Experiences of African American Mothers Following the Death of Their Infants

Katina Jones, Barbara S. McAlister, Barbara K. Haas & Gloria Duke

ABSTRACT

Objective: To explore the lived experiences of African American mothers after the death of their infants.

Design: Qualitative, interpretive phenomenologic study.

Setting: Northeast Louisiana.

Participants: Seven self-identified African American women whose infants died during the first year of life; the women's ages ranged from 18 to 38 years at the time of the infant's death.

Methods: Heidegger's interpretive phenomenologic approach guided the data collection and analysis. The women were interviewed using in-depth questioning to determine the meaning of the infant loss experience and their subsequent efforts to cope.

Results: Six themes represented the experiences of loss for the mothers: *Shattered Dreams*, *Questioning God*, *Dissociation*, *Paralyzing Fear*, *Left in the Dark*, and *Uniqueness of Grieving.* Three themes affected the women's efforts to cope after their loss: *Authentic Presence*, *Spiritual Empowerment*, and *Disconnectedness.*

Conclusion: African American women who experienced infant death described intense feelings of loss, guilt, and isolation. These negative emotions can potentially affect their physical and psychological health. These findings may help health care providers develop culturally sensitive understanding of African American mothers' experiences of loss and equip providers to provide holistic assessment, appropriate support, and treatment for these vulnerable women.

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KEYWORDS: African American, bereavement, disparities, grief, infant death, infant mortality, non-Hispanic Black, preterm birth

CLINICAL IMPLICATIONS

- Anticipatory social support and spiritual assessments of African American women completed during the early weeks of maternity care may be helpful in planning interventions in the event of loss.
- African American mothers reported feeling "left in the dark" during their experiences of loss and longed for clear communication from the health care team about what was happening to them and their infants.
- Members of the health care team who allow themselves to exhibit feelings of sadness at the time of infant loss provide meaningful comfort to grieving African American mothers.

Infant mortality is a public health concern in the United States, especially among non-Hispanic Black women. According to the Centers for Disease Control and Prevention (CDC, 2020), in 2018 non-Hispanic Black women experienced infant loss at a rate of 10.8 deaths per 1,000 live births compared to a rate of 4.6 for White women and ranging from 3.6 to 9.4 per 1,000 for other racial and ethnic groups. This significant disparity in rates of infant death is largely attributed to greater rates of preterm birth and low birth weight for Black infants (Riddell et al., 2017). Although several studies have documented racial disparities in infant mortality rates, non-Hispanic Black women's experiences of infant loss are not well documented in the literature. Because the participants in this study self-identified as African American women, where appropriate, the words used in this article will be consistent with the women's descriptions instead of the CDC's categories for race and ethnicity.

Loss of a child is one of the most indelible trials that humans endure. Bereaved parents experience grief more intensely than adults who experience other losses (Morris et al., 2018). Although the literature is inconsistent on whether the age of the infant at the time of death correlates specifically with the severity of the parental grief responses (Hawthorne et al., 2017), parental grief is described as intense regardless of whether it is in response to a recent or longstanding loss (Boyden et al., 2014). After her infant's death, a mother may experience depression; posttraumatic stress disorder; and increased risk for cancer, diabetes, psychiatric hospitalization, suicide, and a host of other chronic physical and psychological challenges (Snaman et al., 2016; Youngblut et al., 2013). Symptoms of depression (e.g., sadness, guilt, inability to perform day-to-day activities, and changes in eating and sleeping habits) are prevalent among both African American and White women who have experienced loss of a child. However, there are differences in how these women cope with their symptoms (Cadigan & Skinner, 2015). Before health care providers can intervene to help bereaved African American mothers cope, it is critical that they understand the women's perspectives. Therefore, the purpose of this study was to explore African American mothers' experiences with an infant's death and their subsequent attempts to manage grief.

