Perinatal Loss in Emerging Adults: A Review of the Literature

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Abstract

The purpose of this study was to discover the unique experience of perinatal loss in emerging adults. With this compilation of research, the hope is to improve the therapeutic practice of practitioners who come in contact with these patients. Emerging adults are age 18-25 and are in a life stage of transition and exploration, both emotionally and financially. Perinatal loss is any type of pregnancy loss from conception to one month after delivery. Emerging adults that have experienced a perinatal loss grieve in ways that are both similar and different than their counterparts in different life stages. In order to provide patient-centered care to this unique population, health care professionals must practice sensitive and thorough communication, encourage tangible grief aids such as memento boxes, and socialize the loss through interventions like support groups. My research has shown that there can be no standardization in care, but it should be tailored to each patient based on his or her needs. Pregnancy loss care in this life stage is further complicated by the differences between couples and their assigned meaning to each pregnancy, especially since a large number of pregnancies are unplanned. This study was a literature review and included three interviews of men and women that experienced a perinatal loss. Possible implications of future work could be the implementation of a screening tool to provide information about the couple in order to predict their needs and grief responses should there be a perinatal loss.

Keywords: perinatal loss, emerging adult, grief
Introduction

Many people choose to enter the profession of nursing because it integrates concepts of compassion and skill with profound knowledge in order to provide exceptional patient-centered care. Nurses have a unique opportunity to exercise this powerful skill set when working with patients that have experienced a perinatal loss and are in the emerging adult life stage. The purpose of this paper is to describe perinatal loss through the lens of emerging adulthood using real life experiences in hope to both ignite a passion and equip health care professionals with the knowledge necessary to provide compassionate patient-centered care during this vulnerable time.

Emerging Adulthood: Demographics of Emerging Adulthood

Emerging adulthood is the time period in one’s life from age eighteen to twenty-five (Arnett, 2004). This time frame is more than a range of ages, but of transition, identity, and personal growth. Emerging adulthood is a unique stage in life typically limited to industrialized countries, mainly because of the opportunity for further education and a prolonged period of personal exploration. Furthermore, this novel life stage is unique to middle and upper class socioeconomic classes of America and industrialized countries. This distinction is present because of the family’s financial ability to provide their child with an opportunity like college or a similar opportunity that serves as a transition between high school and the work force (Arnett, 2001). Examples of transitional periods are attending a University away from home or a gap year where the student travels abroad or away from home in pursuit of work or volunteer experience.

Disparities in health are defined as incongruent elements of health that are associated with inequalities in social structures determined by race, ethnic background, gender, age, sexual orientation, and immigrant status (Stanhope & Lancaster, 2016). These disparities bring along a
complex social structure that results in ethnic minorities representing the majority of the population in poverty. This financial burden creates a barrier to the opportunity to attend college and engage in the transitional time that is influential to emerging adults. While ethnicity does play a factor for the inclusion of the opportunities that come with the developmental stage, socioeconomic status is the most important factor. This is because the transitional stage of life comes with a price tag. Emerging adulthood most accurately represents middle to upper socioeconomic classes aged 18-25 in industrialized countries, due to the constraints of this transitional phase imperative to the development of this age group. If the person does not engage in transitional activities such as college or a gap year, they are more accurately described by the young adult life stage (Arnett, 2004).

**Neither Adolescence nor Adulthood**

Emerging adulthood poses a unique phenomenon named “pseudo independence” because often times the person is still financially dependent on the parents while having the freedom to make their own decisions on an everyday basis. Many have tried to call this period of time “prolonged adolescence” or “young adulthood”, but Arnett (2004) argued that to simply define it as adolescence or young adulthood would fail to recognize the unique challenges and opportunities of progression this stage has to offer. Neither adolescence nor adulthood captures the uniqueness of this stage because the three life stages are “conceptually, theoretically and empirically” different (Blinn-Pike, Worthy, Jonkman, & Smith, 2008, p. 577). Emerging adults have overcome the adolescent-specific struggles, but have yet to encounter responsibilities of adulthood.
**Adolescence Defined**

