

1-1-1997

## The Impact of an Educational Program on Anxiety of Student Nurses Related to Perinatal Loss

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### Recommended Citation

Telles, Connie, "The Impact of an Educational Program on Anxiety of Student Nurses Related to Perinatal Loss" (1997). *Master's Projects*. 889.

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Perinatal Loss 1

THE IMPACT OF AN EDUCATIONAL PROGRAM ON ANXIETY  
OF STUDENT NURSES RELATED TO PERINATAL LOSS

by

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## Perinatal Loss 2

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### Perinatal Loss 3

#### Abstract

1  
2  
3 **Objective:** To measure the effectiveness of a perinatal loss workshop on death  
4 anxiety of nursing students.

5 **Design:** Simple, pretest-posttest.

6 **Setting:** A classroom at a State University in California.

7 **Participants:** 20 junior students in a baccalaureate nursing program in a maternal-  
8 child rotation.

9 **Intervention:** A 60-minute perinatal loss workshop including Worden's tasks of  
10 mourning, therapeutic and non-therapeutic nursing interventions, photographs,  
11 poetry, and coping skills.

12 **Main Outcome Measure:** Anxiety towards perinatal death was measured by  
13 Spielberger's State Trait Anxiety Inventory (STAI Form Y-1). Data were also  
14 gathered with a demographic questionnaire and a posttest.

15 **Results:** The mean score on the PRESTAI was 52.3 and the mean score on the  
16 POSTSTAI was 44.8. Post workshop scores decreased by 7.5 points indicating a  
17 decrease in anxiety. When asked, "If you had the chance to choose your  
18 assignment in labor and delivery how likely would you choose the woman with the  
19 intrapartum death?" the mean score changed from 2.6 before the workshop to 3.3  
20 after the workshop ( $p < .05$ ).

## Perinatal Loss 4

21 Conclusions: Students that participated in an educational program on perinatal  
22 loss reported a decrease in anxiety level towards death. Future studies should  
23 include a control group to compare educational interventions to the current  
24 curriculum in nursing programs.

25

**Perinatal Loss 5**

26

**Callouts**

27

**1. Death of a child can be the most devastating event in a parent's life.**

28

**2. Nurses play a significant part in the grieving process that begins in the hospital.**

29

**3. Mean scores for the PRESTAI and the POSTSTAI show a significant decrease**

30

**in the anxiety level.**

31

## Perinatal Loss 6

32           “When your parent dies you have lost your past. When your child dies you  
33 have lost your future” (Walsh & McGoldrick, 1991, p. 38). Death of a child can be  
34 the most devastating event in a parent’s life. Even if that child has been in a  
35 woman’s womb for only a few months, the death of a baby can be as traumatic as  
36 the death of a grown child. Thomas (1997) reports that 20% of all pregnancies end  
37 in miscarriage. Many families are torn apart after the death of a child. “Perinatal  
38 grief has been associated with the loss of self, self-esteem, sexual problems, and  
39 marital discord” (Wallerstedt & Higgins, 1996, p.390). Relationships between  
40 spouses are changed forever. The loss of a child may bring them closer or tear  
41 them apart. Mothers and fathers mourn for their child in different ways. Society  
42 expects fathers to be stoic and hold the family together. Mothers are allowed to  
43 grieve longer and express emotion.

44           Nurses are often the first ones present when a woman learns that her baby  
45 is dead and what a nurse says and does will be remembered by this woman forever.  
46 Leoni and Woods (1997) and Lowe and Neuman (1995) describe ways to help  
47 families deal with loss. Nurses need to offer nonjudgmental caring and personal  
48 involvement. Parents must be allowed to express grief in unique ways. Nurses can  
49 facilitate relationships between spouses by informing parents of the stages of grief  
50 and the importance of open communication