Katina Jones, PhD, RN, is the Integrated Care Manager at Northeast Delta Human Services Authority in Bastrop, LA. **Barbara S. McAlister,** PhD, RN, CNM, is an associate professor at the University of Texas in Tyler, TX; ORCID: https://orcid.org/0000-0002-4943-8279. **Barbara K. Haas,** PhD, RN, is the Dean for the College of Nursing and Health Sciences at the University of Texas in Tyler, TX; ORCID: https://orcid.org/0000-0001-8299-2936. **Gloria Duke,** PhD, RN, is a professor at the University of Texas in Tyler, TX. **Address correspondence to: bmcalister@uttyler.edu**.

Background

Perinatal Health Disparities

Health disparities experienced by the African American population are challenging and persistent. Adverse birth outcomes, poor health behaviors, and chronic diseases are all disproportionately greater in this demographic group (Peoples & Danawi, 2015; Robbins et al., 2018). Pregnancy complications affect women of all races, but African American women are affected at a disproportionate rate (Howell et al., 2016; Leonard et al., 2019). Infant mortality is one of the most marked perinatal health disparities. Since infant mortality data began to be collected more than 100 years ago, differences in rates between some races and ethnicities have persisted, indicating that all groups in the U.S. population have not benefited equally from social and medical advances (CDC, 2011).

Causes of Infant Mortality

Congenital anomalies, disorders related to short gestation (preterm birth), low birth weight, maternal complications of pregnancy, sudden infant death syndrome, and injuries were the leading causes of infant mortality in 2018 (CDC, 2020). African American infants are disproportionately affected by each of these causes (Peoples & Danawi, 2015). Preterm birth is defined as the birth of an infant at least 3 weeks before the due date or at less than 37 weeks gestation (CDC, 2019). The risk of preterm birth for non-Hispanic Black women is approximately twice the rate seen in non-Hispanic White women, and this gap has increased throughout the last decade (Manuck, 2017). The causes for this disparity transcend sociodemographic factors alone and likely include an intricate and perplexing mix of genetics, epigenetics, and the microbiome (Manuck, 2017).

Parental Grief

Parental grief has been described as extreme, regardless of the length of time since the loss, the age of the child at the time of death, or the cause of death (Boyden et al., 2014). Losses due to stillbirth, miscarriage, or neonatal death may have a debilitating impact on a mother and are associated with posttraumatic stress, depression, anxiety, and sleeping disorders (Biaggi et al., 2016; Kersting & Wagner, 2012). Although

TABLE 1 DEMOGRAPHIC CHARACTERISTICS OF STUDY SAMPLE AT THE TIME OF LOSS

Participants (N = 7)	Age of Participant, years	Education Level	Gestation, weeks	Infant's Age (N = 8)	Reason for Death
Tiffany	27	High school graduate	22	3 days	Prematurity related
Mary	18	9th–11th grades completed	26	2 days	Prematurity related
Rose	23	Some college credit	39	5 weeks	SIDS
Jennifer	26	Bachelor's degree	27	2 days	Prematurity related
Nancy (twin A)	38	Associate's degree	25	2 weeks	Prematurity related
Nancy (twin B)			25	$2^1/_2$ weeks	Prematurity related
Kenya	28	High school graduate	37	3 months	SIDS
Amber	26	Bachelor's degree	24	2 days	Prematurity related

Note. Participants' names are pseudonyms. The mean age of participants was 26.57 years. SIDS = sudden infant death syndrome.

Cadigan and Skinner (2015) found that symptoms of depression after infant loss among African American and White women were often the same, there were differences in how they managed those symptoms and where they sought help. African American women turned to religion to deal with their feelings and sought no formal treatment with pharmacotherapy and/or psychotherapy, whereas White women were more likely to seek formal treatment (Cadigan & Skinner, 2015).