Psychologist, Erik Erikson described the life stages of adolescents as a struggle between identity and role confusion and young adults as intimacy and isolation (Leifer & Fleck, 2013). Adolescents either achieve a sense of self or end up struggling with an identity crisis. Young adults strive to form meaningful romantic relationships or struggle with commitment and intimacy. Emerging adults are in between this stage as they work towards independence after understanding their identity, but before they are ready to share life-long partnership with another. Biological maturity, legality, and a sense of emotional independence from caregivers support the argument that emerging adulthood is not adolescence (Arnett, 2016). Because menarche is occurring sooner and testicular development in males is occurring earlier than previous generations, by age 18 puberty is often times an issue of the far past. Along with age 18 comes the right to vote, enter the military, have the ability to provide consent in medical decisions, among other privileges that distinguish this age group from the dependence on guardians in adolescence (Arnett, 2000). Emotional independence is a working definition in that individuals are independent from consultation of parents in everyday issues, but are still very much financially dependent of guardians. Emerging adults make independent decisions about their lives, have undergone physical development resembling adulthood, and have some responsibilities reserved for legal age. These factors distinguish them from adolescence, but they are also set apart from full on adulthood because they have not mastered the independence or encountered the responsibilities required by adult life.

**Adulthood Defined**

Emerging adulthood as a development phrase raises the question of when adulthood starts. Adulthood is defined by emerging adults with an emphasis on individualism. They spend
this time working towards making independent decisions, accepting responsibility for their own actions, gaining financial stability, and becoming conscientious in character. A study proposed by Arnett in 2001 set out to discover the criteria for adulthood. The ramifications of adulthood were broken down into categories of individualism, family capacities, normal compliance, biological transitions, legal and chronological definitions, and role transitions. The study assesses the obtainment of adulthood by asking participants a series of questions related to the aforementioned qualifications. The study asks the individual if he/she decides on personal beliefs independently from parents’ opinions, are financially independent, capability to keep a family safe and functional, avoidance of drunk driving and use of illegal drugs, capability of fathering/mothering a child, employment status, marital status, and the ability to control emotions to name a few. These questions were formed from anthropologist, sociologist and psychologist in research to define the achievement of adulthood. The top three requirements for the attainment of adulthood are to accept responsibility for yourself, make independent decisions and become financially independent (Arnett, 2001). The defining event of breaching adulthood used to be the commitment and personal growth that must come with marriage. (Arnett, 1998). The more modern view of achieving adulthood is financial and emotional independence along with meeting career goals and less about relational maturity.

**Significance of Emerging Adulthood**

Emerging adulthood is imperative to one’s life because it lays the foundation for the rest of life. The education and skills obtained in this time frame will be carried with them for the rest of their lives. When surveyed, the majority of participants claimed that the decisions they made during this time period brought with them some of the most important events of their life (Arnett, 2000). The main distinction is that emerging adults are obtaining preparation for a life-long
occupation while adults have already assumed that role. Emerging adulthood does not fit in the adolescence category because they have more autonomy of their lives by moving out of their parents’ homestead (Arnett, 2000). Emerging adulthood is more than an in-between age; it is a stage defined by exploration in all aspects of life that surpasses mere identity discovery as addressed by Erik Erikson’s developmental stages (Leifer & Fleck, 2013). Emerging adulthood is the age of instability, possibilities, self-focus, feeling in-between and identity exploration (Arnett, 2004). It is a time where one is fully encouraged to experiment and explore different avenues of life with the hope that their adulthood will bring a career that is fulfilling and a personal life that is enriching.

This life stage is revolutionary because there are significant changes in the normal progression of life events. In the past fifty years alone, there has been a distinct delay in life events such as marriage and procreation because of this idea of exploration of life possibilities. The median age of marriage in 1970 was 21 for women and 23 for men (Arnett, 1998) while today it is 26 and 28 respectively (Arnett, 2004).

**Cultural Differences in Emerging Adulthood**

Emerging adulthood is a feature of the middle, socioeconomic class but is applicable to working class Americans if the individual is able to experience a transitional stage between high school and entrance to the work force. However, there are stark differences in how ethnic groups view this developmental stage and the attainment of adulthood (Arnett, 2004). When surveyed, Blacks and Latinos were more likely to accept gender norms in relation to adulthood as evidenced by answers like, “if a man, become capable of supporting a family financially” and “If a woman, become capable of running a household”. Blacks and Latinos were also more likely to accept norm compliance such as “avoid becoming drunk” and “avoid illegal drugs” as an
important indicator of adulthood (Arnett, 2003). Arnett argued that these ethnic groups value the opinion of others in regard to their definition of adulthood.