## Perinatal Loss 7

51           The term “perinatal loss” includes miscarriage (loss before 20 weeks),  
52 stillbirth (death in utero after 20 weeks), and neonatal death (death of a liveborn  
53 neonate up to 28 days after birth). In the *Annual Summary of Vital Statistics*,  
54 Guyer, Martin, MacDorman, Anderson, and Strobino (1997) reported that the  
55 1996 infant mortality rate in the United States was 7.2 deaths per 1000 live births.  
56 These authors estimated that there were 28,237 infant deaths in the United States  
57 in 1996. The infant mortality rate by race was highest among African Americans,  
58 twice the rate of the Hispanic and White populations. In comparison to other  
59 countries with at least 2 million population, the United States and Greece have the  
60 highest infant mortality rate (IMR). Sweden has the lowest IMR at 3.7 percent for  
61 1995 (Guyer et al.).

62           The curricula in nursing schools often do not allow enough time to  
63 thoroughly cover perinatal loss. Consequently, students spend limited time on this  
64 topic. Many nurses have complained about the lack of educational programs about  
65 death, dying, and bereavement in nursing schools. (Coolican, Stark, Doka, & Corr,  
66 1994). When dealing with perinatal loss Vogel (1996) feels caregivers “freeze up”  
67 and do nothing because they are afraid of saying the wrong thing. He suggests that  
68 this fear is based on ignorance or unfamiliarity with death.

69           This author has 12 years experience in labor and delivery, and realizes that  
70 nurses sometimes avoid dealing with perinatal loss. When assignments are made in



## Perinatal Loss 8

71 the hospital the patient experiencing fetal or neonatal death is often a nurse's last  
72 choice. The lack of education regarding death may be a contributing factor.

73 The purpose of this study was to determine if an educational program on  
74 perinatal loss would decrease the anxiety level of nursing students about caring for  
75 a grieving patient. The expectation of this researcher is that if nursing students  
76 learn while in nursing school how to therapeutically care for grieving patients, they  
77 may experience less anxiety and not avoid this type of patient in the future.  
78 Furthermore the skills learned in communicating with bereaved parents could be  
79 transferred when dealing with other situations involving death and bereavement.

### 80 Literature Review

81 Much of the literature on perinatal loss focuses on parents and how nurses  
82 can help them cope. The nursing literature also includes a large number of studies  
83 regarding nurses' attitudes towards grief; most of these studies involve pediatric,  
84 AIDS, or oncology patients. Various studies have been done regarding student  
85 nurses' attitudes towards death and dying, but this researcher found no studies  
86 which specifically addressed perinatal loss with student nurses.

87 In the literature regarding nurses Hinds et al. (1994) did a study using a  
88 grief workshop to compare the grief and stress responses of experienced nurses  
89 (two to five years) to nurses with less experience (six months to two years).  
90 Findings indicated that the grief workshop caused significantly higher stress levels

91 in the experienced nurses. The authors attributed the greater stress in experienced  
92 nurses either to the nurses realizing they were using defense mechanisms to protect  
93 themselves from the pain of loss or to an ineffective workshop. This author feels  
94 further qualitative research needs to be done to discover the reasons for the greater  
95 stress in experienced nurses.

96 In the literature on students attitudes towards death and dying Clingerman  
97 (1996) tested two unique teaching strategies during an oncology rotation in a  
98 baccalaureate-nursing program: *AIDS: A Frame of Reference* (an art gallery) and a  
99 bereavement service. Students provided artistic collections for an art gallery on  
100 campus. The bereavement service allowed students to light candles and share  
101 thoughts and prayers. Students cried together and held one another. These  
102 strategies allowed students to explore their feelings about death. Both strategies,  
103 Hinds et al. and Clingerman, were identified as a success with students requesting  
104 more classes.

105 Calhoun (1994), Thomas (1997) and Primeau and Lamb (1995) studied  
106 parents' perceptions of nursing interventions after the death of their child. Findings  
107 indicated that parents were grateful that the nurse cared enough to cry. Tears  
108 validated their loss and showed the nurse's compassion. However, health  
109 professionals often feel that crying is "unprofessional" and they try to avoid  
110 showing their own grief (Saunders & Valente, 1994).