Although parents who do receive counseling are more likely to work through their grief, many African American parents do not attend support groups or seek counseling after the loss of an infant. In a qualitative study of eight young, single African American women who had incurred perinatal loss, Fenstermacher and Hupcey (2019) reported that the women were not enthusiastic about attending a bereavement support group. The women explained that beyond not wanting to keep reliving the experience, being in a group with older, married women made them feel out of place. Boyden et al. (2014) found that some women who attended support groups stated that the lack of diversity prevented them from sharing their feelings because many preferred to speak with people from their own culture. African American women who experience grief may appear apathetic and unaffected by their loss but may eventually begin to express their feelings if they can interact with someone who shares or is sensitive to their culture. Some African American mothers try coping with the loss of an infant by not communicating and attempting to move forward. Their silence is often interpreted in the African American culture as a demonstration of inner strength. However, less time spent discussing the loss can be associated with greater grief intensity; this can complicate the grieving process and lead to poorer outcomes (Boyden et al., 2014). Although studies have established risk factors and prevalence of infant loss among African American women, there is little published research on the experiences of these women.

Methods

Research Design

Hermeneutical interpretive phenomenology served as the framework for guiding this study to understand the phenomenon of infant loss "from the inside" of the participant's world (van Manen, 1990). A fundamental hermeneutical belief is that that there is more in the lived experience than can be seen; hermeneutics goes beyond describing experiences to learning the meaning of those experiences (Lopez & Willis, 2004). Because interpretive research cannot be value-free (Denzin, 1989), researchers approach the data with having some experience with or presuppositions about the phenomenon being studied (Polit & Beck, 2017). The research team consisted of a PhD student preparing a dissertation, an interpretive expert in hermeneutic phenomenology serving as the dissertation chair, and two committee members. During the conception and design phase of this study, the nurse researchers, all with experience in perinatal nursing, qualitative research, or both, acknowledged any prior assumptions about the topic (Crist & Tanner, 2003). This "fore-structure" (Heidegger, 1962, p. 194) of the research team's knowledge can help inform the interview guide, probe for in-depth experiential narratives, and interpret the meaning of the experiences.

Sample and Setting

The population for this study consisted of non-Hispanic Black women, self-identifying as African American women, who lost an infant during pregnancy or the first year of life. All the women resided in northeastern Louisiana but represented a variety of educational backgrounds. Inclusion criteria were (a) non-Hispanic Black woman, (b) 18 years of age or older, (c) self-report of death of an infant, and (d) willingness to be interviewed about experiences relating to

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> Bereaved parents experience grief more intensely than adults who experience other losses

the loss. After institutional review board approval, volunteers were recruited using flyers, bulletin board postings, church announcements, and snowballing. Recruitment flyers were distributed in African American neighborhoods and at African American churches. Interested women contacted the principal investigator (PI); appointments were scheduled at the women's convenience and at their choice of location. The PI did not have prior relationships with any of the participants. No preestablished sample size was planned because participants were recruited until a point when data saturation was achieved or when the researcher continued to hear repetitive patterns in the data (Polit & Beck, 2017). Similar patterns were perceived with six participants; a seventh was recruited to confirm that data saturation was achieved.

Data Collection

Although a series of interviews may have potentially gleaned additional meaningful data from participants, the investigators planned only one interview with each individual. This approach was deemed appropriate in view of the sensitive material being discussed. All interview sessions were held in quiet, private locations chosen by the participants. To respect the women's time and prevent potential data loss, all interviews were digitally recorded on two audio recorders. Once introductions were made, the woman's comfort was ensured, and the informed consent was explained. After consent, casual conversation was initiated to facilitate trust and relationship building.

A grand tour question was used to begin the interviews: "Tell me about the time when you lost your daughter/son." Responses to this question were followed by appropriate probes to gain an in-depth understanding of the loss of an infant for African American mothers. An interview guide developed by the PI and validated by the research team members was used to facilitate the questions covered during the interview. The PI provided nondirective prompts to prevent accidental influence of answers. Nonverbal cues and elaboration of answers encouraged participants to continue conversing during the interview process. Silence between questions was also used to allow participants time to thoughtfully reflect.

The recorded interviews ranged from 45 to 75 minutes in length. After each interview, the PI wrote detailed field notes with observations of the women's body language, behaviors, or attitudes. All recordings were securely kept in a locked box to which only the PI had access. Interviews were transcribed, stored on a password-protected computer, and analyzed by the PI before the next interview.

