaningful component of the investigation and will later be presented in more detail. To control a few of the digressional variables and to insure consistency in each of the interview samplings, semi-structured guides* were utilized. Although these guides were presented in the format of a questionnaire, they were actually reminder sheets for me. Regardless of the areas explored in each interview, the guide questions were discussed sometime during the interview. Only the interviews with each of the thirteen graduate nurses selected from the maternity area of a large metropolitan hospital were recorded during the actual discussion session. Those of the physicians were recorded at the time of the interview in topical form only. Immediate recall was the tool employed to complete their records. When interviewing the mothers no notes of any kind were kept during the discussion. Again, immediate recall was the method whereby these sessions were recorded. The first mother I visited seemed to express a certain reluctance to participate in the study when she observed me taking notes; therefore, the verbatim recording was discontinued for this interview and not attempted in any other. In summary, the tools employed in

* See Appendixes A and B.

this study were - (1) the interview, (2) observation, (3) guide questionnaires, (4) records--part verbatim, but predominately from immediate recall.

Procurement of Data

I have often heard it said, once the data is collected the real work begins. Perhaps this is so, but for a moment let's examine how the data for this study was collected, the feelings involved for both participants in each interview, and the various ways in which they were handled. Geography played a very important role and offered a certain luxurious freedom that was rather foreign to me, a nurse who had always functioned within the limits of a hospital community. Interviewing other graduate nurses was a new and sometimes threatening experience; fortunately, however, the subject of stillbirths aroused sufficient interest in everyone so little time was given to examining the investigator. The major portion of the graduate nurse interviews was derived from the maternity staff of one hospital in Boston, offering me a certain central location and a familiar professional scene. As I stated earlier, a private room was available for our use, but the nurse being interviewed had the final decision in selecting the area in which she would be most comfortable. These areas ranged from the supervisory office to the lavatory. In one instance it seemed feasible to work

in the newborn nursery feeding infants in order to help one nurse complete her work early. She wanted to participate in the study and tried very hard to rearrange her schedule so that we might find a time when she could be interviewed without interruption. An hour was selected, the work shared, and the interview completed.

Another interesting experience occurred during my visit to Hartford, Connecticut. A nurse educator, who had been following the work in this study, invited me to attend one of her classes where a group of public health nurses was presenting a symposium on the stillbirth problem. Not only was I able to hear their ideas, but I was able to interview two nurses who had themselves delivered a stillborn infant, and two other nurses who were actively engaged in family health nursing in the community.

As more nurses were informed of the study they began to "become more aware of the problem for the first time" and wanted to know "how other nurses felt". It was through this media of conscious awareness and concern that six nurses were interviewed during my maternity nursing field practice experience in New York. Two of these six nurses became so interested in the study that they provided several opportunities for me to actually care for mothers who had delivered a still-

born baby. However, this limited the interview area primarily to the support they received during their post-partal period as I had been directly responsible for their intra-partal care and felt the mothers might be reluctant to express their feelings in this area.

The home interviews presented certain barriers both to the mother and myself. Being outside the hospital community with no symbolic identity as a uniform or cap, seemed to place me (I thought) in a relatively powerless position. I was now the guest of the mother. She, in turn, was not certain of the depth of the interview and showed an initial wariness of being part of a research project. In one instance, at the completion of the interview, a mother rather embarrassedly confided - "I hope you won't mind but I called my doctor yesterday and asked him to tell me more about you and the project. It was really my husband's idea; he thought you might be a Kinsey investigator".

An appointment for the interview was made in advance with each mother, except one who did not have a telephone. At this time the purpose of the study was explained, the author identified. and the mother informed that I had received her name through her physician. Every mother I contacted agreed to participate, with the exception of two. In both

instances her own mother answered the telephone first and required a detailed description of the study and much reassurance that such an investigation would not be too traumatic to her daughter. The loss of the grandchild seemed so upsetting to the grandmother, in both instances, that she was unable to permit me to talk to her daughter. I did not pressure either grandmother any further but interpreted their uneasiness and reluctance as refusals.

All of the interviews with the mothers were of an informal nature. The mothers were eager to talk but in almost every instance they had to discuss the significance of their loss and receive much reassurance and support that they were neither directly nor indirectly the cause of their infant's death. As these findings were not the prime concern of the study, the interviews varied in length from one hour to three and one-half hours. Only when the mother was certain that I was interested in her was she then ready to help me. This readiness was exhibited in many ways. One example might be the mother who confined the interview area to her cluttered kitchen until I had listened to her express many feelings and suspicions that she was the indirect cause of her baby's death. Somehow I must have said something that she wanted to hear, for she jumped up from the table saying, "My goodness what are we

doing talking in here. The chairs are so hard. Let's go into the living room". She brought a coffee pot into the living room with her and continued the interview, now able to move into the area I wished to explore. I fed her (reassurance and support) and she fed me (coffee and data). Another illustration could be the mother who filled me with coffee and doughnuts, only to insist that I remain for lunch with her two children. The feeding process became an important part of the methodology used to procure the data explained in the following chapter.

CHAPTER IV

FINDINGS

Presentation and Discussion of Data

In analyzing the interview material to discover the feelings and attitudes of nurses and mothers as they relate to the problem under investigation, themes correlating with the hypothesis were postulated as an aid in identifying pertinent data. Excerpts from the interviews which seem to validate these predetermined themes were extracted and considered significant as supporting evidence.

These threads, selected in an effort to identify material which might indicate that the feelings and attitudes of the graduate nurse substantiated or contradicted those expectations of the mother, could be related to the following general areas:

(1) Rationalization

(2) Guilt

(3) Grief

(4) Replacement

Data will be presented and discussed as it bears a relationship to the above themes.

Theme #1

(Rationalization)

For many of us, verbal communication with our "mothers" seems virtually impossible unless we are able to be logical or rational. Some of us feel "intelligent", sequential, measurable facts are mandatory in our relationships with mothers. The nurse frequently casts herself in the role of feeling she must have the answers and above all else, they must be logical, well informed, scientific explanations. An ability to utilize our technical skills and a "sound" understanding of human physiology, as it is intrinsically related to our patient's health needs, can be recognized and accepted as a "must" tantamount to the basic foundation of every nurse's education. However, technical skill and knowledge should be viewed as an important beginning and not necessarily a desired singular outcome. Although our mothers expect, and rightly so, to receive their nursing care from well "trained", educated, professional nurses, they take our technical competency and factual knowledge for granted. Mothers generally assume we know or we wouldn't be practicing in the profession. It seems though that many of the mothers are saying,"we know you can meet our physical needs, you can teach us much, but can you care? Do you really understand how we feel?"

Nursing education, in its striving to improve the status of the profession, may have contributed and initiated many of these feelings that we must have the answers, that our mothers expect us to know the "hows and whys" of their ills. Or, perhaps much of the popular literature has helped convey to the mothers our seemingly "omnipotent" role. The reasons why we have the"power"image we do are not a justifiable concern of this investigation, but what we do when we are incapable of coping with the demands of such a role is our concern.

When we feel that we are letting ourselves down we often have a tendency to take our emotional conflicts into the sphere of the intellect, divest them of effective and personal meanings and work on them as problems of science, pathology or reason. This process of rationalizing conflicts has been interpreted by many as a way in which we make excuses for our feelings and behavior. As long as we feel that it is necessary to substitute reason and logic for our basic feelings of wanting to care, we will have mothers with unmet needs. When we rationalize we tend to find a certain comfort in denying our actual feelings or attitudes. We cannot feel what we do not see. If we can find reason in our feelings and logic in our explanation, then we can deny those discomforts within ourselves which others tend to jog.

Relationship to Theme #1	NURSES	MOTHERS
DENIAL	We tend to send the mother to her room (from delivery floor)* as soon as possible so she can be with her husband.	My husband was the biggest help. He was so understanding. He knew how I felt.
	Once the mother knows, we send her husband in to see her.	I was so lonesome. I wanted my husband. He understood my feelings.
	We can't talk to her (mother) about the baby until the doctor tells her what happened.	The nurses don't like to talk about it. They let the doctor do it.
	If the doctor isn't there when she wakes up, we have to wait and look stupid.	I knew something was wrong when the nurse wouldn't tell me the baby's weight.
	The doctor should tell the mother first. She knows him and will listen to what he says.	The nurse was so vague and upset looking I knew something was wrong.
	The prepared ones (mothers) don't whimper or carry on. They are reasonable.	I asked the nurse what was the birth time. She got so flustered, I just knew something was wrong.
RELIGION	The ones who come in knowing the baby is dead don't carry on. They feel God is protecting them because He knows best.	I expected the priest to help me. I didn't want any religion from anybody else.
	You can always say, God has His reasons and we must have faith.	I couldn't care about what God thought. I only knew how I felt.

*Words enclosed within parenthesis are the author's and will appear throughout the chapter.

Relationship to Theme #1	NURSES	MOTHERS
	:in Him.	:
	:	:
	:You can tell her this :was God's way of pro- :tecting her, if the :baby was abnormal.	:I thought I'd scream if one :more person mentioned God. :I just didn't care.
	:	:
	:If the baby is per- :fectly formed, you can :always say, God has :His reasons and we :must accept them.	:Religion is a help after :you feel better, but it :really wasn't my first :thought or what I wanted :to hear.
	:	:
	:It's easier if the :mother is religious. :You can tell her God :did it.	:My minister visited me at :home. I wanted to talk :then but not when it first :happened.
	:	:
	:	:
	:	:
ANOMALIES	:If the baby has an :anomaly you can always :say it happened for :the best.	:Until I got home, I never :thought much beyond the :fact that I had nobody.
	:	:
	:If the baby had a cere- :bral defect, you can :tell the mother she :was lucky it died.	:I didn't care at first :why the baby died, just :that I lost her.
	:	:
	:If the baby had an ir- :reparable defect, you :can tell her it was :for the best.	:I didn't want to be ration- :al, I just wanted someone :with me who'd let me cry.
	:	:
	:If the baby was pre- :mature you can at :least tell her why he :probably died.	:I think your first concern :is that you have no baby-- :why isn't the most important.
	:	:
	:I think it's easier :to talk to the mother :if the baby has an :anomaly. You can	:I suppose it is best but :when your baby dies you :don't look for logical :reasons you just feel you

Relationship to Theme #1	NURSES	MOTHERS
	tell her it saves her from future misery.	lost your baby.
INTELLECTUAL	It's easier if they are educated. They can understand your explanations better.	
	They (mothers) seem more interested in what you say if they are higher class or educated.	
	The lower class ones are too hysterical. They don't listen to what you say.	
SUBSTITUTION (REASON FOR FEELING)	They don't seem so upset if the baby was unwanted or illegitimate.	
	The young ones are so hysterical. They won't listen to you.	I know I had time for more babies, but it was this one I was thinking of.
	The older woman internalizes more. She is calmer and will listen.	
	I don't like to work with the older ones. Their chances are so limited.	I was thirty-six (years) when I lost the first but I have two girls now.