## Perinatal Loss 10

111           Saunders and Valente (1994) interviewed over 300 nurses that attended  
112 their bereavement workshops. These authors feel nurses must understand theories  
113 of bereavement to facilitate their own grief and make sense of death. To cope  
114 effectively with dying clients nurses must come to terms with their feelings related  
115 to dying and mortality. Findings concluded that nurses get very little training in  
116 how to deal with death.

117           In the literature regarding perinatal loss Kavanaugh (1997) interviewed  
118 eight parents who had experienced the death of a newborn weighing less than 500  
119 grams at birth. The findings indicate that having a newborn on the margin of  
120 viability demands supportive, caring behaviors from the nursing staff. The data in  
121 this study also suggest that these mothers may have an increased sensitivity to pain  
122 because of the emotional pain of their loss.

123           Armstrong and Hutti (1998) measured anxiety of 31 expectant mothers  
124 who had previously experienced a perinatal loss. Results showed greater levels of  
125 anxiety and lower levels of prenatal attachment compared to a group of  
126 primiparous women of similar gestational age. The authors suggest that nurses  
127 working with these mothers need to be aware of the heightened anxiety and  
128 encourage actions to decrease the level of anxiety.

129

130

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Theoretical Perspectives

132

Stress Response Model

133

Elliot and Eisdorfer (1982) developed the stress-response sequence model

134

that was used as a framework for this study. This model has three interrelated

135

components: (a) stressors, (b) reactions, and (c) consequences.

136

A stressor is an event or condition that has the potential to produce a

137

change. Stressors are internal and external events that change a person's state. For

138

the purpose of this study, the stressor used was a video showing parents who were

139

experiencing a perinatal loss.

140

Reactions to a stressor as defined by Elliot and Eisdorfer (1982) are

141

biological or psychosocial. The reactions related to anxiety about caring for a

142

patient with a perinatal loss may include symptoms of stress. The term "anxiety" is

143

defined as an uneasiness and distress about future uncertainties. It is characterized

144

by feelings of tension, nervousness, and worry. For the purpose of this study,

145

reactions were measured in terms of state anxiety using the State Trait Anxiety

146

Inventory (STAI, Spielberger, 1983).

147

Consequences according to Elliot and Eisdorfer are positive or negative

148

sequelae that are sometimes confused with reactions. Usually consequences occur

149

after a period of time. For purposes of this study, consequences were measured

150

with a question on the posttest asking the student if he or she would be more or

## Perinatal Loss 12

151 less likely to accept the assignment of a patient who was experiencing a perinatal  
152 loss.

153 A mediator or filter according to Elliot and Eisdorfer is a factor which  
154 modifies consequences. The workshop on perinatal loss was intended to be a  
155 mediator to modify the student nurses' attitudes and decrease anxiety. The  
156 intention of this workshop was that students would be less anxious and more  
157 confident about caring for a patient experiencing a perinatal loss.

### 158 Worden's Four Tasks of Mourning

159 The theoretical framework on which the perinatal loss workshop was based  
160 is Wordon's task based model. Coolican et al. (1994) surveyed 650 baccalaureate-  
161 nursing programs and recommended Worden's task model when teaching nursing  
162 students about death. Worden (1991) uses the term mourning to indicate the  
163 process that occurs with a loss, and grief as the personal experience of the loss.  
164 There are four tasks which Worden suggests are necessary for dealing with a loss.

165 Task 1: To accept the reality of the loss. Many times parents will ask the  
166 nurse to check again for a heart rate after learning that the baby is dead. This  
167 response is a simple example of the initial reaction of disbelief which people  
168 experience when they first hear of a death. In the workshop, students were  
169 provided examples of how to assist parents with this task.

## Perinatal Loss 13

170 Task 2: To experience the pain of the loss. The goal of this stage is to  
171 experience the pain so it will not be carried on throughout life. Encouraging the  
172 parents to express their grief, through words, tears, and activities can facilitate this.

173 Task 3: To adjust to an environment in which the deceased is missing.  
174 Parents go home without a baby to an empty nursery. Often women want to  
175 immediately get pregnant to fill the empty space left by the death of their child.  
176 Students in the workshop were helped to understand the underlying feelings of  
177 parents so they could help them come to terms with the emptiness of the loss.

