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Exploring Parent Experience of Communication about Therapeutic Hypothermia in the Neonatal Intensive Care Unit

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Abstract

Background—The unique communication challenges faced by parents of infants undergoing therapeutic hypothermia have not been well characterized.

Purpose—To develop awareness of communication challenges experienced by families of infants treated with therapeutic hypothermia.

Methods—Semi-structured interviews were conducted in a group setting with parents matched into groups according to the severity of the infant's presenting encephalopathy. The interviews were transcribed and coded into principal and additional sub-themes.

Results—Thirty adults were interviewed including 15 mothers, 12 fathers, two grandmothers and one grandfather. The 15 infants were between two and 24 months at the time of the interviews. The principal theme of communication included the following three subthemes; transparency, consistency and delivery style. Parents reported a strong desire for improved early and transparent communication about therapeutic hypothermia, particularly during transfer from an outside hospital. Parents also reported a preference for consistent communication and highlighted parental touch of the hypothermic infant, obstetrical nurse to NICU nurse communication and parent and visitor presence in the infant's room as areas in need of greater communication consistency. Parents valued direct and compassionate communication styles that excluded medical jargon.

Implications for Practice—All providers can implement recommendations for communication to parents of infants treated with therapeutic hypothermia by increasing transparency, developing greater consistency in the communication delivered and employing a direct and compassionate style to improve the parental experience of therapeutic hypothermia.

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Implications for Research—Further investigation is needed into the specific challenges parents face with a lack of transparent communication prior to the transfer of an infant for therapeutic hypothermia.

Keywords

communication; therapeutic hypothermia; parent experience; transparency; consistency; delivery style; neonatal encephalopathy; traumatic birth

Hypoxic ischemic encephalopathy (HIE) is a condition that occurs in newborn infants due to deprivation of oxygen and glucose rich blood flow to the brain.¹ Mortality from HIE is estimated to be 15–20% and 25% of survivors experience significant morbidity.² Until recently, infants suspected of having HIE were treated with supportive care alone as there were no known effective therapeutic interventions. Approximately ten years ago however, treatment options dramatically changed with the introduction of therapeutic hypothermia, a novel therapy which involves decreasing the infant's body temperature to 33.5°C for 72 hours to provide neuroprotection.

The early safety studies of therapeutic hypothermia were published in the late 1990's and the results of the first efficacy trials in 2005^{3–5} catapulted this therapy from the research arena into the mainstream. While there have been numerous publications about the positive impact on the outcomes from this intervention, there is only a limited body of work describing the psychological implications of this treatment on parents and providers. Ten parents of infants treated with therapeutic hypothermia in Sweden described the emotional challenges associated with therapeutic hypothermia and cited nurses as a major source of support.⁶ Another study of 20 parents of infants treated with therapeutic hypothermia in the United States described fragmented communication about this complex therapy with an uncertain prognosis as a major challenge.⁷ At our own institution we surveyed nurses involved in providing therapeutic hypothermia to infants and they highlighted emotional challenges faced by parents including concerns around the use of morphine, lack of adequate parent education about therapeutic hypothermia, and parents not being able to bond with their infant normally through feeding and holding in the first days of life.⁸ The goal of this study was to develop a more in depth understanding of the parental experience of communication about therapeutic hypothermia with aspirations for future improvements in the delivery of family centered care.

Methods

This was an exploratory, qualitative study on the experiences of parents of infants treated with therapeutic hypothermia in a 51-bed Level III Neonatal Intensive Care Unit (NICU) at a single tertiary care center in the Northeastern United States. The principal investigator is an attending neonatal and pediatric neurologist with an extensive background in use of therapeutic hypothermia. The research team consisted of two child psychiatry fellows, one NICU social worker and a NICU nurse.

Sample

A convenience sample of parents of infants treated with therapeutic hypothermia was selected from an existing hypothermia database (2013–2015). To maximize diversity, parents of different ages, socio-economic and educational backgrounds were asked to participate. Parents were included if therapeutic hypothermia had been performed in the 24 months prior to the study initiation and if they lived in a 100-mile radius of the hospital. Parents were excluded if they did not speak English or if their infant did not survive therapeutic hypothermia. Parents were contacted by phone by a member of the research team and the study was described to them. If they opted to participate, the group interview was scheduled. At the start of the interview, parents were each asked to sign an informed consent document. This study received approval by the local institutional review board.