Relationship to Theme #1	NURSES	MOTHERS
	If the mother is mature you can use logic.	
	If she's an illegit (unwed) she doesn't have to worry about the baby now.	
	If the mother comes in knowing she has a dead baby, it's not such a shock when she delivers it.	I knew my baby was dead but it wasn't real until after I delivered him. It was still awful.
	Find out about their hobbies - the mothers like to talk about them.	I felt some of the nurses wanted to avoid talking about the baby.
	It's easier to talk to the mother if the doctor would only give her history.	I found it hard to talk to the nurses. I never felt I knew any of them.
	You can talk to the mother if someone would give you some facts---cause of death, etc.	I expect the doctor to tell me what happened.
	If there is no reason for the death, what's there to say?	I felt so lonesome I wanted to talk to anybody about anything.
	I think the mother should be in a room by herself. She's so upset.	I wanted to be in a room alone, but not forgotten.
	The mother feels	My children were such a

Relationship to Theme #1	NURSES	MOTHERS
	worse if it's her first baby.	comfort when I got home. I don't know how I'd feel if I had none.
	If the mother is quiet or withdrawn, she wants to be alone.	I didn't want to talk but I didn't want to be alone so I talked.
	A good obstetrical knowledge helps as you can tell the mother what happened.	I never questioned the nurses' skills; after all she went to school to learn them.
	To really be at ease you need scientific facts so you can tell her what happened.	I expected the doctor to tell me but I wanted to talk it over with the nurse.
	The mother should not be in the maternity department, it's too upsetting to her.	I had children at home and I could talk to the other mothers about them. I don't know why the nurses made me stay in my room.
IDENTIFICATION	The students avoid these mothers; they need help.	I liked the students. They were upset but so helpful. They used to visit.
	The students need help. They have trouble talking to people.	The nurse seems upset when she just talks. I feel she wants to leave.
	Students need encouragement. They feel useless and stupid.	The nurses seemed more relaxed when they had something to do.
	Someone should help the students. It's rough on them.	I guess I upset one nurse when I cried. She told me to stop and she'd be back later.

Relationship to Theme #1	NURSES	MOTHERS
	I let the mother take the lead--if she doesn't want to talk that's fine with me.	I didn't want to talk about the baby, but I was so lonesome.
	DOCTORS **	
	I'm glad you're doing this study and not me.	Do you really want to know how I felt? Does it make any difference?
	Any way you can help the nurse understand the mothers' needs is valuable.	Do nurses feel the way we do or are we part of the job?
	I'd like to know what you find from this study. I never thought of how the nurses must feel.	I never thought nurses had feelings. I just thought they were trained for the job. I didn't know they wanted to know how we felt.

Rationalization seems to play a more important part in the nurses' feelings than in the mothers'. Our image of the nurse as a "doer" seems so deeply implanted, we have difficulty functioning comfortably in any other role. We have considered ourselves to be "suppliers" of things, "doers" of tasks and performers of skills for so long that it is unlikely we

**Doctors' remarks will be placed at the end of the "Nurses'" comments if pertinent to the theme.

would believe other avenues to "good" patient care could be utilized or even needed.

When the mother experiences a loss, she has no past formalized training which would inhibit the free sharing of her needs. Her feelings are important to her. She has such a deep need to have someone with her who cares that she has no time to waste trying to be a rational adult. Only when she has the opportunity to share her own feelings, complete with their absent logic, will she be able to resolve some of the grief associated with such a deep loss.

Theme #2

(Guilt)

The interview data revealed many threads of unshared, though interrelated feelings of guilt. Irrational guilt feelings often occur in "normal" people but only the mothers were openly recognized as the unhappy possessors of such anxieties. Guilt is a feeling that is perceived when the way in which we function or view ourselves reveals inadequacies in our concept of self. How we feel we should function and how we really do brings up discrepancies in our own image. Quite often it is not what we say, but how we look and what we do that reveals so much; feelings of guilt usually operate

beyond the realm of awareness. Recognition of grief and suffering in others, sublimation of our own needs into activity directed toward relieving the anxieties of others, are ways of overcoming and appeasing our own feelings of inadequacy. A nurse cannot function effectively in any patient relationship when her own anxieties limit her awareness that she is unwittingly focusing upon ways in which her needs could be met by the patient.

The nurse, caught in her feelings that "losing" a patient can be directly equated to her failure as a healer, develops a self portrait of being a very powerful person. She is not often given the opportunity to express and share her feelings but she certainly has been given the idea that she is the initiator of all patient disasters. Both the nurse and the mother are consumed with guilt whenever a baby dies but only the mother is permitted to express her feelings of self blame. The nurse is expected to assuage the mother's feelings by letting her "talk it out" or "work it through", but the nurse cannot be this permissive with herself. Her needs, unrecognized, remain unmet.

Relationship to Theme #2	NURSES	MOTHERS
Obligation	I don't like to talk to them (mothers) but someone has to.	I wish the nurses could relax a bit and visit or chat a while.
	I don't think they should be ignored but it is frustrating.	I almost felt abandoned, I was so lonesome.
	I don't know what to do or say but you have to say something.	I didn't want to talk about it at first but I did want to talk, I was lonesome.
	I don't like to work with them.	Some of the nurses looked ill at ease.
	I feel upset and frustrated. There's nothing you can give but reassurance. I'd rather not work with them.	I wish the nurses didn't always have to be doing something, they seem afraid to just talk.
	I don't like to be with the mother, but they shouldn't be ignored.	It was being abandoned that I hated. I wanted a private room but I didn't want to be the only one in it.
	If the doctor tells them first it's easier to go in and reassure them it wasn't anyone's fault. It just happened.	I wanted explanations from the doctor. I trusted the nurses but I felt it should come from him.
Identification	I wouldn't like to be in this mess myself - it must be awful.	I felt so alone and useless, I just wanted to hide.
	If you can establish a relationship before she delivers, she'll	I think your first thought is, what did I do; was it my fault? You never

Relationship to Theme #2	NURSES	MOTHERS
	trust you and believe you when you tell her it wasn't anyone's fault. It just happened.	really get over it though you know such thoughts are foolish.
	The mother is usually guilty and we have to wipe that out first. No one is to blame.	I got out of bed with a bad cold and went to see the doctor. I delivered two days later. Do you think I should have stayed home?
Failure	Just the other day a mother came in bleeding. Something happened from the time we got her on the table until we delivered her. We lost the baby.	I think I have always taken the nurses' skill for granted. They have been trained for this work and I've just assumed they know what to do.
	Some mothers shop for doctors and hospitals. That's foolish - it won't make things any better to change.	My husband asked me if I wanted to change hospitals for luck. I don't because they know me there and gave good care.
	One mother was bleeding and we told her not to worry. She hemorrhaged and we did a section. The baby died and we felt terribly.	Sometimes I think the nurses felt worse than I did. They seemed so ill at ease and I know they know what they're doing. They have been trained.

Relationship to Theme #2	NURSES	MOTHERS
Ambivalence	I should let the students talk this out in class but it upsets me too much.	The nurses never seemed to have time to talk--they were always in a rush. I wonder if I upset them?
	I don't encourage the students to talk about it as I don't know what to say; but they do need help.	You don't really expect anyone to say much but you hate to have your problem taken for granted as just one of those things.
	Someone has to be blamed and it's usually the nurse. It's not fair.	You always wonder if -- if I had gotten to the hospital sooner, if I'd done something wrong.
	The mature ones (mothers) don't make unnecessary demands - they understand no one was to blame.	I know there's not always an answer but you feel - oh maybe I gained too much or I didn't eat the right things. Stuff like that.
	Some mothers are always finding fault and demanding things. They take their guilt out on you and you had nothing to do with the baby's death.	I'd rather be alone than with someone who had to be there. I had to ask for everything and felt like a pest. They (nurses) were very nice but I was lonesome too.
	DOCTORS	
	I feel just terrible. It is not unusual for me to weep with the mother. You always wonder if you could do more.	My doctor helped the most. He was so kind and reassuring. You still wonder though if it wasn't a little your fault.

Relationship to Theme #2	DOCTORS	MOTHERS
	I always feel I could have tried harder even when I know it's foolish.	I didn't stay in bed when I had a cold. Do you think that had anything to do with it?
	You wonder if there wasn't some little clue you missed.	I wonder if I called the doctor and got to the hospital faster - would it have happened?
	You always wonder if there wasn't something you could have done to prevent it. It's a terrible feeling.	My doctor was so understanding. I cried and carried on like a baby and he still stayed with me!

For the most part, each individual appears to be working independently in the area of his guilt and little or no opportunity has been provided for "working through" these overwhelming feelings through a sharing process. The mothers want reassurance so badly that they were "good" mothers throughout their pregnancy and that they were notresponsible for the death of their babies. Giving birth to a dead infant is threatening enough to the mother's role concept without superimposing feelings of guilt. The mothers tend to blame themselves for what they might have "done to the baby", whereas the nurse internalizes her guilt and says,"I don't do enough". Both tend to personalize the infant loss and question their own adequacies. *The mother* wants to share her feelings and absolve her guilt phantasies. The nurse, "trained to respond" wants to support

the mother but seems inhibited by her own picture of one who cannot admit she too is experiencing a loss.