178 Task 4: To emotionally relocate the deceased and move on with life.  
179 Parents need to learn to let go of the past. Students were provided with  
180 interventions to support families in this process. Eventually memories will be less  
181 painful.

### 182 Methodology

183 A convenience sample of 20 junior nursing students in a baccalaureate  
184 program was used for this study. Although the convenience sample reduces the  
185 generalizability of this study, this sampling procedure best fit the limitations of the  
186 site, and was considered adequate for a pilot study. The Human Subjects  
187 Institutional Review Board at the university approved the study. The students were  
188 in their maternal-child rotation and represented diverse cultural and ethnic  
189 backgrounds.

## Perinatal Loss 14

190           A simple, pretest-posttest design was used for this pilot study. Because of  
191 the nature of the course calendar one class session served as its own control group.  
192 Students completed a demographic questionnaire and then viewed the video, *When*  
193 *the Bough Breaks*. This is the story of a family that experienced the death of a  
194 child soon after birth. After the video, anxiety levels were measured using the  
195 STAI Form Y-1. A one-hour workshop including Worden's framework followed.  
196 After the workshop students again completed the STAI and a posttest.

### 197 Instruments

198           The instruments used included a consent form, a demographic  
199 questionnaire, a brief posttest, and the Spielberger State-Trait Anxiety Inventory,  
200 Form Y-1. The researcher developed the demographic questionnaire and posttest.  
201 The demographic questionnaire consisted of 12 questions regarding age, gender,  
202 religious affiliation, and previous experience dealing with death. The demographic  
203 questionnaire and the posttest had two identical questions using a Likert scale  
204 asking the students to identify their comfort level in caring for a patient  
205 experiencing a perinatal loss. See table 1 for the three questions that were used on  
206 the demographic questionnaire and the posttest. The posttest consisted of four  
207 questions to evaluate the course objectives and three questions (two the same as  
208 the demographic questionnaire) regarding comfort level in caring for a patient with  
209 a perinatal loss.

## Perinatal Loss 15

210           The STAI Form Y-1 evaluates apprehension, tension, nervousness, and  
211 worry--how respondents feel "right now". State anxiety is a reaction at a given  
212 time. Trait anxiety (STAI Form Y-2) refers to individual differences between  
213 people and how they typically respond to stressful situations. For this study the  
214 researcher used the anxiety portion of the STAI Form Y-I. Possible scores range  
215 from 20 to 80 points, which includes 20 statements based on a four point Likert  
216 scale and takes about six minutes to complete. Sample questions include, "I feel  
217 nervous," "I feel upset," and "I feel at ease."

218           Spielberger established construct validity by comparing the mean scores of  
219 various neuropsychiatric patient groups with those of normal subjects. Lower  
220 scores of the character disorder group, for whom the absence of anxiety is part of  
221 their illness, provided further evidence of construct validity of the STAI.

222 Cronbach's alpha coefficients were .91 for males and .93 for females when testing  
223 stress levels of college students. Alpha reliability coefficients were higher when the  
224 scale was given under conditions of stress. The STAI is considered to be a valid  
225 and reliable instrument for measuring anxiety and is widely used for this purpose.

### 226 Perinatal Loss Workshop

227           The 60-minute workshop included Worden's tasks of mourning, types of  
228 perinatal loss, therapeutic and non-therapeutic nursing interventions, spirituality,  
229 poetry, music, and caregiver coping skills. Photographs from the book by Johnson,



230 Cunningham, Weinfeld and Gough (1997) entitled, *A Most Important Picture* were  
231 shown to the students. The researcher obtained permission from the author of the  
232 book to use the photographs in the research. These are tasteful pictures of families  
233 holding dead babies. The fear of what a dead baby looks like is often worse than  
234 the baby's true appearance. The workshop outline is shown in Table 2.