Interview

Participants in each group were matched based on the severity of the presenting neonatal encephalopathy according to Sarnat criteria, a clinical classification developed to distinguish mild, moderate and severe forms of neonatal encephalopathy and prognosticate outcomes.⁹ Parents were interviewed by a child psychiatry fellow (C.J. or R.G.) and a social worker (J.B.), none of whom provided direct care to the child or parent during the NICU admission for therapeutic hypothermia. Interviews were held in a group setting with the parents of three children present at each session. Interviews typically lasted about 90 to 120 minutes and were conducted using an open-ended question approach. Parents were asked a series of questions targeting various aspects of their experiences. Examples of questions include “Please tell us about your experience in the NICU” and “Please tell us about your experience of your baby being transported” (Supplemental Digital Content. Table 5). Parents were provided with dinner during the session and a \$100 gift card/gas voucher to thank them for traveling to participate. Upon conclusion of the interview, parents were provided with resources for emotional and psychiatric support. Parents were contacted by an investigator (C.J. or R.G.) within 48 hours of the interview to assess need for additional support. The interviews were recorded and transcribed verbatim.

Demographic data

Clinical characteristics about the mothers and infants were manually extracted by a research coordinator from the electronic medical record and entered into the hypothermia database from which the cases were extracted.

Data analysis

Descriptive frequencies of quantitative data for Table 1 were generated using R software.¹⁰ A qualitative analysis was performed using an inductive approach with thematic saturation achieved after the first four focus groups (24 parents). Twenty-two of these were parents of infants transferred from an outside hospital for therapeutic hypothermia. A fifth focus group was therefore held specifically to interview parents of infants born within our institution to assess whether or not there were differences in the experiences of inborn versus outborn babies. Four investigators, from separate backgrounds including child psychiatry, NICU nursing, social work and neonatal neurology (R.G., S.E., J.B. and A.C.) independently read

the transcribed interviews multiple times and met as a group to develop predominant themes. Using a commercially available software program, MAXQDA, each manuscript was individually coded by the four investigators for the four major themes. The four investigators then met again and developed sub-themes within the principal themes. The four investigators then independently coded the sub-themes and then met five more times, once for each interview session, to review the entirety of each manuscript and to resolve differences in the coding of both the principal and sub-themes.

Results

The parents and grandparents of 15 infants participated in five interview sessions (relatives of three children present at each interview). Table 1 describes the characteristics and clinical course of the infants. In total, 30 adults were interviewed including 15 mothers, 12 fathers, two grandmothers and one grandfather. Grandparents were in attendance when there was no direct involvement of the infant's biological father at the time of therapeutic hypothermia treatment. At the time of the interviews, the infants were between two months and two years old. Principal themes of the interviews were identified as communication, managing expectations, emotional experiences and supportive or healing experiences. The communication theme and its three subthemes including transparency, consistency and delivery style are discussed in this manuscript.

Transparency

Transparent communication, for the purpose of coding, was defined as communication that was clear and direct and included features of openness on the part of the provider that engendered parent trust. Parents reported many examples of excellence in transparent communication (Table 2). Overwhelmingly, parents reported a positive experience with daily bedside rounds and felt encouraged to participate and to ask questions. Parents commented positively on physicians and nurses standing at the bedside and explaining the devices attached to the baby. Parents appreciated the electroencephalogram (EEG) updates regarding changes in the prior 24 hours and when nurses at the bedside provided the family with frequent updates (e.g. that baby passed first meconium or CPAP was weaned) or when nurses explained the big picture to extended family members thereby removing the burden of this from the parent.

Parents also reported many examples where transparency in communication could be improved (Table 2). Experiences at outside hospitals prior to transport were described as times in which parents often had inadequate information. One mother delivered her son under general anesthesia due to a complication from an epidural and woke up two hours later expecting to see and hold him. The baby was in the newborn nursery following his resuscitation (a word which both parents recalled having difficulty hearing for the first time). Then due to a desaturation episode prompting concern for seizure, he was transferred for therapeutic hypothermia, a treatment which his mother "had just never heard of before". Lack of information at the outside hospital was attributed by parents to provider inexperience with therapeutic hypothermia treatment. This situation often improved with the

arrival of the transport team with one parent reporting that the transport nurse practitioner in charge of the team “in five minutes...had us up to speed and we felt really comfortable”.