Theme #3

(Grief)

The symptons of grief and guilt are so closely interwoven it is often quite difficult to differentiate the dynamics of the two. However, so many feelings of anxiety and hostility were expressed that a closer inspection of the data seemed to reveal that a certain vagueness or detachment was shown by the grieving mother; she verbalizes her feelings of loss but she did not feel; she rebuffed the concern of her friends when she wanted them most. Again we see a dichotomy in action. The mothers want someone to care about them, to share their grief, to guide them in their acceptance of their loss, so they turned to the nurse. No one expects the nurse to grieve, yet are quite alarmed and somewhat dismayed when she responds in a formalized, stiff, unfeeling way. She makes a special effort to maintain friendly relationships and is then criticized when no one recognizes her, the grieving nurse.

Relationship to Theme #3	NURSES	MOTHERS
Promoting	I just offer the old shoulder and let them cry it out.	I guess I wanted to share everything; my loneliness and my tears too.
	I think you should encourage crying. Let them know it's good.	I suppose I wanted to be taken care of but I felt alone even when the nurse stayed with me.
	Crying makes you feel better and we should let the mother feel it's all right.	One nurse let me cry and I bawled buckets and felt much better.
	Some mothers are hostile toward you but there is grief in both of us and we should try to understand how she feels.	One nurse seemed so kind. I felt she understood and would want to help if I asked. I didn't but I know she would be there.
	I feel terrible and have cried with them (mothers)	My family was upset but it was still good to be with someone.
	I stay with them and let them cry it out. It's so frustrating	I used the hospital for crying and could see the good in things when I got home.
	Usually they're weepy for the first few days. I let them cry it out.	You're in shock for a while but you do want to share it after a while.
Inhibiting	The baby never lived anyway. I think the dying adult is worse.	Someone said, "Well at least you never saw him". I could have hit her. That's not the point at all.

Relationship to Theme #3	NURSES	MOTHERS
	:I want to cry with them but of course you can't do that!	:I wanted to cry, but it seemed to upset the nurses. They're so efficient and all.
	:I feel terrible too but you can't be upset and make the mother worse.	:I remember the terrible loneliness most of all. I'll never forget it.
	:If the mother cries I leave the room. It's too upsetting.	:I wanted to cry but the nurse wouldn't let me. I did it alone.
	:When the mother cries I leave the room and tell her I'll be back later when she feels better.	:I liked to be with another mother in the same situation. We could cry together and upset no one. We were company for each other.
	:I don't believe in letting them wallow in self pity. It only upsets her.	:I used to cry at night when I was alone. The nurses made me stop.
	:I never know what to say but at least I can control myself.	:I never thought about nurses having feelings. You see so little of them.
	:You have to keep calm. Being upset won't help the mother.	:I guess nurses have been trained not to show their feelings. The nurse I liked best was a student.
	:When I feel too inadequate I change the subject and get the mother to laugh.	:She used to visit and bring me juices and books. She told me all about the senior dance and graduation. She helped me understand the efficient graduates. I really liked her.

Relationship to Theme #3	NURSES	MOTHERS
	:The students are afraid of their feelings and need help.	:The nurses really want to help but they seem so upset, they do what they have to and leave.

The doctors did not seem to specifically discuss feelings applicable to this area. The feelings expressed through self blame could be interrelated with grief.

Theme #4

(Replacement)

When someone we love very much has been taken away from us our first reaction, even during grief, is possibly an unconscious searching for a substitute. These desires to replace a loss may not necessarily operate as a conscious awareness, but they appear to be present as an integral part of the image of a "good" nurse. In the grief which we are unable to share with the mother, our unconscious desire to replace her loss can be witnessed through the many and devious ways we attempt to satisfy her needs. The

impossible task of even attempting to fulfill these needs creates many frustrations for the nurse. In her nursing role she has many anxieties, as exhibited by her feelings of guilt, that she did not do enough to prevent the death; that she is realistically unable to replace the dead infant with the healthy baby the mother so desperately desires. As a person, she needs to share her grief with someone; as a nurse, she finds this in conflict with her role concepts. Yet, she continues to seek substitutes for the mother, hoping to realize her unmet needs through her patients. Is this what mothers expect?

Relationship to Theme #4	NURSES	MOTHERS
Conscious	I don't like to be with the older ones.	
	You can't give her anything, not even hope.	
	It's too bad you can't give her an illegitimate baby for the one she lost.	
	I'd like to give all the unwanted babies to mothers who lost theirs.	
	You can only give her hope and what use is that?	If someone had just said they understood and were sorry.

Relationship to Theme #4	NURSES	MOTHERS
	There is nothing to give but support. Try to let them feel all is not lost.	I didn't want pity but I sure wish someone had felt my loss with me.
	It's easier if you can offer them something, but hope doesn't seem like much. Reassurance doesn't seem to be much to give.	I would have talked about anything. I was so lonely. I just wanted someone who looked like they cared.
Unconscious	A mother with no children is hard to comfort as she has nothing.	I think it is easier for the nurses if you have children. It gives them something to talk about.
	If she is young, you can tell her she has time for more. It gives her hope.	I don't care how many I can have. It's what I lost that's important to me.
	You should tell the mother to think of the children at home, if she has any.	I think I would have screamed if I heard another person tell me how lucky I was to have two children at home. I love them very much but I loved the one I lost--in a different way. He was a part of me that you can't deny or replace.
	You should look at what they have and not what they lost. (children)	

Relationship to Theme #4	NURSES	MOTHERS
	I try to make small talk, hobbies, weather or something. Anything to get her mind off what happened.	The nurses seemed so upset unless they had something to do, like in a rush always. They made me more uncomfortable.
	It's easier if you can talk about her children at home, or the reasons why the anomaly may have happened	I couldn't think of the children at home. I could only think of the baby I had lost, though I love my children too.
	You should emphasize her future productive years, not what she lost.	I didn't care about what I could do, it was what I couldn't that got me.
	If she has children at home, tell her to think of them. She's lucky.	The kids were a comfort when I got home, but not while I was in the hospital.
	DOCTORS	
	I try to give them all the time I can and all the facts I know.	My doctor was so kind and patient. He was really concerned.
	I encourage them to get pregnant again as soon as possible.	I am glad I got pregnant again so soon. I was real worried but it would have been worse if I had waited. I was so scared.
	The nurse has lost much when she gives up the use of her hands. So much feeling can be conveyed	One nurse didn't say much but she sure looked concerned and used to give me extra rubs and fruit juice. I just

Relationship to Theme #4	DOCTORS	MOTHERS
	through the hands.	knew she understood and I felt I could talk to her when I needed her and she would be there.
	Without words so much understanding can be relayed to the mother by holding her hand or touching her. Or, oh well, you nurses have it anyway. You can do so much through the bath or backrub.	Some of the nurses would drop in to fix my pillows or bring me juice. You knew they would be there when you wanted them.
	The physical comfort you give to the mother can show so much. Either you care or you do it fast and leave.	The nurses always gave me good care but I felt they were in a hurry and wanted to get out of the room real fast.
	You nurses can give so much through your hands. You can show you really care.	I loved those backrubs.
	ONE NURSE	
	Physical contact is very important. If we are able, we can convey so much through our hands - in just the simple backrub. I have learned so much from -----(Cocker Spaniel dog), the way she responds to warmth and petting. We give	I wish I could say what I feel but it's not clear in words. Somehow you knew, by the look, the tone of voice or something, that when your nurse gave you care she told you how she felt about you. That was all I wanted then.

Relationship
to Theme #4

:up so much when we :
:turn this aspect of :
:nursing over to others:

It would seem that the nurse becomes anxious when she fimds using herself the only recourse available in caring for mothers; whereas, the mothers want just that sort of support and comfort which the nurse is most uncomfortable in giving. We tend to overlook the most important gift that can be given to any mother, ourselves; yet seek relief in attempting to give the impossible, a baby.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary and Conclusions

The nature of this study has been primarily exploratory. There seems to be nothing available in the literature to directly substantiate the findings of the investigator; therefore, the conclusions drawn from the presentation of the data could be interpreted as somewhat subjective. These were the observations and opinions of one person interacting with fifty other adults. The nature of the role I assumed carried with it certain inherent conflicts. As a nurse, I could deeply empathize with each of the nurses I interviewed. Her attitudes and feelings were my anxieties; her approaches to coping with the problem were also my solutions. I so hoped we were both directing our energies toward "good" patient care as it was viewed by the mothers. During the visits with the mothers I found my anxieties and concerns heightening to a point of despair. Why, these mothers weren't saying what I wanted to hear! They felt alone, abandoned, misunderstood and unwanted. I couldn't help but wonder, what happened to all the feelings and con-

cerns presented so warmly by the nurses during their interviews. Why didn't they flow to the mothers? The concern and wanting to care were certainly there. The nurses and the mothers shared many of the same feelings; yet, the ways in which they handled them were quite dissimilar. Although the nurses were aware of the mothers' needs, they were unable to move or effect mutually satisfying relationships.

When the mother enters the hospital community she imagines herself as one taken into the care of those who know her needs and are able to meet them. Her nurse has been prepared to give her the care and understanding she must have; and she is bitterly disappointed when her preconceived ideas are not realized. To her, the hospital is the place where you act out hostilities, experiment in aggression and develop feelings of trust; and above all, you are cared for, supported and reassured. To the mother, the hospital symbolizes her family; the nurse her mother; and she, the dependent child. She expects understanding and love, whereby her dependent needs must be recognized and met before she is able to get better. Each mother will test your concern, either through hostility, depression, aggression or withdrawal. When she feels her nurse still cares, she is then able to move and "work through" many of her feelings and

needs. If such caring and acceptance are not evident to the mother, she leaves her "foster home" and "substitute mother" unable to completely re-enter her own family relationships until she, alone, resolves the feelings experienced by giving birth to a lifeless child.