Data Analysis

Data analysis involved an ongoing, iterative process between data collection and analysis. Examination of the parts to the whole and the whole to the parts was done, reflecting the hermeneutical circle, a critical component of this research design (Heidegger, 1962). Preliminary data analysis occurred within 24 hours after each interview. The PI transcribed the interviews verbatim and then compared the transcribed interviews to the digital recordings for accuracy and integrity. Next, interpretive reading of transcribed interviews was done by the PI and dissertation chair to facilitate illumination of subthemes. They met regularly between interviews to review the data, expand the analysis, and identify central concepts. Data gleaned from these analyses informed the PI's approach to subsequent interviews, as recommended by Crist and Tanner (2003). Data were organized in a digital spreadsheet formulated with each interview question placed in a row followed by the correlating transcribed data. The PI identified central concerns—important meanings that were developing among participants that were ultimately labeled as subthemes. Emerging interpretations were manually coded and examined concurrently within the circular process without losing focus on each participant's story (Crist & Tanner, 2003). The PI cycled between the field notes, transcripts, reflexive thoughts, and coded subthemes to thoroughly search for additional substantive meanings (Creswell, 2014; Thomas-MacLean et al., 2005). The dissertation chair's expertise enriched the interpretation of the data ". . . through debate, brainstorming, and discussion" with the PI (Crist & Tanner, 2003, p. 203). Subthemes were grouped according to abstract similarities, and a descriptive thematic label was assigned to each cluster. Throughout the analysis process, the research team reviewed and confirmed emerging themes. After all interviews were coded, the spreadsheet was organized into three different sheets: the participants' experiences of loss, coping mechanisms after the loss, and clustered themes and subthemes.

Trustworthiness

Trustworthiness was facilitated by following established criteria (Patton, 2015). The audit trail included demographic forms, informed consents, personal and reflexive notes, transcribed interviews, and code books. Decision processes for themes were kept current and appropriately accessible for review by research team members. The dissertation committee verified that steps of the analysis process were clear (dependability). The PI obtained participant validation by returning findings to three participants to verify the accuracy and resonance with their experiences (credibility). The PI engaged a nonstakeholder person with knowledge of African American culture to read and comment on the study. The nonstakeholder and the dissertation chair agreed that the identified themes would be meaningful to individuals in clinical and public health practices (transferability).

Results

All seven participants self-identified as African American women who experienced the death of their infants. Demographic characteristics of the participants are presented in Table 1.

In response to the grand tour question, "Tell me about the time when you lost your daughter/son," the women's stories reflected six themes with subthemes that described physiologic, psychological, and emotional challenges subsequent to their experience of loss (see Box 1). Fictitious names are used in the following interview excerpts.

BOX 1 THEMES AND SUBTHEMES

Shattered Dreams
Loss on Top of Loss, Unexplainable, Etched Images, Broken Bonding/Connectedness, Emotional Attachment, Adding Insult to Injury, Perceived Susceptibility Intensifies, Bad to Worse, Agony, World Upside Down, Agonizing Times, Disappointment, Helplessness, and Bad Dream

Questioning God
Why Me?, Why My Baby?, and Guilt

Dissociation
Disbelief, Unreal, Inability to Process, Disconnection, Emotional Blocking, Emptiness, and Dazed State

Paralyzing Fear
Fear, Nervousness, Realization of Problems, and Powerlessness

Left in the Dark
Lack of Understanding

Uniqueness of Grieving
Individualized Grieving; Hurry Up and Move On; Sadness; Depressed/Crying; Inability to Sleep; Attachment to Baby Clothing, Linens, etc.; Attachment to Memories; Self-Preservation; and Preservation of Others