## 235 Results

### 236 Demographic Data

237 The convenience sample was comprised of 18 female and 2 male nursing  
238 students (n = 20). Eighteen subjects were age 20 to 30 and two were age 30 to 50.  
239 Seventeen subjects were single and three were married. Twenty-five percent have  
240 children, and 85% indicated some religious affiliation. All of the subjects had had  
241 someone close to them die and 10% had themselves experienced a perinatal death.  
242 Thirty-five percent had attended a class on death and dying and 45% had  
243 experience with death in a clinical practicum (10% neonatal death and 35% adult  
244 death). See table 3 for further demographic data.

245 Question number 11 on the demographic questionnaire and question  
246 number 5 on the posttest is, "How comfortable do you think you would be taking  
247 care of a woman experiencing a stillbirth?" The pre workshop mean score was 2.5  
248 and the post workshop mean score was 2.6. This represents only a tenth of a  
249 change after the workshop and is not significant.

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250           However, question number 12 on the pretest and question number 6 on the  
251 posttest, "If you had the chance to choose your assignment in labor and delivery  
252 how likely are you to choose the woman with the intrapartum death?" showed a  
253 significant change after the workshop ( $p < .05$ ). The mean score to this question  
254 changed from 2.6 before the workshop to 3.3 after the workshop. This suggests  
255 that the subjects are more likely to choose this assignment after the workshop. One  
256 subject did not answer this question.

257           A five point Likert scale was used for the posttest question, "How do you  
258 feel this workshop affected your ability to care for a patient experiencing a fetal  
259 loss?" with scores ranging from 1 (not at all) to 5 (very much so). The mean for  
260 this question was 4.37 which means the workshop affected them "very much so" in  
261 their ability to care for a perinatal loss patient.

262           Mean scores for the PRESTAI were 52.3 ( $SD = 9.3$ ) and POSTSTAI  
263 scores were 44.8 ( $SD = 9.6$ ) These scores show a significant decrease in anxiety  
264 level by 7.5 points. Means and standard deviations of PRESTAI and POSTSTAI  
265 were computed with differences between means analyzed by the use of a  $t$  test  
266 (paired samples test). The mean score was 7.50,  $SD = 9.68$ ,  $t = 3.5$ ,  $df = 19$ ,  $p <$   
267 .003.

268

269

270

Discussion

271           According to Elliot and Eisdorfer's stress model the workshop was a  
272 mediator for the student nurses anxiety level. All 20 questions on the STAI  
273 showed a decrease in anxiety level after the workshop. The difference between the  
274 preworkshop scores for "If you had the chance to choose your assignment in labor  
275 and delivery how likely would you choose the woman with the intrapartum death?"  
276 and to the post workshop scores, showed a 30% increase in students likely or very  
277 likely to accept this assignment after the workshop. This indicates that the  
278 workshop was a positive mediator to prevent avoidance of perinatal loss patients.  
279 Because the students reported positive results after the workshop in their ability to  
280 care for the fetal loss patient, these findings support the importance of classes on  
281 perinatal in nursing programs. Comments from students to the researcher after  
282 class included, "I wish I had this workshop earlier in the program." "Now I know  
283 what to say to these patients." and "I'm so glad its OK to cry."

284 Limitations and recommendations for further research.

285           The lack of a control group and the use of a convenience sample are two  
286 limitations to this study. Due to the limited number of subjects and the lack of a  
287 control group the results cannot be generalized to other baccalaureate nursing  
288 schools.

289 Further studies with a larger sample size and a control group are  
290 encouraged. A study using a mix of qualitative and quantitative data is also  
291 recommended. Research could be done comparing the anxiety of experienced  
292 nurses working in birthing centers to their educational background. Follow up data  
293 could be gathered at six months and one year after the workshop to see if anxiety  
294 levels were maintained.

295 Implications for Nursing Practice

296 Nursing educators need to include content on death and dying. Maternity  
297 nursing instructors need to provide students with various opportunities to learn to  
298 respond to perinatal loss. Strategies that influence the affective domain appear to  
299 work well when teaching death and dying (Clingerman, 1996). This author feels  
300 that movies, pictures, music, and poetry are some strategies that made this class so  
301 effective. The students in this study were very moved by the pictures of dead  
302 babies and the stories of past experiences of the researcher. Death is a part of the  
303 circle of life and as nursing educators we must thoroughly teach death to students  
304 in nursing school.