What of the nurse? She evidently has the awareness that the grieving mother needs support and understanding; she is concerned; and she has indicated a sincere desire to care for and protect the mothers. The nurse seems frozen in her own professional image. She may remember past cautions and possibly even reprimands, that her feelings were "showing". She seems steeped in the traditional concepts that the nurse never allows herself to become "involved" in patient contacts or shows any feelings of grief or deep concern. She must remain in control of the situation; this in itself presents the picture of the cool, efficient, bustling nurse, void of all obvious feelings of concern or need. Trends in nursing education today are indicating the awareness that the nurse is first a person and second, a comfortable person giving nursing care to others. She has the spontaneous need to give, the educational endorsement that it is valuable and the nursing image that it is unprofessional. Until the needs of the nurse are met first, she

will be unable to meet the needs of her patients.

The conflict of wanting to give and being unable to participate in such satisfying relationships evidenced itself during the nursing interviews. Many nurses shared indications of self awareness and desires to really help the mothers. They recognized her needs during the grief period but were unable to take the initial step necessary to show the mother their concern. The mother, of necessity, had to be the obviously feeling person. It was she who looked for every conceivable sign or indication that her nurse cared. It was she who tried to share her loss only to be continually rebuffed. And it was again the mother who assumed the responsibility of interpreting the nurse's "doing" to signify "caring".

There was no data in this study that could in any way imply that nurses did not care or were unaware of the needs of a grieving mother. However, there were many indications that little thought or effort has been directed toward helping the grieving nurse. The methods employed by nurses in an effort to provide "good" care for the mothers are neither rewarding for the nurse nor satisfying for the mother. The four general themes discussed in the presentation of the data are integral, though opposing, components of the dis-

satisfying relationships existing between the nurses and their patients. The way in which each party in the relationship utilized these themes was self evident. In the area of rationalization, the nurses attempted to assume the entire responsibility of caring for these women. They used intellect and logic in a relationship demanding emotion. They attempted to deny the presence of death by stating they were unable to talk to the patient until the doctor told the mother what had happened to the baby. It is true that this is a recognized policy of many hospitals; however, there are many ways the nurse may comfort her patients without being the "giver of bad news". Again denial was employed by stating the husband's presence would be best for the mother during this initial shock. Is the father not grieving too? Religious interpretations were utilized extensively; yet, the mother stated she felt this was her clergyman's responsibility and she was reluctant to share such feelings with anyone else. Rationalizing that the baby's death was undoubtedly a relief when serious abnormalities existed was of no initial comfort to the mother. The loss of her child was tantamount, not the condition of the child. The findings seemed to vividly indicate that the mother had compartmentalized the functions of her "hospital family". She

expected facts from the physician, collaboration from the pathologist, spiritual guidance from the clergy and feelings from the nurse. The nurses attempted to meet the needs of the mothers but were uncomfortable in an area where relationships were important instead of the traditional functions of physical treatments, information giving and health supervision.

It would be difficult to deny that both the nurses and the mothers were suffering from guilt. But again, we see the feelings flowing in opposite directions. The mother was ready to express her feelings of self blame as she recognized the need to talk them through and be reassured of their falsity. The nurse also suffered from guilt though it was of a different nature. Her professional image governed her feelings. Her nursing goals were all directed toward denying death, preserving life and accepting the irrational cliches: did I do my best; did I do enough; did I overlook a sign; was it my fault? Her role concept was so much a part of her very being, she felt responsible for events occurring in her absence. The nurse, caring for postpartal patients was guilty although she never met the mother until after the delivery. She wondered, did we do our best? The grief the nurses had seemed evident in her

every action; yet, unable to express her own feelings she attempted to fulfill the mother's needs. The only feasible way seemed to be through replacement. Many nurses expressed the actual desire to give the mother another baby. Others were more subtle; suggested hobbies; suggested looking for the good things that the mother already had, such as children at home or the many reproductive years remaining. During her hospitalization the mother's needs were far more basic. She seemed to say, "tell me it wasn't my fault. Don't give me a substitute. Accept the fact the baby is dead and care about me".

The mother saw the nurse as one who should care. She wanted physical comforting, support and warmth from her nurse. She was looking for someone who would understand, accept and most importantly, share her experience with her. The nurse had cast herself in the role of "a doer or giver of things". She was anxious and frustrated when stripped of her tools: pills, pans, policies and palaver. She seemed unable to believe that such little, unimposing words as "warmth", "feelings", "needs" and "self" could possibly justify her existence in the profession. She had been "trained" to be so efficient, controlled and productive that the giving of self seemed to be a weak excuse for being. It appears

that only when we are able to accept ourselves as unique individuals, and recognize the existence of our own needs, will we be able to give of ourselves and form comfortable, mutually satisfying relationships with our patients.

The hypothesis that the methods employed by the nurse to support the mother of a stillborn infant were not felt by the mother to be satisfactory, has been supported through the data presented in this study. However, I was not convinced. One of the most meaningful experiences I have ever had was not presented in the findings, but does validate, at least for me, the significance and importance of using yourself when caring for others. Working with the mothers of stillborn infants had been one of my most traumatic nursing experiences and one area I had consciously avoided. I was unable to see my role in meeting the needs of a mother in grief. She wasn't really physically ill; there were no special pills I could give and I certainly couldn't give her another baby. I only felt that I was in the way. A back rub wasn't much to offer and just sitting with her to visit seemed a waste of valuable time for both of us. As I talked to these mothers during the study period, it seemed they placed a high value on the "duties" I had cast aside as"non-therapeutic". With each ensuing interview I became more comfortable and found I was actually enjoying just

sitting and listening. Was I relaxing because I was in the mother's home or because I was beginning to see the value in being a sharer and listener? Was this what the hospitalized mother wanted - someone who would listen and share with her her feelings and needs?

There would be no value to this study if even the writer couldn't believe the findings. Since interviewing the mothers in this study, I have given nursing care to fifteen hospitalized mothers of stillborn infants. The beginning use of self was not at all comfortable and on several occasions I would have been quite happy to revert to my former role of "doer". As I became more sensitive to the importance of the mothers' needs and could see them respond so completely to my halting attempts to share their experience, I found the relationships to be very meaningful. The mothers were quite aware of who visited them spontaneously and sincerely and who came to help because of a sense of duty. The uncomfortable nurse produces the anxious patient. The rewards inherent in the honest use of self have been innumerable and indisputably satisfying. Caring for the mother of a stillborn infant could hardly be called pleasurable, but the awareness that I was able to give of myself and was able to share a painful experience was satisfying.

RECOMMENDATIONS

1. Since this study is an exploratory one, the nature of the findings suggest that further study relating to this particular problem could be done. These studies might be:

   (a) to determine if the same needs are evident in the primigravid mother.

   (b) to determine the current nursing image and the conflicts this image imposes in family crisis situations in maternal and child health nursing.

   (c) to validate the findings of this investigation with comparable data obtained in similar settings.

2. A need exists for a comparative study, done ideally by the same nurse, to determine the attitudes and feelings of the hospitalized mother of a stillborn infant and her needs as expressed later within the home environment.

3. A study to determine the feelings and needs of the father of a stillborn infant seems indicated since he is expected to provide the necessary emotional support his wife requires during the

maternal and child health crisis.

4. A study to determine the needs of the grandmother and her attitudes toward the parents of a stillborn infant seems feasible as the data gives an indication that grandmothers might be unable to comfortably resolve their own feelings of loss.
5. Provisions should be made for an exploratory study to determine the role of the maternal and child health nursing specialist in the area of patient and family follow-up and counselling.
6. A study could be done to determine the role of the public health nurse in the follow-up care and counselling of the mother and family of a stillborn infant and how such a role could be interrelated with that of the hospital maternal and child health nursing specialist.
7. It seems feasible to determine if nurses who feel the mother should be allowed to express feelings of loss are consistent in their behavior and actually do create an environment for the free expression of feelings of grief and loss.

8. A study to determine why the student of nursing seems to give the mother in crisis the support she needs that the graduate nurse cannot, would be meaningful.

9. A study to determine the possible existence of a mother-daughter relationship and its significance to the patient seems indicated as the data in this study implies that the young student of nursing may meet the needs of the patient by means of a daughter role. The data also hints that the maternal graduate nurse may meet these needs by means of a mother relationship with the patient. Therefore:

   (a) Do these relationship patterns actually exist?

   (b) Are both relationships inherent in meeting the mothers' needs? Does she need to be both a mother and mothered in order to effectively "work through" her feeling of grief and loss?

10. A study to determine what is meant by the phrase "meeting the spiritual needs of the patient" should be explored in terms of its significance to both the mother and the nurse,

as threads in the data show that the mother does not accept or expect religious interpretations from the nurses, but leaves this aspect of their care to the spiritual specialist.

11. A study could be done to determine if the needs of the nurse, not the mother, are of first importance when she employs religious rationalizations in grief or crisis situations.

12. Provisions should be made within the basic maternity nursing curriculum for the student expression of feelings during the entire maternity experience and that the area of grief and loss be specifically included in these discussions.

13. Provisions should be made in the nursing curriculum, both basic and graduate, for a long term placement in family work so that the nurse may experience values inherent in a sustained relationship, develop feelings of self, and utilize and realize nursing skills inaccessible in the traditional clinical environment.

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APPENDIX A

Interview Guide A.: all questions are directly related to the attitudes and feelings of the NURSE toward the mother who had a stillborn infant or an infant who expired shortly after birth.

1. How do you feel about the mother who had a stillborn infant or lost her baby shortly after birth? (anomaly, premature, unexplained).

2. How do you feel about being assigned to her care?

3. Is it difficult for you to approach her?

4. How do you feel if the mother wants to, and does, talk about her delivery?

5. How do you feel if the mother ignores the whole subject?

6. Do you tend to avoid patient contacts, if not directly assigned to their care?

7. Is there any particular "type" of patient you can talk to best?

8. Is there any particular "type" of patient you wish to avoid, or have difficulty in approaching?

   In both questions the information is to include:

   a. Does the mother's age have any influence?
   b. Are feelings different if this is a first pregnancy?

c. Are feelings different if the mother has other living children?