Themes Underlying Participants' Experiences of Infant Loss

Shattered Dreams. The most frequently made comments involved memories of having felt optimistic about being pregnant and looking forward to motherhood. Women described bonding that began while the infant was in utero, feeling fetal movement, and "anticipating meeting that person." One who had a previous miscarriage described feeling hopeful of having a successful pregnancy, but after giving birth prematurely, she experienced feelings of "loss on top of loss." Most never considered the possibility of pregnancy complications that could affect their infants. The women recalled their expectation of birthing healthy full-term infants. They shared that after going into labor early, the hopes and dreams they once possessed no longer seemed achievable. The realization of dreams being shattered became more pronounced for some women after they saw their infants for the first time. The images of the infants being connected to "all kinds of tubes" to sustain life and the fragility of their appearance substantiated the mothers' concerns. Many described these images as something they would never forget. Tiffany commented, "I was used to him being in my stomach and feeling kicks. All the good stuff was just beginning to happen. It's just a hurtful feeling and it something I'll never get over." Another mom poignantly described the shattering of her dreams:

> I would have rather not get pregnant at all than to lose him like that. I felt like I was robbed. I felt like I was robbed from being a mother, a wife . . . just robbed. When I walked out of that hospital I was a totally different person. I was not the same. . . . My life was forever changed. . . . It was hard walking into that house and seeing a nursery and having no baby to put in that beautiful mahogany baby bed. (Rose)

Questioning God. Women posed questions to God after their infants' death, indicating that these experiences caused their faith to waver. The women recalled trying to understand what caused their loss or why God allowed it to happen. Feelings of unfairness and unjustness were prevalent. They had wanted to experience being a mother and believed they were doing the right things yet had heartbreaking outcomes. These women questioned why this happened to them and why it happened to their babies. They described how unfair it felt that women who did not provide appropriate care for their children could experience what they perceived as the joys of motherhood, while they could not. Women expressed how they would cherish the experience of motherhood if they ever got another chance. Nancy indicated, "I couldn't help but thinking about my twins and questioning God. Why? I didn't do bad stuff like take drugs or smoke. Nothing. That's who I thought had babies early. I was pretty healthy. So why? Lord have mercy, why?"

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> Well, there was a time it [punishment] did cross my mind. Like, women in the world that don't take care of their kids, and I asked God how people can give their kids up for adoption or women throw their kids away in the trash. How they able to have kids and here I am. . . . I can't have one. (Tiffany)

Dissociation. Women reported often blocking their emotions after the loss by not talking to or interacting with significant others, family members, or living children. They expressed the need to limit interactions with others and not express their true feelings. Furthermore, they described feeling empty and withdrawn after losing their infants. Relationships with husbands, significant others, children, friends, and other family members often suffered, and some were unable to be reconciled. Jennifer reported that her marriage suffered after the loss of her son. Shedding tears, she shared, "My husband was so withdrawn when we finally tried move forward; I tried to be there for him. I tried so hard. We just couldn't get past it. We divorced last year." Some women described having difficulty processing or making sense of what was happening and reported feeling "in a daze."

> I felt like I was in a dream. You know how you hear people talking when you are in a pool or under water . . . like muffled and you can't make out what they are saying. I saw the doctor's lips moving and I could read his lips, but I couldn't hear him. I just heard muffled sounds. . . . I just stared at him. I felt puzzled and not sure. . . . I can't explain it. . . . I read his lips. . . . I knew he was telling me Justin didn't make it, but it did not register in my brain. (Jennifer)

Paralyzing Fear. Women described nervousness, powerlessness, and fear that ranged from just being afraid to fear that affected bodily functioning. They described being worried and afraid about giving birth so early and what it would mean for their baby's health. Some expressed a fear so intense it affected them physically, such as "shaking," "throat tightening up," and "lungs not working." Others stated fear of the unknown regarding their infant's preterm status and experiencing fear unlike any they had ever known before. Mary stated, "I was so scared. I mean, like shaking scared. I was thinking about everything. I didn't want to have surgery. I was worried about the baby making it or if something may happen to me." Rose relayed her intense fear as well, stating,

> I was shaking. I grabbed her out the bed and tried to get her to move or something. It felt like my throat was tightening up and I couldn't scream for help or breath or nothing. Finally, I screamed, and my boyfriend came in. He called 911. Even thinking about it now, makes my throat feel tight. I can't even explain it. . . . It's like I had to tell myself to breathe at first. My brain wasn't doing what it was supposed to . . . and it felt like my lungs weren't working . . . not working right.