A more recent study by Syed and Mitchell (2014) concluded that emerging adulthood possesses a racial disparity because of the way young people define adulthood. The most important aspects of adulthood are financial and personal independence resulting from a complete independence from family (Syed & Mitchell, 2014). This is a mainly westernized idea, as other cultures do not value independence as a defining factor for adulthood.

The main argument is that different ethnicities experience the five pillars of emerging adulthood: (a) the age of instability; (b) possibility, (c) self-focus, (d) feeling in-between, and identity exploration differently because of social structures and culture (Syed & Mitchell, 2014). The segs of socioeconomic class and ethnicity are interrelated and difficult to connect in terms of scientific analysis of an entire population. Because of this difficulty, researchers understand that there are differences in how emerging adults experience this life stage, but the exact differentiation is not well understood.

**Perinatal Loss: Definition of Perinatal Loss**

Researchers have spent countless hours in an effort to define what exactly “perinatal loss” means. The World Health Organization states that perinatal loss is a pregnancy loss from twenty-two completed weeks gestation to seven days of completed life (World Health Organization, 2006). This definition does not include miscarriage, infant death, abortion or any other fetal demise modern women and their partners endure today. The Children’s Project on Palliative/Hospice Services (a division of the National Hospice and Palliate Care Organization specifically focused on children) later included miscarriage, ectopic pregnancy (extrauterine pregnancy), molar pregnancy (noncancerous tumor after nonviable pregnancy), stillbirth (death
of the fetus before birth), neonatal death (fetal demise from birth to 28 days), and elective abortion to this definition with hopes to accurately depict all types of loss that parents experience (CHiPPS, 2007). Researchers specializing in grief associated with pregnancy loss, Black and Sandelowsk (2013) aimed to create a more inclusive definition of perinatal loss. In their research article, *Personal Growth after Severe Fetal Diagnosis*, they state “Perinatal loss refers to any type of event related to conception, pregnancy, birth (Callister, 2006), including infertility (Gonzalez, 2000), miscarriage (Brier, 2008), stillbirth (Hughes & Riches, 2003; Jonas-Simpson & McMahon, 2005), preterm delivery of a previable or marginally viable infant (Kavanaugh et al., 2008; Kavanaugh, Moro, Savage, Reyes, & Wydra, 2009), delivery of an infant with anomalies (Lutz & May, 2007), and neonatal death (Hutti, 2005)” (p. 1013). With the advancement of technology like ultrasonography and genetic testing comes information about pregnancy sooner and with more accuracy than ever. The search for clarity becomes convoluted because parents have the knowledge of pregnancy much sooner than previous generations where a more conservative definition of perinatal loss would be more accurate. In today’s world, perinatal loss pushes the boundaries of older conceptualizations because modern women experience pregnancy related loss weeks before previous generations found out that they were pregnant. In this paper the most inclusive definition of perinatal loss will be used in order to serve the widest array of patients and cater to the specific struggles of modern day couples in their reproduction journey.

Although the etiologies of some perinatal losses are clear, in many cases the cause is elusive. Women’s socioeconomic status and thus access to care is a significant factor that can affect prenatal and postnatal care, nutritional status of both the woman and fetus, and other basic needs (Wright & Black, 2013). Many governmental programs like Women, Infants, and Children
(WIC) and Children’s Health Insurance Program (CHIP) have been put into place to provide mothers and children with resources to attain a healthy life. These programs are a product of the first welfare system, the Sheppard-Towner Maternity and Infancy Act (Dieckmann, 2017). The Sheppard-Towner Program’s founder learned that the infant mortality rate was negatively correlated with income, and thus aimed to provide resources to needy families with the result of a more proportionate and lower infant mortality rate as a whole. This first welfare program was very successful and laid the ground work for governmental assistance programs for the future.

Other risk factors of perinatal loss are multiple pregnancy, pregnancies closer than two years apart, young age of the mother and cultural practices that are not so easily understood. These cultural practices are throwing away colostrum and feeding newborns other food and leaving the newborn cold and wet after delivery rather than drying and stimulating them at birth (Wright & Black, 2013). There are many risk factors to perinatal loss. Programs that have been implemented to combat these pregnancy losses have made great strides, but much research is to be done to both prevent loss and support families that much endure it.