9. Has anyone ever talked to you about your own feelings toward these mothers; or tried to help you find it easier or more comfortable to approach and talk to these women?

10. If anyone did help you, who was it: doctor, supervisor, head nurse, instructor? Did this occur during your student preparation or your graduate experience?

11. Were you ever upset, uncomfortable, or disturbed enough to seek help in working with these mothers? Whom did you ask for help, and did you receive it?

APPENDIX B

Interview Guide B., all questions are directly related to the attitudes and feelings of the MOTHER toward the nurse or nurses who cared for her during the hospitalization when she experienced the loss of her baby.

1. How did you feel about the nurses during this particular hospitalization?

2. Was there any particular nurse you liked best? Why?

   a. Did she give you physical care, such as a back rub, to show she was interested and wanted to help you?

   b. Did she talk to you about the baby before you mentioned it?

   c. Did she wait until you indicated you wanted to talk?

   d. Did you want to talk to the nurse about the baby?

   e. What sort of a person was she: quiet, warm, sympathetic, or cool, reserved, brusk, busy "doing things"?

   f. Did she ignore the whole area of your feelings about the baby?

   g. Did she offer any kind of encouragement? What did she say to you, or do for you?

   h. When you cried, what did she do? Did she touch you, hold your hand, tell you to stop, or just stand beside you?

3. Was there any particular nurse you liked least?

   a. What was she like?

   b. What did she do or say that annoyed or upset you?

   c. What didn't she do that dissatisfied you?

   d. What sort of information or help did she give you?

4. Can you remember if the age of the nurse had anything to do with how you felt toward her?

   a. Was it easier or more comforting to talk to someone your own age, younger or older? Why?

   b. Did you prefer to have a graduate or student nurse care for you? Why?

5. Was this pregnancy your first?

APPENDIX C

Seven Nurse Interviews Out of a Total of Twenty-five.

1. DELIVERY FLOOR HEAD NURSE, 10 YEARS' EXPERIENCE.

We attempt to send the mother to her room as soon as possible to be with her husband. Of course we cannot talk to her about the baby until after her doctor tells her; and you know what a problem that is. He usually is not here when she wakes up, and we have to be vague and stall around. Makes us look pretty stupid sometimes. Once the husband and the mother know, we put him in a cap and gown and let him come in and see her. As a rule, I do not mind talking to these women; it is not the most pleasant, but they need someone with them. A mother with no living children and several miscarriages is very difficult to comfort; and it wouldn't seem fair to give her false hope or tell her to try again. Or, if the mother is elderly, 36 or 38 or more, her chances of having a baby seem less each day. About all you can do there is to let her know you're sorry, not pity her as that never helps, and that you are interested and want to help. Now and then you get one who got pregnant by accident or unplanned and unwanted---possibly even in the process of divorce---these gals don't seem to be as noticeably upset. Some almost seem relaxed. A few are very quiet and remote, probably quite guilty as may be they wished for this during early pregnancy. The unwed girls are another thing again. Quite a few have said they feel sorry, but now they don't have the problem of what to do with the baby. After the initial shock, I wonder how all these mothers are when they get down to their rooms. We see very little of them as we get them ready for transfer as soon as they wake up. I feel very badly for the mother who lost a baby---want to bawl right with them. For example: just the other month we had an elderly mother admitted in violent, active labor. The foetal heart was strong on admission, but something happened during the time we got her on the table and the delivery---the baby was stillborn---her second. The same thing happened the year before, so for this baby she

changed her doctor and hospital, for luck I suppose. Well it's hard to say if she'll have another and reassurance was the last thing to offer her. I tried to let her know I understood her feelings and wanted to help her in any way I could. Some patients really shop for doctors when they have this or a sterility problem; they are the hard ones to face as there is little to offer them but your willingness to comfort and understand. The younger girls tend to be more emotional or hysterical when they first hear of the baby. They are so disappointed and show it more violently than the older ones. They are not ready to, nor do they want to hear of the "whys". They just want to be near someone and bawl. The older woman perhaps feels things deeper, tends to internalize more, sees things as futile and hopeless. In a day or so, the younger one usually is eager to go home, rest and try again. It's probably easier for us on delivery as we have them for such a short time after the delivery they are still sort of in shock, and we stay with them and let them cry it out. Be kind, but words of encouragement are wasted---they are in too great a period of grief and tend to disbelieve you at this time.

2. NURSERY SUPERVISOR: 15 YEARS' EXPERIENCE:

I do not believe in being overly sympathetic to the point you keep the mother feeling sorry for herself or constantly thinking how tragic her lot is. I very strongly feel that our biggest responsibility to these women is to erase all feelings of guilt. We must be very careful that whatever we say can in no way be interpreted to insinuate that any of their difficulty was because of something the mother did or did not do during any part of her pregnancy. I think it is natural for them to think it was their fault, and they either look for encouragement from us that it wasn't or a look, word or phrase that it was. To me, removal of the guilt complex is most important. Also, it is my own personal opinion or feeling that there is a reason for

having a stillborn other than the purely physical aspects. If the baby dies in utero or soon after, he probably is a child who, if he lived, would have spent his life in hospitals or be mentally retarded, and the Lord takes away life for a good reason--though it is hard for us to understand at the time. I think this happens because it is His way of protecting us from future unhappiness. I don't feel that we should isolate or ignore these women. I think we should be honest and tell her you know she lost her baby and would like to help her in any way you can. Ask her if she would like to talk to you about the baby. Of course it is easier for you if you can offer her something concrete, either by telling her she has many productive years ahead (if she has) or emphasize how fortunate she is to have a child or children at home, or that it was the Lord's way of helping her avoid future unhappiness as He took the baby's life because the child would probably spend his life as an invalid or mentally retarded; and though we do not understand why these things happen, He had a reason and it was for the child's protection and the family. I think the whole issue should be faced honestly and sincerely; also the age of the nurse is important too. An older patient would probably relate better to someone near her own age..... she'd feel they had something in common, if it's only life's general experiences and it might be easier for her to face her situation; whereas she might resent the young nurse and feel that she couldn't really understand or care because she only knows about it from a book, and it could be hard to talk to someone so much younger. By the same token, the young patient might look upon the older nurse either as a mother figure or someone too old to understand; especially if the nurse were single. The mother might feel she isn't even married, what could she possibly know about how I feel. The young patient can sometimes relate easier to the young nurse as she feels they have something in common. Of course, I think the young graduate of today is more alert to feelings and attitudes and the reasons why people behave as they do and we need to help them really see the patient and see what is going on around

them. Those of us with experience can help the young graduate fully develop her potential and get additional practice, if you want to call it that, in helping the mother and in developing skills in the nurse. To me, the most important things are - help remove all feelings of guilt from the mother, be honest and sincere, look at the facts and face them, though we don't always accept it or understand why, the Lord has a reason for this and it is for our protection and the baby's.

3. POSTPARTUM HEAD NURSE: 15 YEARS' EXPERIENCE:

Of course it's hard to face any of these mothers but I do visit them frequently and offer the old shoulder. I've found that almost all of these women want to talk about the baby and birth in some way or another. Usually the first couple of days they are in the weepy stage and I just stay with them and let them cry it out. Quite often we can't be very intelligent in helping these mothers understand why this tragedy happened because we don't always know what caused the stillbirth. If it is possible we try to explain what happened, and I usually in some way let them feel they can try again. If the mother knows she is having a stillborn, then it is not such a shock to her after the delivery--- though it is more real now. She usually responds to sympathy and comfort. By sympathy I mean the patient feels you have a sincere interest in them and what has happened to them; that you're warm toward them and you in some way convey the idea to them that you really are sorry and will do all you can to help them in this initial adjustment. I think it is easier to talk to the mother if you know something specific about their problem such as, cause of death from anomaly, other children at home, or the mother still young, it in some way gives hope to you and you in turn somehow let the mother know all is not lost. The hardest ones to visit are the sterility problems; quite elderly primips or the ones who were emotionally disturbed before pregnancy and are now quite hysterical and guilty or profoundly depressed and see no future with a child in the family. We try to separate these

mothers from those who have a baby, if they desire it; but I personally would rather see them remain in the room with the mother who has a child. This is something they'll have to face shortly--seeing women--their friends with babies and it's better if they start now while we are here to help them rather than doing it alone or running away. I also urge them to visit the nursery and watch the nursery nurses and babies for short periods. How you feel about caring for these people depends alot upon your experience and how you feel about people in general. If you are at ease with people, it's not so hard to approach the ones with painful problems like these.

4. INSTRUCTOR: BASIC COLLEGIATE: 2 YEARS' EXPERIENCE:

I feel that the students should be able to talk about this in class, but I don't know what you'd say to them. I feel so helpless and useless with these mothers that I am too uncomfortable to be of any help to the student. How do you know what is right to say to a mother? I avoid such discussions in class; I don't encourage the students to ask about it because I feel so inadequate. As for my own experiences: I was very uncomfortable and ill at ease. If the mothers accepted it calmly and rationally, I could answer their questions; but if she just cried all the time, I left the room by telling her she will probably feel better after she cries it out and I will be back later--or else I just stood there looking real stupid, not knowing what to say or do. With some mothers, the young ones, you could just help them accept the fact and reassure them that they have lots of time for more. Or, if she has other children living, you can tell her to think of the healthy ones at home. When they have none and have lost several, I feel so hopeless and seem to have nothing to say. I honestly do not like to work with them. Also, I feel too inadequate myself to urge any mother to talk about the tragedy. If the baby died

from an anomaly, it's a little easier to approach the mother because you can always encourage her to see that it happened for the best, and the next one will quite likely be just fine. Sorry I can't help you but the whole thing seems so futile and tragic. I never know what to say and standing around seems useless too. It's very upsetting to me to work with these women. Some blame themselves, some the doctor, and some the nurses and the hospital. It seems as if they have to blame someone and for no cause either. It's hard to work with the emotional ones---crying and carrying on all the time, or those who just dissolve into tears the minute they see someone. The ones who have accepted it as fate or God's will are a little easier to work with. They are calm, mature and ask intelligent questions. They don't make unnecessary demands on you either; always wanting something, like water, pills, the bed up or down--that sort of thing. They don't harp on their tragedy, but accept it calmly.