Left in the Dark. Feelings of not being included in what was happening to their infants were frequently described. Some women indicated they were not able to see what was going on once the infant was born. Health care professionals administering treatment blocked the mothers' view of the infants, causing them to feel left out. The women also indicated not understanding the medical jargon being spoken by health care professionals regarding medical procedures and their infants' prognoses. These experiences amplified women's anxiety and stress.

> I was like, something is really wrong. I remember them rolling me to the back and turning me on my side to put medicine in my back and my legs being heavy. Then there was a curtain, so I couldn't see my stomach. They cut her out and took her to a baby bed and started doing stuff. I didn't even see her at first. Taking my baby and not telling me nothing. I couldn't see what they was doing and they was saying stuff I didn't understand. (Mary)

Uniqueness of Grieving. Participants described grieving in various ways after the loss of their infants. All of them expressed feelings of extreme sadness. One mother expressed feeling that she had to "hurry up and move on" for the purpose self-preservation and preservation of others, although she was secretly grieving intensely. She stated that she realized how her grief affected everyone else and how their lives were on hold. Her parents left their own home and came to stay; even with her parents' presence, her husband would not take business trips out of town. Some women reported experiencing insomnia and uncontrollable crying. Attachment to the infant's clothing, linens, and other items was commonly felt. One mother stated she could not pack up the infant's room and that those who were trying to get her to do so "were trying to erase" her memories. It took her a year to be able to remove those precious items.

> I could not get rid of her stuff. I remember that . . . because people thought it wasn't "healthy." [She put air quotes up when she said this.] I kept the bed up for over a year. I did not wash the bedding because I thought her scent would wash off; I wanted to just look at it. I don't know. . . . I kept all her clothes folded and even the diapers. . . . I didn't want to get rid of the bags of diapers (Rose)

Themes Underlying Coping With Infant Loss

Women described experiences, feelings, and thoughts that led to the identification of two themes related to facilitation of coping after the loss of their infants: *Authentic Presence* and *Spiritual Empowerment*. Their recollections also included interactions that interfered with attempts to cope. These instances were clustered under the theme of *Disconnectedness.*

Authentic Presence. Women described authentic presence as friends, family, church members, and health care

professionals being sincere and genuine after the loss of their infant. Authentic presence helped the mothers express how they were truly feeling. They characterized this presence as being supportive and aware of their needs without being told. The participants indicated these individuals held them, listened, or merely offered words of comfort. Most women indicated family and friends were the main source of their strength and helped them through this difficult time. Only one woman spoke of having an older child at home. She recalled not being able to cook for her 10-year-old daughter or even comb her hair. She stated, "I had to send her to live with my aunt for a while. I don't know how my daughter would have made it without family."

> Several women in our study shared that the presence of family members and health care workers whom they perceived as genuinely empathetic and compassionate provided some consolation

Women also stated that the compassion and empathy expressed by health care professionals felt sincere. They recalled health care professionals hugging them and sometimes shedding tears with them after their infants died. Tiffany recalled: "The doctors made me feel so warm and welcomed. Some nurses was crying as well and had to leave out of the room."

> The most helpful was my family being there. Even when I was not the nicest and was mad at everybody. They never got frustrated with me and never gave up. Yea that was the most helpful . . . my family not giving up on me and giving me time to heal. . . . Being patient with me. (Jennifer)

Spiritual Empowerment. Spiritual empowerment embodied prayer, reading the Bible, spiritual counseling, and interactions with pastors and preachers. Most of the participants discussed some level of spiritual guidance or faith that helped them cope with the infant's death. Prayer was predominately mentioned as something these women did to help them understand and deal with this experience. Although some participants questioned God, they realized at some point after the loss that it was through God they would be able to manage the despair and pain they were feeling. Participants spoke of spiritual counseling that helped them process the experience and begin to heal. Two women provided details about how spirituality helped them work through their grief.