Issues with transparent communication were also present at the tertiary center (Table 2). Parents reported feeling overwhelmed at times with too much information and were internally conflicted about both the necessity of getting this information and simultaneously dealing with the emotional load of the information provided. Some parents reported inadequate information on the night hypothermia was initiated. Specific issues included lack of clarity around the timeline of therapeutic hypothermia with some parents not initially aware that the treatment was 72 hours in duration, some not aware that the rewarming phase occurred over 12 hours and others thinking they could take the child home upon completion of rewarming, “I was under the impression that we’re going home at the end of this 12 hour [rewarming] period.” Other technical oversights in communication included families thinking that their babies were actually frozen due to lack of awareness that the goal temperature of 33.5° was measured in Centigrade not Fahrenheit. Many parents had only a vague understanding about the purpose of therapeutic hypothermia saying things like cooling a baby keeps the brain from swelling or it works in the same way icing an injury works, but few had any comprehension of the specifics of why their infant met inclusion criteria for therapeutic hypothermia treatment. Several parents reported a desire to have a more in depth understanding of why therapeutic hypothermia was implemented and some even suggested a written brochure would be beneficial.

Consistency

Consistent communication, for the purpose of coding, was defined as occurring when multiple members of the treatment team provided parents with the same or at least similar information about various aspects of the therapeutic hypothermia treatment and the infant status. Parents were most positive about consistent communication when the nursing team was the same for several days in a row, “[RN name] was with us for five or six straight days...so we had a lot of continuity in care which was awesome; it really made things easier on us.” Another parent commented on the emotional connection with the baby that was facilitated by the information the NICU nurse shared about the baby’s progress, “It was pretty awesome you know how much they would tell us about ...everything that he was doing ...and just make us feel a part of the process of him getting better and really making us feel connected to him which was great”.

Parents reported challenges with consistent communication in three primary areas including parental touch of the cooled infant, obstetrical nurse to NICU nurse communication and parent and visitor presence in the infant’s room (Table 3). Parents who were not lucky enough to have several day/night shifts of the same team of nurses caring for their baby experienced confusion when one nurse would for instance let them stroke the infant’s leg and then under the care of a different nurse, they would not be permitted to do the same. One parent commented that the lack of consistency between nurses was a clear indication that they were not communicating well with each other “They [nurses] all have different opinions...I had one... let me change the diaper and there was another that came in right after and said, no, no, no you can’t do that... You know they’re not communicating”. Lack of

communication between the NICU nurse and the mother's obstetrical nurse was also commented upon. Another area of inconsistent information was the number of visitors allowed in the infant's room at a given time with some nurses being more liberal with more than two or three visitors at a time than other nurses. One parent reported significant emotional distress at being told that her infant was being overstimulated when she did not see or appreciate evidence of this.

Delivery Style

Delivery style, for the purpose of coding, was defined as elements of communication not necessarily involving the actual spoken content of the communication, but the manner in which information was conveyed involving aspects such as body language, demonstration of empathy and willingness to spend additional time with families. Delivery styles that were commented on positively were ones in which providers expressed compassion (Table 4). Parents were also receptive to providers who made extra efforts to explain things, "We always felt the most excited on the days that we saw [doctor] because we felt that she truly cared about us, about what was going on and tried her best to give us any kind of information she had".

Parents described a difference between their perception of the competence of their providers and their ability to deliver information effectively, "Certainly the doctors here are very, very smart. I'm not trying to knock their intelligence at all, but I think smarts and bedside manner are two different things and sometimes doctors don't have both". One parent noted that lack of eye contact from a provider made it harder to hear the news being shared and another parent commented on the medical jargon used in rounds which made it hard to understand, "You know they talk in doctor lingo...what she's on and amounts of stuff...[rounding team would turn to leave room] then we're like, hey well, now what? And they'd...turn around; we're like hey wait you know, like what about us? And I think that was probably the hardest thing..." Another parent reported being taken aback finding out from a physician that they were now "out of the woods" when it had never been made clear to him/her that they were in the woods in the first place. This parent regretted the "extremely flippant" communication style of that provider.