5. HEAD NURSE: DIABETIC SERVICE: 7 YEARS' EXPERIENCE:

The diabetic mother seems more prepared for not having a live child. Even if the child is born alive, the mother is warned not to expect a good infant until at least 72 hours after birth because of the high incidence of hyaline membrane disease. I don't try to avoid the subject but will tell the mother I know what happened and how she must feel; also, I find that the mother will usually begin to talk about the baby. I don't feel inadequate if I just stay with the mother and talk as this is quite often the most effective help. Although it is perhaps easier for some people to avoid discussion, I do not feel comfortable doing this as I do not think we are helping the mother adjust or receive the comfort she needs. It's like cheating her; no baby and no help. I also feel it is wrong in a way to isolate these mothers; they should not have to hide from the fact that someone did have a healthy baby and it's better for them to see this while they are still in the hospital and can receive help or comfort

from the staff than to experience it alone when they first see or visit their friends and see their babies. Of course it is a little easier to talk to the mother with children as you can gear the help given to how fortunate it is they do have a family at home; or, if the baby was very abnormal, you can talk along the lines that perhaps it was best for her and the baby that he did not survive. When the mother is elderly, childless or a sterility problem, about all you can say is that for some reason unknown to us you were just not meant to have a child. You can almost always use the religious approach that the Lord felt that this was best for the child and the mother. Or, the child died for a reason and we will just have to accept the fact God knew best; perhaps had the baby lived he would have been a sickly child and the Lord, knowing this, tried to spare you both this additional grief. I usually let the mother know I am sorry and want to help in any way I can; then I carry on according to her actions. She will either cry or talk it out or say she does not want to discuss it. If she avoids it I let her get to know me better first, then they usually want to talk later. The students find this a very difficult floor to work on---they are so afraid.

6. STAFF NURSE: 3 YEARS' EXPERIENCE:

It is easier to approach them after the doctor has told the mother. Then the patient needs someone to be with them. I don't relish the idea but I don't really mind being with them. I usually tell them I know what has happened and is there anything I can do for them or anything I can get them. Sometimes it is a little easier if the patient expresses a religious attitude. As you can express your own feelings by saying: it's God's will, or if the baby died from a gross anomaly you can say this is the way God spares you and the baby from later disappointment --- especially if the baby had possible cerebral damage too. I do not like to be the first one to

tell them; I think the doctor should. She knows him better and will probably hear him through. Once they do know I like to go right in to them. They should not be all alone unless they ask you to leave....but at least they know you are interested enough to offer to be with them. If the doctor tells you what they are like as a person, how they felt about the pregnancy, some of their past history (multips or such) or if they have children at home or are young, it's a little easier because you can offer encouragement and reassurance and a little hope. The older women keep things more internalized and they are harder to reach but once you have it is rewarding to both. If you are with the mother during labour and she is awake, you have time to establish a relationship whereby she trusts you and you know a little about her; then after the delivery it's easier to talk to her and you are someone she knows, which means a lot to them. I think this whole area is something that students need help in. I had to work it out myself and it was rough. I felt so useless and stupid, but I guess it's mostly just having the ability to talk to people. If you are comfortable with people and interested in them for what they are, it's not too hard to work with the mothers who have problems. You must try to be calm and reassuring and at ease, but warm too or else you make the mother uneasy about your feelings and you are more upsetting then helpful. I try to get help in this area in this way; usually there is someone wherever you work who is warm and interested in people and I ask them how to approach these women. I don't feel I need so much help now, but like to swap notes now and then. I don't like this part of my job and feel very badly for these mothers, but I'm not uncomfortable working with them; they can talk it out, ask questions or just cry, and I feel I can handle it.

7. PUBLIC HEALTH NURSES: SYMPOSIUM - HARTFORD, CONNECTICUT: MAY 13, 1958:

1. NURSE AS A PATIENT:

My fourth pregnancy was a stillborn; I have the R.H. factor. I was placed in a private room on the postpartum floor. I didn't care as I was too tired. The nurses were very kind while they were "doing things" but left the room as soon as possible. When I visited the other mothers, they would tense up. The mother with the stillborn had to take the initiative. She would have to lead any discussion or conversation there might be. I had other children at home and this seemed to make it easier for the patients and the nurses to talk to me. Actually I wasn't interested in that.

2. NURSE IN THE DISTRICT:

Find out as much as possible about the mother and family before entering the home; help the children accept this too. Quite often the shock is not realized until the mother goes home. Crying is the patient's self treatment and she should be made to feel that this is good. After a good cry it is easier to go on and talk about it. You could approach her by saying; I know you lost your baby, would you like to talk about it? Even if the mother does not want to talk about it now, you would be the nurse she would eventually approach. Also there is no reason why you have to feel you must talk. Nurses who keep talking about totally unrelated topics just to keep a conversation, never give the mother an opportunity to talk or cry--even if she wanted to.

3. NURSE IN THE DISTRICT:

I think your project is very interesting and an area that needs much investigation;

however I don't think I can add much to what the other people have said. I remember when I lost my baby and that was 25 years ago, a very close friend specialed me; I felt I had all the understanding and support I needed. I do feel the mother is not interested in the past (children at home) or in the future (future pregnancies) but only in what has happened to her now. Let the mother take the lead in the conversation---be available to her, interested in her, and understanding of her problem-----all this can be handled without direct conversation concerning the stillborn.

APPENDIX D

Four Sample Interviews Evolving From Seeking Permission to Visit Mothers of Stillborn Infants.

1. DOCTOR: OBSTETRICIAN: PRIVATE PRACTICE:

I feel just terrible but believe in being completely honest with the mother, both in my feelings and in my knowledge. It is not unusual even if I weep with the mother, and spend more time with her than the other mothers. If they want to talk and ask questions, I try to give them all I can and know. If the baby had an anomaly, I explain fully what it was and what happened and encourage the mother to get pregnant again as soon as possible. I am also very honest in telling the mother I do not know what happened or why---- this sometimes happens even after a gross and microscopic post mortem. When I encourage mothers to become pregnant I am very honest in telling them they will have a rough time and I ask them to call me any time they want help or just to talk, day or night. Quite often I get a few frequent calls early in pregnancy, I think usually just to test if I really mean it; after that the calls are much less. They do have a rough time too until the pregnancy is over; they are extremely hypersensitive, fearful and anxious; needing much reassurance and someone to talk to. Many mothers change hospitals and doctors after they have had a stillborn, just to make a clean start, not that they really believe that this is always valid; and the doctor is not without guilt either, you always wonder if you could have prevented some of them. About this project of yours, I think it should be on a larger scale to be statistically valid. I think you should have some limitations on it such as: the mother must not be under now or have had any psychotherapy. She should have living children at home now, born either before or after the stillborn delivery. I would want to contact them myself and explain who you were and what you wanted to do. I think you should ask yourself this question: do

you have any psychiatric backing or encouragement that the interview will not unearth unresolved feelings of the mother regarding the delivery of the stillborn.....the degree of upset directly related to the meaning the pregnancy had or still has to the mother?

At this meeting no positive plans were made; I had neither permission or refusal in a direct sense. "I guess I want reassurance that this project won't hurt or upset these mothers. I am probably too sensitive about the subject, but I wish you would re-evaluate your purpose and be very sure of what you are doing. I would like to hear of your results and what happens to you in this. Now, are you taking me to dinner or am I stuck with you?" He took me and it was the nicest refusal I ever had.

2. DOCTOR: OBSTETRICIAN: PRIVATE:

I think your project is extremely worth while and you are more than welcome to my patients and my records. Unfortunately for you I only have two mothers who meet your requirements. If you will wait a week, I will be seeing one and will tell her you are going to call. I am sure the other girl will talk to you. Just call her up and explain you are doing interviews to see how nurses can help the mothers during their hospitalization. If you let her know it is the nursing care you are interested in and not her "psyche" or what the loss of the baby meant to her, I am sure they would like to talk to you very much. Any way you can study patients' feelings to help nurses is worth while and worth every effort. I am sorry for you I have only two patients and they live quite a distance from Boston, but I do think they will want to help. You know I guess I am old fashioned in some ways, but although I don't agree with the old formalities, I think both professions have come too far in our relaxed ways. There was something in the nurse doing for the patient and using her hands that we've lost. Patients are not so concerned with our

skill and knowledge; they take that for granted, but they are noticing or watchful for our greeting, our interest in them, our warmth and our understanding. They are very willing to get out of bed early and care for themselves, if we would teach them why, and not let them feel it is one less for us to do. I want to wish you all the luck I can for your success. If you will see my secretary, she has the names and addresses for you. I told her to have them ready just in case I was held up at the hospital and couldn't see you. Would you let me know how this all comes out and how the mothers feel about all this?

3. DOCTOR:OBSTETRICIAN: PRIVATE:

I have been through my records for the past two years and have only found three women whom I think you could interview. This last month has been terribly busy so I have only had time to go through my records for the past two years. One of the women is a nurse; is that all right with you? They all seem to be rather stable girls and all have other children at home. One girl had a section for a praevia and lost the baby within a few hours from respiratory distress; another girl lost her baby about three minutes before I had her delivered. Autopsy never revealed the cause. Your project seems quite valuable, and I would like to hear how you come out----whenever you have the time. You know, I have never given this area much thought before you called. It is a very unfortunate part of my job and I hate telling the mother, though I think it should be done as soon as possible; however, I I have honestly never given much thought to how the nurses must feel, or what kind of care the mothers expect from them. If you can give me a day or two, I will call these girls, explain what you are doing and tell them to expect a call from you very soon, all right? Good luck to you. If there is any other way that I can help you let me know. If any of the mothers refuse to see you, I will be glad to talk to them for you.