> At first praying. . . . Praying to God to help me understand and help me learn how to deal with this because I felt like I didn't have anyone to talk to. Then when I turned 21 I was introduced to a pastor at a church that prayed with me and gave me spiritual counseling and he basically had to help me forgive myself; forgive myself for getting pregnant; forgive myself for doing what I thought was best; forgive myself for everything. (Mary)

> I know it doesn't seem like it and at first you don't want to hear it but remember Romans 8:28: "And we know that all things work together for good to them that love God, to them who are called according to his purpose." The Bible does not say some things will work . . . it says all things . . . and all things includes some bad things. (Kenya)

Disconnectedness. As participants reflected on conversations with various individuals around the time of their loss, they described interactions that interfered with their coping. Their expressed thoughts and feelings implied there was disconnectedness between themselves and others, represented by strained communication. The women described people not knowing what to say, saying something insensitive, or not mentioning the infant at all. They described awkward interactions with some friends and family and, at times, awkward silences. Mary recalled,

> I think my family was the least helpful because they acted like because she was a baby and was premature and that she was only here a couple of days, I didn't have a reason to mourn and be so sad. They made me feel like I wasn't looking at the bright side, but there is no bright side. She was my baby; she was a living breathing person. One of my aunties said, "God knows best and that maybe I didn't need a baby and that I could go on to college and not have my life ruined." I was so hurt by that; I didn't say it to her because we were taught not to disrespect our elders, but I wanted to tell her so bad. . . . That is crazy.

Discussion

The six themes that emerged from the interviews deepened our understanding of these women's experiences of infant loss. Women expressed intense grief that they felt unprepared to handle. Devastating emotional pain pervaded major facets of their lives, including self-perceptions, relationships, visions for the future, spiritual foundations, and physiological well-being. Berry et al. (2020) published an interpretive metasynthesis of parents' experiences of perinatal loss. Findings from five qualitative studies indicated that perinatal loss is an intricate, multifaceted phenomenon with transformative power. Although several elements of their analysis mirrored our findings, African Americans were not well represented in the synthesized studies' populations. The authors reflected on the need for further research on the experiences of loss by members of minority groups and men.

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The interviews also shed light on the women's perceptions of their attempts to cope. Previous research on coping with perinatal and pediatric death indicates that African Americans rely on religion, spirituality, and family during the grief recovery process (Boyden et al., 2014; Cadigan & Skinner, 2015; Hawthorne et al., 2017). Several women in our study shared that the presence of family members and health care workers whom they perceived as genuinely empathetic and compassionate provided some consolation. Women interviewed by Fenstermacher and Hupcey (2019) recalled similar experiences after their losses, noting that nurses, providers, support staff, and chaplains were helpful and sympathetic. They also found great comfort in their mothers, grandmothers, and other young Black women who had experienced similar losses. A few mothers in our study consistently shared that misguided, awkward, or hurtful commentary from their family members negatively affected their coping efforts, whereas mothers studied by Fenstermacher and Hupcey (2019) reported that interactions with friends and boyfriends were the most disappointing and hurtful.

> The potential for women experiencing loss to feel "left in the dark" represents a serious person-centered need that should be discussed, anticipated, and met by the health care team

Although some of the women in our study recalled questioning God and his will during the experience, they also reported that prayer and their faith ultimately provided a measure of comfort. Fenstermacher and Hupcey (2019) recounted that all their participants espoused a deep faith in God and believed that their faith would sustain them. The consistent discussion of solace from spirituality suggests the subject is replete with research potential. Women's interactions with and reactions to hospital chaplains provide one avenue for inquiry. Another potential research study could focus on spiritual support by leaders from the women's identified communities of worship. Cadigan and Skinner (2015) noted that although African American women turned to religion to manage their feelings, White women were more likely to seek formal treatment. Results from this study of African American women support Cadigan and Skinner's findings as none of the mothers in our study sought professional assistance for managing their grief.