Timeliness of conveying information is also important to parents with a focus on early communication "It is going to be hard no matter when you tell me...So just tell me from the beginning". After a challenging delivery, a mother was concerned that her obstetrician did not come speak to her about the delivery in a timely fashion and this made her suspicious. Overwhelmingly parents reported a desire for and an appreciation of a direct and honest communication style that empowers them as the parent and the decision maker.

Discussion

Transparent communication is inherently challenging due to the complexity of therapeutic hypothermia treatment and the uncertain prognosis for the infant. Parents responded positively to the opportunity to participate in bedside rounds and to all providers who took the time to review the function of all the machines monitoring the baby. Parents report

several areas for improvement including better explanations of therapeutic hypothermia from the outside hospital at the time of transport as well as better clarification of the timeline and other specifics about therapeutic hypothermia treatment which several suggested may best be achieved through a written brochure.

Consistent communication is challenging due to the large number of providers with varying roles who are involved in the care of the mother and infant and this issue is magnified for the majority of patients who are transferred from outlying hospitals for therapeutic hypothermia treatment. Communication was perceived most positively when the same nurse team cared for the baby for several days at a time. Parents reported feeling involved in the infant's care and that this improved their sense of connection with their baby. There were three main areas for improved consistency in communication including parental touch of the cooled infant, obstetrical nurse to NICU nurse communication and parent and visitor presence in the infant's room. It is likely that many NICU's have existing protocols addressing these issues, however improving consistency in their implementation may be beneficial.

Delivery style can be challenging for providers given time constraints in busy NICU's, differing levels of provider expertise at conveying challenging information and parents' heightened state of stress and fear. Overwhelmingly parents express a desire to be told what is happening to their infant in a timely fashion with compassionate and non-medicalized language. Parents shared that they can rapidly become suspicious in the absence of clear communication.

This research identified several specific areas within the overarching theme of communication upon which clinicians can focus in order to improve the parent experience of therapeutic hypothermia. These include the following;

1. Extend the principles of family engagement in rounds to the outlying hospital at the time of transport.
2. Provide parents with written information that explains why therapeutic hypothermia is used, outlines the typical course of treatment (72 hours for hypothermia and 12 hours for rewarming) and describes the expected course of the hospitalization after therapeutic hypothermia is completed.
3. Provide as much continuity in NICU nursing care as possible.
4. Develop communication expectations between the NICU nurse and the obstetrical nurse.
5. Develop or implement existing policies consistently surrounding parental touch of the infant during therapeutic hypothermia and the number of visitors allowed into the infant's room.
6. Avoid unnecessary medical jargon when communicating with families.
7. Communicate with parents in a direct, honest and compassionate style in as timely a manner as possible presenting a spectrum of possible outcomes.

These recommendations are similar to some of the 11 themes that were described in a review article on NICU care for all infants. The 11 themes included providing parents with assurance, caring, communication, consistent information, education, environment, follow-up care, pain management, participation, proximity, and support.¹¹ The themes from our study were also similar to the those suggested by Lemmon et al specifically for therapeutic hypothermia parents which included improving community providers knowledge of therapeutic hypothermia, leveraging technology to give mothers at outlying hospitals access to information, provide written materials to parents about therapeutic hypothermia, provide consistency in nursing and explanations that incorporate a best case/worst case approach.⁷

Communication concerns are not specific to the NICU in which this research was done. In a recent written survey of parents of infants treated with therapeutic hypothermia in the United Kingdom, a need for improved communication was highlighted.¹² Sixty-one percent of parents felt they lacked adequate understanding of the reason for therapeutic hypothermia, 71% reported needing higher quality communication and 48% desired an increased frequency of communication. Communication concerns are also not specific to parents of infants treated with therapeutic hypothermia. In 2009, a literature review of the information and communication needs of all parents in the NICU, many similar sentiments to those of our therapeutic hypothermia parents were described.¹³ Communication was considered optimal when parents were informed in an honest and open manner with humility on the part of the provider. Parents reported a wish to have detailed information imparted in understandable terms as did the parents in the study by Lemmon et al.⁷ The sentiment of mistrust in the context of limited or confusing information was also articulated in prior publication in which providers at outlying hospitals had limited expertise about the therapeutic hypothermia intervention.⁷ The findings in our study echo the sentiments of both of these publications. It has been clearly demonstrated in the preterm population that quality provider communication to parents can reduce parental stress¹⁴ thereby facilitating bonding and it is very likely that similar principles apply to the term population of infants treated with therapeutic hypothermia.