4. DIRECTOR: NURSING SERVICE & NURSING EDUCATION:

As for your request to visit clinic mothers, that permission will have to come from _____, as he is in charge of the clinic. I think you know me well enough to realize that I am not the best one to ask about personal feelings. I think your project is a very important and necessary one, but I would not like to be the one doing it. To me, having a stillborn is just another one of life's processes and adjustments we have to face, and the adjustment must be made alone by the one involved. I do not really know how these women will receive you or what feelings you will expose, but I am sure that is a chance you'd have to take. I think nursing has lost its best gift, the use of our hands. All the words in the world will never take the place of the back rub and the bath: the hands can lend more warmth and understanding than anything else I know. I personally do not like a lot of talk, questions or gushiness---just the feeling, by actions, that warmth, understanding and a wanting to help---are there. I believe you would have to be very careful in approaching these women. I wonder how vividly they will remember their hospital experience as far as the nursing care is concerned; they are in such a state of shock and are in the hospital such a short time. If I were such a patient and someone came in asking if they could do anything to help, I would probably hit them; but if the nurse came in and gave me a simple back rub or fixed my bed, I'd probably think she was very warm and understanding and interested in me as a person; perhaps later I would want to talk, I don't know. It would probably be best to interview some of the mothers who are home now and at that time ask them if they can remember anything about the nurses during their hospitalization, and how they felt about them. After you have some data, depending upon what it is, then I would make an appointment to see _____ and ask how he feels about your seeing the clinic mothers here in the hospital. I am very interested in your project and you are always welcome

to return and interview any of the other nurses that you may have missed. By the way, you are a very curious person and probably would be less traumatic than many to these mothers; my very best wishes to you on your work.

APPENDIX E

Five Sample Interviews of Mothers
Who Have Had a Stillborn Infant or
One Who Died Soon After Birth.

1. Roxbury, Massachusetts:

Gravida 3 para 1: has one living child, age two years; second pregnancy terminated four weeks early and the infant died one hour after delivery of a congenital heart condition. She is now 38 weeks pregnant. (April, 1958).

I am looking forward to returning to the hospital as everyone was so nice and kind to me. The only thing I can remember vividly was the lonesomeness. I was in a room all by myself, and had nothing to look forward to but visiting hours. My family was so upset and didn't know what to do or what to say. They talked about everything but the baby. My husband and Dr._____ helped the most. The doctor was very good in explaining about the baby's heart and why an operation would not have helped. Even though they both helped me realize it wasn't my fault, you just can't help but think over all the things you did during the pregnancy. Every so often I read about a new heart operation and wonder; but my doctor is always so kind and patient in explaining that it wouldn't have helped our baby. My husband was very upset too, especially as the baby was a boy, and he wanted one so much. He hasn't said too much this time, but he did ask me if I wanted the same doctor and hospital again. Of course I do - they both know me. He just wanted to be sure I wasn't doing this because my sister-in-law has the same doctor and recommended

him to me. My husband always wants to know if I am all right; and he wants to know everything the doctor says to me when I go for my visits. I guess he is more worried than he wants to let me think he is. His final exams are this week, so I bet I'll go into labour for sure. I didn't want to get pregnant again after the last baby, but I am glad I didn't wait. I know I am more aware of things this time; any little thing that I feel is different worries me that something may be going wrong; and I worry if the baby seems quiet. The doctor told me that I would feel this way, and he has been so understanding and patient. Well, it will be over soon. I guess it was the loneliness that got me the last time. One of the nurses told me that I wasn't to leave my room. I wanted to use the telephone; visiting hours seemed so far away and I wanted to talk to someone, about anything. You can sleep and read just so long. I guess the nurse thought she was protecting me from seeing the babies and having the other mothers ask me about my baby. I had the baby at home so I didn't think I would have minded seeing the babies or the other mothers. I never asked anyone else if I could leave my room; I thought it was a rule and I didn't want to be a pest. The student nurse really was nice though. She brought me juices, coffee, things to read and didn't seem to be in a rush. She told me about her husband, their plans, and that she was graduating soon; and we talked about the baby too. The midwife frightened me though, her face looked angry and she kept saying I shouldn't do this and I shouldn't do that. I don't know what I did wrong; I just got out of bed to try the chair. The student explained her to me and I didn't feel too badly. I guess she was trying to help, but I had trouble trying to understand her. I can't remember if I really wanted to talk about the baby or just wanted to talk---I was so lonely. Crying helped and I sure did a lot of that, but alone; guess I wanted to share that too. The Priest was very helpful too. He visited me and we talked about the baby and God; and he said I was still young and not to wait too long or I would be too afraid to try. Also, we talked about my little girl at home. Though I felt badly leaving the

hospital without a baby, Debbie was waiting in the car for me and that sure helped a lot. I don't know if I wanted another mother in the room with me or if I just wanted to visit and be talked to; anyway I was lonely. The rooms they use for mothers without babies seem so far away from everyone. Well, I guess I wasn't much help to you, you never got a chance to say anything. Don't you have any questions you want to ask? I want to thank you for talking to me. Guess I am a little worried about this baby and I'm glad I could talk to you.

2. Brookline, Massachusetts.

Gravida 3 para 2: has two living children ages four and five. The first child was born eight years ago with a spina bifida and died in a nursing home at one month of age. This mother was not excluded from the study as she never saw the child and knew his life span was very limited, as the infant had many other anomalies also.

Gee, I hope I can be of some help. I'm someone who goes to pieces when anything upsetting happens, and I like to do it alone. When I don't feel well I like to be alone; when I get better I like to get up and visit others. I certainly thought the nurses were wonderful. I am not sure if this is a fair evaluation for you though because when I had this happen to me, the department had just opened the day before and I was the fourth patient, so I guess there were more nurses than patients. They were very kind to me. I asked to have my room changed because I could hear the patients on the delivery floor, or at least I thought I could, but I never heard them when I was

in for my other two. They put me down at the opposite end of the hall, but I never felt neglected or really alone. The nurses would visit me often; they waited for me to talk about the baby and I liked that because I just couldn't face it the first few days; yet I knew that when I wanted to talk they would be there. They were always coming to my room to see if I was all right. The nurses seemed to make up reasons such as coming with some fruit juice or fixing my bed or giving me a back rub---just to see if I wanted some company and wasn't too lonesome, I guess; so I felt they were interested and had the time to spend with me. One thing did happen that upset me but I guess it was my own fault. When the special nurse came to get the baby to take him to the nursing home, the nursery nurse came to my room to get the baby clothes. I felt terrible as everyone had to wait until my husband went home for some clothes. I suppose that because I didn't have a baby to bring home, I just never thought about clothes for him. It was my own fault for being so stupid but if someone had just mentioned it to me, or if they thought I was too upset, they could have told my husband. I really thought that everyone was very nice; the nurses were kind and interested; they let me know they were sorry and wanted to help and had the time. I took the whole thing very hard and was a wreck during my next pregnancies. If the least little thing seemed different or out of the way, I'd call the doctor. He was so kind and so patient in accepting my behavior and explaining everything to me. You know, I never thought about nurses having feelings. I have always just accepted the fact that they knew what to do and how to act, no matter what the situation. I just thought they knew what was the best way to be with a patient and went ahead. I hope I have been of some help to you; I don't think you ever got a chance to say much. Is there anything else I can help you with? It has been so nice to talk to someone. Wouldn't you like some root beer before you leave, it is so hot out. I don't know why you bothered to come out today. Oh, by the way, I have a confession to make. After you called the other day, I called my doctor to check

up on you. I was so interested I just gave you my address and then I started thinking of all the questions my husband would have that I thought I had better have a few answers. I hope you aren't angry. If I can help any more don't forget to call me, I'm home all the time.

3. Belmont, Massachusetts.

Gravida 5 para 5: has three living children ages five, seven and nine. Twins were delivered in the first pregnancy and both expired within ten hours after birth. The fourth pregnancy resulted in the birth of a stillborn infant. During the fifth and last pregnancy she developed a pulmonary embolus at four weeks gestation and was hospitalized for five weeks prior to surgery for a venal caval ligation.

I hope I will be able to help you and I want to thank you for asking me to participate in your study. I'm not too clear about certain feelings during my first hospitalization as so much has happened since, and now I don't know if that's the way I really felt or if it's the way I have come to feel. But I do remember that I didn't feel as badly about losing the twins as I did about my other baby. People think this is very strange but I don't. The first time I did not realize what I had lost as I never had a baby to love. But after having _____ and _____ and realizing the love and happiness I had with them, losing the other child seemed to be the worst thing that ever happened to me. I kept thinking of my other two and what if I never had them, and the fact that this other baby would have

been just like them. I think you feel a loss more when you have had happiness and know what it is. During the first pregnancy one nurse was very warm and understanding. You knew that if you had wanted her she would have come. She looked as if she had the time to spend with me and I wanted that. The other nurses were kind but they worked fast and you had the idea that they were busy. They did whatever you asked them but efficiently and quickly, and left. I didn't want to talk about the baby but I did want to talk to someone about anything. Had I wanted to talk to someone about the baby, I would have asked for the other nurse who seemed interested. When I first met her she said she knew what had happened, that she was sorry and wanted to help me. She asked if there was anything that she could do to help. I can't really explain feelings but the expression on her face, the warmth in her eyes, and the fact she didn't rush out of the room, made me feel she was sincere and really felt badly and honestly wanted to help. That was all I wanted to know; someone was interested in me. As I said before, the other nurses were kind but I just had the feeling they didn't want to be with me too much. I didn't have to call the nice nurse for anything; she would just drop by and ask if I needed anything and how did I feel. I bawled the whole time I was in the hospital and she made me feel that this was good. It was too. I have to cry things out, then I feel better and I can really begin to face up to things. Guess I sort of look to the hospital as a place for crying; I get it all out of my system while I am still dazed. Then when I go home I can look at things more rationally. It is too early, in the hospital, to think through anything. This is something that you have to settle for yourself and you just can't do it when you are still so upset you cry every time you think about it. The second baby I lost was the worst. I really knew what I had lost and I sure cried. I got real exhausted, had a good sleep and when I got home I could really think things through; and I decided that if I didn't get pregnant soon, I never would, as I would be too