The current literature and our findings suggest that much is still unknown about bereavement support groups and their potential to assist grieving women. African American parents may find it difficult to share their experiences in groups that have few or no other parents from their race or culture (Boyden et al., 2014). The women described by Boyden et al. who had attended support groups stated that lack of diversity hindered them from discussing their feelings because they preferred speaking with someone of their culture. None of the women we interviewed attended support groups. Two indicated their decision to not participate in support groups or to seek formal treatment was due to them "not being ready to talk" and being "uncomfortable" talking to someone unfamiliar to them. Another woman indicated that she did not seek assistance from support groups because she had difficulty talking about her emotions and did not know how to express her feelings, not because of lack of diversity in the group. These perspectives are consistent with those of the bereaved women in Fenstermacher and Hupcey's (2019) study. A few of the participants attended a support group and reported that it was not helpful. One expressed a desire to move on, and another suggested that being sad, depressed, and uncomfortable made a support group not seem like a good idea. The issue of level of acceptance of group support being tied to race and culture is interesting, perhaps crucial, and warrants further research.

Strengths and Limitations

A strength of this study is the focus on African American women from diverse educational backgrounds. Although disproportionately affected by infant mortality, these women and their families are an understudied population after infant loss. The Heideggerian, interpretive approach in this study allowed participants to describe interactions, relationships to others, experiences of the body, and experiences of time so that the lived experience could be placed in the context of their daily lives. The shared rural hometown setting for all the women who participated is a limitation. Per the phenomenologic perspective, the space in which a person lives influences them (Tuohy et al., 2013). Therefore, the experiences of loss for women in rural areas may vary from those of women in urban and suburban areas.

Implications for Practice

Nurses and other health care providers can keep the six identified themes of loss for African American women in mind when planning for their bereavement care. The theme of *Left in the Dark* is heartbreaking, but fortunately it is amenable to improvement. Nurses and other health care providers can play an integral role in preventing or at least minimizing those frightening experiences. Eliminating technical jargon and providing clear communication about what is transpiring may ease those overwhelming moments of loss. The potential for women experiencing loss to feel "left in the dark" represents a serious person-centered need that should be discussed, anticipated, and met by the health care team.

It is still appropriate to offer counseling at the time of discharge and at the postpartum visit, even though some mothers may be hesitant to use such help. It may be even more appropriate for health care providers to acknowledge this lack of willingness to seek assistance and give women, especially in the presence of their family, permission to seek professional help.

Based on limited available research, referrals should be made to African American mental health professionals if they are accessible. Health care providers who routinely care for these women should anticipate the potential need for racially and culturally homogenous social support groups and ideally retain a relatable professional to lead those groups. The dissociation and disconnectedness that the women reported suggest that intentional gestures of caring should be extended at regular intervals after the loss. Perhaps active support from the health care team should persist after the postpartum visit. Phone calls or handwritten notes could easily be provided with a minimal investment of time and money by a nurse involved in the woman's prenatal care as well as a nurse who was present at the time of birth. Gentle reminders about the availability of grief support services could be incorporated into those communications. Anticipatory social support assessment and spiritual assessment completed during the early weeks of maternity care may be helpful in planning interventions in the event of loss. Until research suggests best practices for helping African American women optimally cope with infant death, inferences from the limited available research, common sense, and compassion should guide those of us committed to serving these women.

The obvious research priority is quelling the crisis of preterm birth and subsequent loss of non-Hispanic Black infants. Although researchers pursue mechanisms to ameliorate the associated racial/ethnic disparities, health care professionals, sociologists, and psychologists should pursue interprofessional collaborations to create, pilot, and research options to help these vulnerable women process their grief on a journey toward healing.

Conclusion

Emotional, physiologic, and interpersonal turmoil in the aftermath of an infant's death transcends demographic labels. Although the loss of an infant is a traumatic event for any mother, because of the disproportionate rates of infant mortality in the African American community, women's health care providers should be cognizant of these mothers' perspectives. This study provides insights that may help health care professionals proactively support these mothers through their grief, improving health outcomes for the women, their families, and any future children.

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