A major strength of this project was that the interviews were conducted by individuals who were not members of the maternal or infant care teams. This allowed families to speak freely of their experiences and the group setting permitted families to develop themes in discussion with other parents who had infants that were of similar encephalopathy severity at presentation. The interview questions were open-ended and the interviews were conducted on the largest cohort of parents reported thus far in the literature with the greatest participation of fathers. Recall bias is a potential threat to the validity of this study, however, we tried to ameliorate this threat by recruiting patients who had been treated with hypothermia no more than 2 years prior to the interview. Six (40%) of the infants were less than or equal to six months of age at the time of the parent interview. As we were asking general questions about parent's experiences, rather than specific questions about treatment, we feel that the sentiments expressed by parents were genuine and reflected similarities amongst most of those interviewed. Prior publications have included parents of infants who were much older; 38 months⁷ in one and up to five years in another.¹⁵ An additional strength of this study was that the coding was performed by four individuals each representing different backgrounds including social work, psychiatry, NICU nursing and neonatal

neurology. Meticulous and time-consuming efforts were made to develop and implement the coding system and resolve conflicts between coders.

Weaknesses of this project include that parental responses reflect experiences of therapeutic hypothermia at a single institution in a small rural state and may not be transferable or generalizable to other institutions or states. While the group interview setting allowed families to develop certain themes together, it is also possible that the discussion could have been driven by parents with strong feelings about particular issues and others may not have shared their own experiences and opinions if they differed from their more vocal peers. Methodologically, trustworthiness of the data was not formally assessed through a process of member checking or triangulation.

Conclusion

Parents of infants treated with therapeutic hypothermia have a uniquely stressful NICU experience and parents report that transparent, consistent and timely provider communication improves this otherwise challenging situation. Our research highlights that parents want to be told exactly what is going on with their infant in a compassionate style and that they would benefit from written information about therapeutic hypothermia. Parents desire continuity in the nursing care of their infant and need consistent policies surrounding infant touch and visitors. Written materials for parents and education for providers at outlying hospitals would help to alleviate some of the misinformation that can surround this relatively novel intervention.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations

TH	Therapeutic hypothermia
NICU	Neonatal Intensive Care Unit
MRI	Magnetic resonance imaging
EEG	electroencephalogram

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What this Study Adds

- Similar to parents of other infants in the NICU, parents of infants treated with therapeutic hypothermia wish to have transparent, consistent and compassionate communication about the care their infant is being given.
- Parents of infants who are transported from outlying hospitals for therapeutic hypothermia may be at an elevated risk for inconsistent communication related to provider inexperience with the intervention.
- Parents report that consistent and compassionate communication fostered a sense of connection with their infant.

What we know

- Parents of infants treated with therapeutic hypothermia are exposed to a unique set of stressors in the NICU.
- Communication between providers and parents in the NICU can benefit from a focus on transparency, consistency and a direct and compassionate delivery style that limits medical jargon as much as possible.

What needs to be studied

- Further research may consider the effect of communication in the NICU on parental participation in the care of the infant and subsequent bonding.
- Research may also consider ways in which to improve the communication about therapeutic hypothermia at the time of transfer for infants delivered at outlying hospitals.

What can we do today?

- Efforts can be made to provide families with continuity in nursing care during the days of therapeutic hypothermia and rewarming.
- Providers can conscientiously decrease the use of medical jargon and continue to welcome families into medical rounds.
- Written materials about therapeutic hypothermia can be developed and provided to families at the time of transport or when therapeutic hypothermia is initiated.