**Importance of Perinatal Loss Care in the United States**

The United States is a member of the Organization for Economic Co-Operation and Development (OECD), a collaborative effort between wealthy and developed countries with the goal of sharing information about healthcare, the economy, and education. The organization is not political, but rather serves as a tool for national and thus world improvement (Walters, 2017). The United States ranks relatively high concerning perinatal mortality compared to similar countries with a fetal mortality rate of 7.49 per 1,000 pregnancies in 2015 (National Vital Statistics Report, 2015). Japan, an OECD member, had a perinatal mortality rate of 3.7 per 1,000 pregnancies (Vital Statistics in Japan, 2017), half the frequency of the US. These statistics
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demonstrate a need for both perinatal health improvement and perinatal death-related care in the United States.

**Theoretical Framework**

Although the United States has relatively high perinatal mortality rates compared to similar countries, women are often left feeling alone and misunderstood in their perinatal loss grief period. This concept is named “disenfranchised grief” because the sorrow and mourning period may not be socially recognized and is not openly acknowledged because of various cultural and societal norms (Hazen, 2003). Researchers attribute this unique feeling to perinatal loss specifically because perinatal mortality is highly stigmatized and is not considered a conventional loss.

Another term that attempts to make sense of this unique situation is “ambiguous loss” leading to “boundary ambiguity” coined by grief researcher Pauline Boss. Ambiguous loss has two components: 1) physical, where the person is gone but it is unclear if they are dead or alive: and 2) psychological, where the person is still physically present but does not take on normal personality characteristics because of an outside circumstance such as disease, drug addiction or obsessions. Boundary ambiguity is when the loved ones are unsure about their role and the role of other family members. For example, a mother to a child that has been kidnapped during a physical ambiguous loss is unsure about her title as “mother” (Boss, 2016). While perinatal loss does not fit perfectly into these categories, the loss is unclear because the fetus has never been alive in the outside world or has been alive for such a short period of time that the family must simultaneously confront birth and death. Families often feel unsure about their roles as described by the theory of boundary ambiguity. Parents often feel alone and confused in their journey of
perinatal loss because of the obscurity of the loss in general and the relative rarity of the occurrence.

Due to these two theories of perinatal grief, among others, parents that have experienced a pregnancy related loss are more at risk of suffering from complicated grief. Complicated grief is an amplified and prolonged sense of mourning after a traumatic death of a loved one (Solomon & Shear, 2015). In a recent study, bereaved individuals that had experienced a perinatal loss were more likely to experience complicated grief when compared to other types of loss and death. These individuals were at an even higher risk if they experienced specific types of loss such as: termination due to fetal abnormality, pre-existing relationship difficulties, absence of surviving children, ambivalent attitudes in relation to the reality of the pregnancy (Kersting & Wagner, 2012). This finding directly correlates to the theories of ambiguous loss and disenfranchised grief because parents have an ill defined loss if they chose to end the pregnancy and a poor social support where they can freely express their feelings.

**Standard of Care in the United States**

Perinatal loss and perinatal palliative care professionals have dedicated years of research in order to provide a patient-centered and evidence based guideline to health care providers in women’s health. Most hospital policies have adopted a model that is influenced by the Resolve Through Sharing ® model. Resolve through Sharing® is a resource for healthcare providers providing care to patients and their families experiencing perinatal loss. They recommend bereavement support that begins at the time of suspected or actual diagnosis of a loss to follow-up care after fetal demise. This patient-centered care model includes all types of professionals involved in the process from doula to funeral directors. The educational program recommends urging parents to spend as much time as they need with the baby after delivery in order to create
lasting memories, engage in parenting tasks, say good-bye, participate in rituals, and create keepsakes. This time should not be cut short for pathological studies like autopsies, and parents should have the option of cooling services in order to delay the decline of body integrity like peeling skin and skin slippage. Mementos such as hand and footprints, locks of hair, stuffed animals, and photographs are encouraged in order to affirm the existence of the baby and allow the formation of memories years after the baby’s death. Providers are also to provide as much information as possible about the death process and what to expect in social situations in order to decrease anxiety and provide a more culturally sensitive approach to care (Resolve Through Sharing, 2017). These recommendations create a more meaningful transition for both the baby and the family members from life to death.