afraid and worried. The worst thing in the hospital is the loneliness. I never have much medication when I am in labour, so you are left alone. The doctor couldn't find the baby's heart beat and I knew something was wrong. He explained things to me as best he could, but I would have given anything to have my husband with me. Just to be near me or hold my hand. I was so lonely and had time to let my worst fears run away with me. It was such a shock as the baby had been good until I went into labour. I found out later the cord had a true knot in it and the placenta had stopped growing in the sixth month so the baby was only four pounds at full term. Not being medicated I was left alone and was so lonesome. Although I wanted my husband so badly, I think anyone would have done. It would have been of some help though it's not like having your husband. Perhaps I am different but I got so mad and so upset whenever anyone told me I was lucky as I had two children at home and was young and could have more. You know, babies aren't something you produce without feelings; they are a real part of you even if you have never seen them. I didn't care if I had a house full of children or could have twenty more, this baby was important to me, not the ones I had or could have, but this one. I don't think anyone even understood, they thought I was childish. One day I was having a good cry for myself when a nurse came in, a young student, and became very angry with me. She told me to stop crying and carrying on like a child; I should consider myself very lucky to have two healthy children at home and plenty of chances to have more. You know, I think I could have killed her. I didn't care what I had or could have; all I could think of was that I didn't have this one. I was too upset to realize how young and frightened she must have been herself, and she probably thought she was helping. I am not picking on students as the graduates did it too, it's just that I remember this girl best because she was so angry. I think the kindest thing that could have happened to me would be for the nurse to come in and let me know that she knew what had happened to me; that she

was very sorry and understood how I felt and that I was no baby for crying. If she had just said that she wanted to help and would I call her if I needed anything and wanted a little company for a while. I wanted to be alone but not forgotten; only seeing a nurse when I needed something done to me. I am glad they don't move you out of the obstetrical department because when I am able to get around I like to visit the other mothers and see the babies. The nurses want you to stay in your room when the babies are out for feeding. That's cruel but I think they were really trying to protect me. I would have stayed in my room if I didn't want to see a baby, but I liked visiting. After all I did have two children and could help the young mothers; I had something to share and I wanted to. I think the only people who were really upset were the nurses. The other patients were very accepting and asked a lot of questions about feeding and baby care. I didn't feel left out. I guess what I want to say is this; the baby you have lost is important--now, the past and in the future. I wanted to be in a room alone where I could cry it out of my system, and I wanted the nurses to understand that this was good for me. I didn't want to be lonesome, just alone. I liked to visit the mothers and see the babies when I could get around; but most of all I wanted someone to understand--not talk about it--but wanting to help if I asked for it. How about some more coffee, you're as bad as I am--couldn't live without it. The children will be home from school and I'd like to have you meet them and stay for lunch. Nothing special, just sandwiches. That's all they ever want as we have our big meal at night. Well, if you can't stay for lunch then come on up stairs to see their rooms. We plan to rearrange and redecorate them--see what you think of the idea. I have taken up your whole morning; I hope I haven't delayed you too much. If I can help any more come around any time; you don't have to call as I am home all the time. Thank you for including me in your study.

4. Dorchester, Massachusetts:

Gravida 3 para 2: has two living children ages two and seven years. The third pregnancy terminated in the delivery of a premature infant who expired shortly after birth from incomplete lung expansion. The mother is a graduate nurse who has worked extensively in maternity nursing, particularly in the newborn nursery. On the first meeting she stated she had nothing to say. As she had no phone, this interview was unexpected and unplanned. The interviewer was too hot and tired to leave and delayed departure to the point that the mother asked her in for a cup of coffee.

I really haven't anything to say, probably because I am a nurse. Of course I was upset because I have seen some small preemies live, but I knew it was a chance and you have to expect these things to happen in life. We are still waiting for the autopsy report to see if it was anything besides prematurity and poor lung expansion. No, I didn't see any reason for wanting to be moved to a private room. These things happen and it's something you have to face. Yes, the patient in with me had a baby and I don't think she minded that I didn't have one as she knew I had two boys at home. I know one thing that bothered me and I don't remember which nurse said it but she said that it was too bad it happened but after all it was a boy and I did have two at home. Who cares what the sex was. It was a baby. I thought that was a terrible thing to say. The nurses were nice; I didn't particularly feel like discussing the baby with them and

they didn't bring the subject up. They saw to it that I had what I needed and I think that was enough. I felt badly about the baby especially since we had to wait so long for children, but I thought everyone was nice in the hospital. There were plenty of people around: I visited some, and I did know some of the grads and I think everyone knew how I felt. It was about 9.00 P.M. the night the doctor told me the baby had died and I did ask the nurse if she could get me an extra dose of medication as I didn't want to stay awake all night. She got the order right away and was very nice about it. I guess it was after I got home that things bothered me more. My aunt, who is about five years older than me, had a baby about two weeks after mine; hearing about this upset me very much. This baby was almost four months old before I felt up to seeing her and the baby. Three of my friends had babies about the same time, and I didn't mind seeing them. I think what happened was this. As soon as we heard about my aunt's baby, my husband bundled up all the clothes and equipment we had ready for our baby and we sent them to her. I guess I just couldn't stand to see her baby in the clothes that were meant for the baby we had lost. I had to wait until her baby was out of the real infant stage before I could face seeing him. The other things that bothered me were getting the hospital and funeral bills; no baby, just bills. After I was home about three weeks a nurse came from the health department to check on the baby. She didn't know he had died and was very upset that she hadn't been told. Does the hospital notify the health department, or are they supposed to check with anyone before visiting the mother? About two months after I got home, the State sent me a copy of the birth certificate; everything was filled out but the baby's name. The slip was in red so they knew that he was dead. I could have done this in the hospital and I would not have been so upset. The thing that really saved me was the fact that I got home two weeks before Christmas and with the rush of getting everything ready for the boys no one had time to be sad. I have no complaints about the hospital; the care

was good. These things happen and you have to face it yourself.

5. Randolph, Massachusetts:

Gravida 5 para 2: has two living children ages five years and seventeen months. The second and third pregnancies terminated in five month abortions. The fifth and last pregnancy ended in the delivery of a stillborn infant at eight months gestation. In the fourth pregnancy the mother remained in bed for seven months prior to delivery due to bleeding and a history of premature labour.

When I realized I was pregnant for the fifth time I was very upset and went to see the doctor and asked him if he could perform a legal abortion, as I just knew that I could never have this one either and couldn't face another seven months in bed. Both the time and the mental upset didn't seem worth it. He told me it couldn't be done legally as the pregnancy was no threat to my life and he also refused to tie my tubes after delivery. I don't know why but I am glad that he didn't tie my tubes; it would have been so final. Though I have no intentions of getting pregnant again, I have always wanted three children. Well anyway, during the last pregnancy I got the virus, possibly the flu, and after three weeks in bed I was left with an awful cough. I went in to Boston to see the doctor but he was out of town so I saw his associate about the cough. I told him I didn't expect to keep the pregnancy and he was very upset with me

for saying so; but I thought if I kept discouraging myself I wouldn't feel so badly if I did lose it. Anyway, he didn't really fully understand my case. Once I felt life I was glad I hadn't been aborted and thought perhaps I'd make it this time. About the middle of my eighth month I started leaking fluid and staining. Vaginal examination showed the cervix to be dilated and the membranes coming through. I went home to bed but went into labour shortly after that and this time tne baby was bigger than the other two miscarriages. If I could have only kept it another three or four weeks, I'd have three children now. I felt very badly about this one and always wondered if I had stayed in bed more would it have happened. I feel as if this one was my fault although my doctor feels differently. I'd like to see him some day and really talk it over with him. Do you think I'd have lost it if I had stayed in bed?

At this point I tried to reassure her that no one is at fault for prematurity; and as she kept stressing she had cervical dilitation, bulging and leaking membranes, I again reassured her that no amount of bed rest could have prevented delivery. She talked at length about her feelings of guilt, her seeking an abortion, tubal ligation and eventually losing what she originally felt she didn't want and possibly couldn't have. There was a slight relaxation in her facial expression and a softening of her voice. She now offered me a tour of the house and suggested we find a more comfortable place to sit, as the living room. I had entered the home by the back door and spent the first hour in the kitchen.

As for the hospital and the nurses, when I was on the ****floor it was wonderful. Everyone there has a baby and of course it is happy so I would expect less attention, but that certainly was not the case. Such back rubs! Everyone had at least three a day and the nurses were so interested; you never had to ask for a thing, they just seemed to know your needs and were always explaining things to you. When I lost the babies and was on the **** floor, it was awful. I imagine

the other mothers felt worse but at least I had two children. You were never offered a back rub and always had to ask for things until you felt like a pest and stopped asking. The nurses answered your bell, did what was needed and left. The hours go slow as you have no baby to feed and no one ever drops in to see how you are unless you put on your light. I had a room mate; if I had no children, I probably would have wanted to be alone. I really don't know as I have always preferred semi-private. My room mate and I talked very little about the baby we had just lost, both girls, but a lot about our children at home. She would call her daughter every day and I'd call mine and then we would swap notes. Her visitors would bring things, books and candy, for both of us, and mine would do the same. We'd visit the nursery together and watch the babies. The nursery nurse was very kind about letting us watch her feed and change the babies. In this way we were able to pass some of the time away, but the days were long and dull. The aides were very nice and tried to visit us, but not the nurses. The others with no kids must have been miserable. I felt badly, but after all I'd lost two others and was lucky to have the two I did. The hall was so dark and dull, and other than visiting in other rooms, there was no place to go. You would think that the hospital would have a sun porch with some reading material and a television for everyone. But if you have a baby, you are almost too busy to visit, so I guess mostly the ones with stillborns, miscarriages and that sort would be using the room. It would be a good place for diversion and talking to the patients. I was most upset about always having to ask for pills, bedpan, back rubs and such; no one ever bothered unless you asked. You know it has been wonderful talking to you. I really must see Dr.****. He probably thinks I am mad at him, but I just felt it was my fault that it happened this way and he would be trying to make me feel good by saying it wasn't. It has really been good talking to someone.