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Table 1: Sample Questions Demographic Data/Posttest

353

**Please answer the following questions using the scales provided:**

354

1. On a scale of 1 to 5 how comfortable do you think you would be taking care of

355

356

a woman experiencing a stillbirth? \*

357

358

1

2

3

4

5

359

very

slightly

simply ok

comfortable/

completely

360

uncomfortable

uncomfortable

at ease

comfortable

361

362

2. If you had the chance to choose your assignment in labor and delivery how

363

364

likely are you to choose the woman with the intrapartum death? \*

365

366

1

2

3

4

5

367

very unlikely

unlikely

not sure

likely

very likely

368

369

3. How do you feel this workshop has affected your ability to care for a patient

370

experiencing a fetal loss? \* \*

371

1

2

3

4

5

372

not at all

somewhat

no difference

moderately so

very much so

373

374

\*Demographic Questionnaire #11 and 12; # 5 and 6 on the posttest

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376

\*\* Posttest only

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**Table 2: Perinatal Loss Workshop Outline**

Introduction: Procedure, purpose, consent, confidentiality, and demographic questionnaire.

Movie: *When the Bough Breaks, Working With Families who have Experienced the Death of an Infant.*

Complete the STAI.

**Objectives**

Upon completion of the workshop, the student will be able to:

1. describe the difference between stillbirth and neonatal death.
2. discuss what nursing interventions are therapeutic and non-therapeutic when dealing with a family experiencing perinatal death.
3. state two self-care activities that can facilitate your grieving.
4. explain one of Worden's four tasks of mourning.

I. Worden's four tasks of mourning

II. Types of perinatal loss

III. At the time of the loss

IV. Therapeutic and non-therapeutic nursing interventions

V. Photographs from *A Most Important Picture*

A. How to take a good picture: Mementos

VI. Special cultural considerations/spirituality

VII. Caregiver coping skills/resources

STAI/Posttest

383

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**Table 2: Perinatal Loss Workshop Outline**

385

386

Introduction: Procedure, purpose, consent, confidentiality, and demographic questionnaire.

387

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Movie: *When the Bough Breaks, Working With Families who have Experienced the Death of an Infant.*

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Complete the STAI.

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Objectives

395

Upon completion of the workshop, the student will be able to:

396

397

1. describe the difference between stillbirth and neonatal death.

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2. discuss what nursing interventions are therapeutic and non-therapeutic when dealing with a family experiencing perinatal death.

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3. state two self-care activities that can facilitate your grieving.

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4. explain one of Worden's four tasks of mourning.

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I. Worden's four tasks of mourning

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II. Types of perinatal loss

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III. At the time of the loss

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IV. Therapeutic and non-therapeutic nursing interventions

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V. Photographs from *A Most Important Picture*

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A. How to take a good picture: Mementos

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417

VI. Special cultural considerations/spirituality

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VII. Caregiver coping skills/resources

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421

STAI/Posttest

Table 3 Demographic Data (n=20)		
	Frequency	Percent
Age:		
20-30	18	90.0
30-40	1	5.0
40-50	1	5.0
Gender:		
Male	2	10.0
Female	18	90.0
Marital Status:		
Single	17	85.0
Married	3	15.0
Children:		
Yes	5	25.0
No	15	75.0
Religious Affiliation:		
Yes	17	85.0
No	3	15.0
Years of College (n=19)		
2-4	2	10.0
4 and above	17	85.0
Anyone close to you ever die?		
Yes	20	100.0
No	0	0
Ever had a stillborn, miscarriage or neonatal death?		
Yes	2	10.0
No	18	90.0
Ever attend class on death and dying?		
Yes	7	35.0
No	13	65.0
Ever experience death in clinical practicum?		
Yes	9	45.0
No	11	55.0