Hospitals such as UNC Women’s Hospital in Chapel Hill, North Carolina and St. David’s Medical Center in Austin, Texas have adopted these policies by providing memento boxes that include hand and feet prints with a poem attached, locks of hair and hand-knitted caps made especially for the baby. Providers encourage families to stay with the baby as long as possible and provide professional photographers to capture the short amount of time the family unit has together. The hospitals equip their patients with reading materials such as Empty Arms: Coping with Miscarriage, Stillbirth and Infant death by Sherokee Ilse in hopes that it will equip them to handle expected conversations with friends and family about the experience and equip them with tools to navigate their unique grieving experience.

**Loss in Emerging Adults**

Consistent with perinatal loss in life stages other than emerging adulthood, is the concept that the women’s emotional state, level of attachment to the fetus (McCoyd & Walter, 2016), and meaning attributed the pregnancy (Black & Wright, 2013) affect grief responses if there is to be
a loss. Emotional state is referring to the presence or absence of depression, anxiety, or other psychological manifestations either as a result of pregnancy related stress or from a more physiological perspective because these conditions complicate the grieving process. Attachment refers to the woman’s bond to the unborn child in utero. Attachment is facilitated by ultrasonography, rooming in (the newborn stays in the room with the mother after delivery rather than staying in the nursery), skin-to-skin contact and other activities that help create a connection between woman and child. Attachment between the woman and fetus is also influenced by attachment style between the woman’s mother and herself (Nicolson, Judd, Thomson-Salo, & Mitchell, 2013). Meaning assigned to the pregnancy refers to the woman’s view of the pregnancy, how the pregnancy affected her identity and life trajectory, and the perceived goodness from the pregnancy. These three concepts significantly impact the grief felt by the woman after a perinatal loss.

**Emerging Adults View of Death**

The way emerging adults perceive death is vastly different than any other life stage due to their unique developmental stage. Adolescents have a sentimentalized and romanticized view of death while emerging adults question the goodness and justice of the world after such a traumatic event. After this age group experiences this type of loss, they have an increased risk of maladaptive coping mechanisms after future trauma or loss because their view of the world has been greatly altered. (McCoyd & Walter, 2016). This view is different than adult’s more mature and permanent view of death.

Death is not a foreign concept for emerging adults as approximately 25% of college students have lost a significant family member or friend in the past year and 50% in the past two
years (McCoyd & Walter, 2016). The initial losses for emerging adults are typically the death of an elderly family member such as grandparents rather than a pregnancy related loss.

**Resilience**

While death is not uncommon for emerging adults to experience, they are most familiar with non-death related losses such as moving out of the childhood home and living on their own, loss of friendships, loss of perceived life path, etc. that can bring about intense feelings of grief. Approximately 68% of significant loss for this age group is associated with non-death related loss (Cooley & Roscoe, 2010). Perinatal loss during a life stage where non-death related losses occur frequently results in a compounding of grief feelings and occasionally complicated grief experience.

A unique attribute specifically associated with emerging adults, however, is their capacity for resilience. Resilience is defined by a capacity to recover quickly from trauma and recognize positive outcomes of grief like personal growth, increased personal strength, and a sense of closeness to others and the world (Cooley & Roscoe, 2010). Resilience allows emerging adults to view the world in a different and more positive way than any other life stage, which is attributed to their perceived amount of life left to live.

**Emerging Adult Loss Specific Interventions**

Emerging adults benefit from provider encouragement for the woman to acknowledge the fetus as its own entity rather than an extension of the woman’s body. This concept is due to the life stage task of identity exploration. Emerging adults also benefit from funerals and rituals along with community support because of the high assigned value to social systems (McCoyd & Walter, 2016). These interventions are patient-centered and effective support for a woman experiencing a pregnancy related loss in this life stage. Practitioners are encouraged to use the
Five V Method, validating, valuing, verifying, ventilating and being visionary, with emerging adults specifically because of the woman’s perceived worth of their own future (Cooley et al., 2010). Validating is helping the woman recognize the significance of her loss and valuing is understanding that the baby had value to the mother. Ventilation is the outward emotional expression of grief feelings. Visionary is the encouragement of viewing future events and anticipating events that would precipitate feelings of grief.

**Experiences of Couples in the Emerging Adult Age Group**

The following stories are from a larger study, The Perinatal Care Options Study, which aimed to explore the experiences of couples that had pregnancies with severe fetal defects. These women and their partners chose to either continue the pregnancy to delivery, termination or palliative care. The researcher (Beth Black, PhD, RN and my honors advisor) followed various couples during their perinatal loss journey from diagnosis to one year after their diagnosis. I will refer to two of these couples in order to analyze their experience in regard to the emerging adult age group. One interview that I will refer to as “couple C” was a one-time interview conducted by me. The IRB designated my use of the data and one-time in this project as not human subjects research.

In order to preserve anonymity, I will refer to these women and two men as “A, B, C”. In couple A, Andrew and Ashley, the husband was 20 and the wife was 21 when the pregnancy loss occurred. They got married during the beginning of the woman’s college experience and the man enlisted in the military shortly thereafter. They moved from the Midwest because he was stationed in NC. Their unplanned pregnancy ended with an elective termination after a diagnosis of hydrops fetalis, a serious condition in which there is an excess of fluid in two or more body systems. The relationship ended months after the loss and the woman moved back home to
pursue her dreams of completing her education. Andrew and Ashley demonstrated the clearest representation of “emerging adulthood” because they were both in between total dependence on their parents and independence. Although they were married and living on their own, they remained dependent on their parents for occasional emotional and financial support. Identity and career exploration, key concepts of emerging adulthood, were exemplified by the pursuit of nursing school and military enlistment. Their relationship ended due to the chase of their separate goals, a largely self-focused journey and one that fits the constraints of the definition of emerging adulthood.

In couple B, Ben and Betsy, the man was 18 and the woman was 19 when the perinatal loss occurred. The pregnancy ended by elective termination after a diagnosis of renal agenesis, a condition in which the kidneys failed to develop. The relationship ended a few weeks after the loss; the man moved across the country, and the woman quickly entered another romantic relationship with dreams of going back to school. There was no anticipation of procreation in the near future. This couple most accurately represents the developmental stage of adolescence because they were completely reliant on their parents for both financial and emotional support and attribute little to no value to either the relationship or parenthood. Both lived with their parents separately and depended upon the finances of their parents for the termination, their own housing and basic needs.

A unique attribute of Ben and Betsy was their description of their feelings after the dilation and curettage procedure, also known as a D&C. Ben described Betsy after the procedure as, “her, like peppiness for life kind of increased. I think the, I think the baby was taking so much away from her, that her body seemed a lot better to me.” Betsy agreed with this statement by adding, “I really do feel a lot better now. Like I don’t know why, but I was really, really sick
those last few weeks.” This is an important concept for practitioners because it demonstrates the uniqueness of each couple’s experience, largely influenced by their attributed meaning to the pregnancy. While a majority of young adult pregnancies are unplanned, providers should be aware and well equipped to provide compassionate grief care to all types of couples.

In couple C, Chandler and Courtney, the man was 29 and the woman was 23 when the loss occurred. Although the man does not fit into the age distinction of the emerging adulthood, they are still considered because the woman does fit into the age restriction. The couple was engaged when they became pregnant with twins and described the pregnancy as something that was welcomed and planned. They both shared that they believed their sole purpose in life was to be parents. At eighteen weeks, a diagnosis of cervical insufficiency was found at a routine prenatal appointment. Cervical insufficiency is when the cervix prematurely dilates and effaces resulting in bulging fetal membranes and early delivery. An emergency surclodge was performed in efforts to keep the cervix closed, which would allow sustained fetal development before birth. There is an increased risk of infection with this surgery and the infection ultimately resulted to the premature delivery of both twins at 20 weeks gestation. This was before the point of viability and the babies lived for one hour each before they died. This couple’s experience is most accurately representative of adulthood because they are financially and emotionally independent from their parents and possess a matured sense of meaning from both the pregnancy and their relationship.

Chandler and Courtney shared that they “were made to be parents”, thus assigned great meaning to this pregnancy and addition to their family. This couple experienced profound grief and could have benefitted from patient-centered care that was unique to the emerging adult perinatal loss experience. Courtney said that the lack of communication from providers
contributed to the pain of the experience. During the initial diagnoses of insufficient cervix she stated that the sonographer’s expression changed and she quietly went to ask for the physician without a word to either of them. Courtney was left in the examination room for an extended period of time with nothing but a gut feeling that something had just taken a turn for the worst. Courtney then described moving from her normal OBGYN office to a maternal and fetal health specialist and she did not understand what was going on medically with her multifetal pregnancy. She stated, “I wish my doctors would have told me about the risks of my pregnancy sooner and what to expect if something were to go wrong.” Courtney also experienced a time of positive communication that she admits helped ease the pain of her loss experience. “One of the nurses that had taken care of me for her entire shift came to my room and sat with me for a while. She told me that she was so sorry this was happening to me and she wished that she could change it. During this encounter I felt understood. Her words didn’t take away the pain that I was feeling, both emotionally and physically, but for a moment I felt like I could do this and that we would all be okay.” These feelings are consistent with the literature and point to an area of improvement by all health care workers involved in the perinatal experience. Effective and compassionate communication is a significant part of providing a therapeutic care experience for emerging adults.

Courtney shared feeling removed from society and misunderstood after her loss. She wants more people to talk about loss and make pregnancy related loss less stigmatized and more socially supported. She states that she had no idea how common pregnancy losses were until she joined a support group after the loss of her twin boys. These feelings are consistent with the concept of “disenfranchised grief” previously mentioned. She stated that the name of her diagnosis, “incompetent cervix” contributed to these feelings because she felt as if her body was
to blame for the loss, which resulted in a more ambiguous and punitive loss experience. Courtney confessed that sharing her story with others, looking at her memento box provided by the hospital, and the support of her closest friends and family helped her get through the pain and made her feel stronger and more connected to the world. This concept is referred to as resilience in the literature and proves that hospital based interventions like memento boxes and language have a positive effect on grief experiences, especially in the emerging adult age group.

Each couple represents attributes that align with the theories of “emerging adulthood”. In Andrew and Ashley, the sense of “in-betweenness” both financially and emotionally and the struggle for identity point to this life stage. For Ben and Betsy, their chase for their dreams is most indicative of this stage. For Chandler and Courtney, the concepts of resilience and grief are highlighted and align with what the literature says about loss in emerging adulthood. Their experiences serve as tools that plead for more effective communication and patient-centered care during this vulnerable time.

**Recommendations For Health Care Providers**

The largest shortcoming in ideal perinatal loss care is effective communication. Largely, parents and loved ones feel confused, in the dark, and scared. This anxiety can be relieved by effective communication with patients and their families. Educators and providers should teach to look for early signs of a complication like vaginal bleeding and a decrease in fetal movement, and about the tests that they will endure if a complication should arise. Providers should equip their patients with the knowledge of what the 18 week anatomy scan encompasses as this is the ultrasound that will reveal a fetal diagnosis that may be life limiting. Most patients interpret this ultrasound as the time that they will find out the gender, thus an ultrasound that once held high expectations of a positive experience is now tainted. Patients are shocked because they were not
expecting to find out such life altering news during this “happy” time. Parents want to know what will happen to the baby’s body after delivery or other method of removal such as a D&C (Wright & Black, 2013). Communication is a large portion of healthcare and should not be ignored in obstetrics.

When an unexpected finding appears on the ultrasound, the reaction of the sonographer and the environment as a whole is less than therapeutic. Parents report a sense of uneasiness and sense that something was wrong. “She [the midwife] was very nice, it wasn’t her fault but very soon you could understand that something was wrong” (Larsson, Svalenius, Lundqvist & Dykes, 2010, p 5). Other participants in the study reported a similar feeling caused by prolonged silence and body language ques. Couples A, B and C have similar experiences that describe the ultrasound as being one of the most emotionally painful procedures and shared feelings of foreboding that something was wrong by the lack of communication and body language of providers and the prolonged time period of the scan. Betsy’s experience describes the lack of effective communication by providers, “I didn’t understand what they were saying. And the doctor, he didn’t say anything.” These experience allude to the fact that providers could improve upon therapeutic communication skills, body language awareness, and an increase in the allowance of information the sonographer can give to parents upon detection of an abnormality in efforts to reduce the negative effects of this traumatic event. If an increase in information telling is not appropriate the recommendation of a sonographer stating, “I am unsure as to what I am seeing here, let me get another set of eyes” both acknowledges the feelings of uneasiness of both the professional and the mother and creates an openness that is not as easily facilitated through silence.
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