Table 1

Maternal and infant characteristics

	Characteristics	N=15
MATERNAL	Prima gravida, N (%)	8 (53%)
	Mean Maternal Age in years (SD)	29 (5.7)
	Number delivered by C-section, N (%)	7 (47%)
INFANT	Mean Gestational Age in weeks (SD)	40.0 (1.3)
	Mean Birthweight in kg (SD)	3.70 (0.6)
	Male, N (%)	11 (73%)
	Mean 1 minute Apgar	1.3
	Mean 5 minute Apgar	3.7
	Mean 10 minute Apgar [*]	5.2 [*]
	Transferred from outside hospital, N (%)	11 (73%)
	Number intubated, N (%)	11 (73%)
	Number with seizures, N (%)	8 (53%)
	Abnormal MRI anticipated to effect motor outcome, N (%)	4 (27%)
	NOT orally feeding at discharge, N (%)	2 (13%)
	Mean Length of Stay in days (SD)	12.3 (5.5)
	Normal neurological exam 12 months, N (%)	13 (87%)

^{*} N=14 for 10 minute Apgar score

Table 2

Quotes illustrating aspects of transparent communication

Quote	
POSITIVE	<p>[the doctors] “always asked me, ‘Do you understand what we are saying? Do you need help with anything?’</p> <p>[the doctor would] “come in and she explained what all the machines were, she told me what was going on. Because...when you’re in a room and you see your kid hooked up to wires and have no idea what any of the computers are, it’s freaky”.</p>
NEGATIVE	<p>“I feel like we were not really in the loop”</p> <p>“Maybe it’s because [OSH] doesn’t have the same background in [TH] and that’s why everybody gets transported here. I was trying to ask questions about it [TH] and the nurse just kind of didn’t know how to answer my questions.”</p> <p>“I’m a strong person...don’t sugar coat things but I guess at that point, I probably wasn’t ready to hear that my son could die in the next couple of days”.</p> <p>“We just weren’t really getting any answers or anything right up front and I think that would be huge to sit down and say like look, this is going to be a process...I think you need to talk to someone ...that totally understands what’s going on”</p> <p>“[parents need a]...more comprehensive kind of overview of what it [TH] is...and what the purpose is...what the actual progress is...at the outset would be nice”.</p> <p>“They could just bring a little booklet that says this is what you’re going through and give you the Cliff Notes verbally and then happy reading. I mean that...would’ve helped”.</p> <p>“I don’t remember the 3 day thing.”</p> <p>“I don’t know if I knew what period of time it was going to be”</p>

Table 3

Quotes illustrating aspects of consistent communication

Quote	
POSITIVE	<p>“for the first 2 weeks, we had roughly the same; there was maybe 3 or 4 nurses which got to know us, they got to know [baby name]; it was really comforting”.</p>
NEGATIVE	<p>“We could barely touch her. The nurses would say no stimulation. Some would say you can touch her but don’t talk to her. ... Other days we would come in and we would have somebody...[different]... that would tell us what was going on and go ahead and touch her”.</p> <p>“They yelled at me...they were like...[name] you need to stop rubbing his foot. I didn’t even realize I was doing it...but he was cold”.</p> <p>“My nurses [OB nurses] I don’t think really had a clue about anything that he [baby] was going through”</p> <p>“...the nurses that were taking care of me didn’t have any real knowledge about the baby and I guess maybe they don’t need to but they might, a couple of them might’ve offhanded asked, how is your son doing, but it would’ve been nice ...if they had a way to have updates or something.”</p> <p>“[grandfather] was just talking to him [the baby] and one nurse came in and just said, I think he’s being overstimulated right now...and this is too much for him...and I [mother] was kind of taken aback and I just looked at her and said, so should I go? And she said ok. And I was very, very upset...It was very hurtful”.</p>

Table 4

Quotes illustrating aspects of delivery style

	Quote
POSITIVE	<p>“the nurse was explaining in a very kind way that the more you touch him, the more we have to make him cold which means the more he’s going to shiver, which means the more we have to go up on his morphine. So even though it was really hard to hear, I think it justified it a bit in my brain, Like okay, so instead of just, don’t touch him; it’ll make him warm...I know it’s just words... but...it justified it a little bit for me”.</p> <p>“she’s [doctor] talking to you like a person, not like your, like your baby’s just a patient and you’re just people that she’s trying to get through an explanation with”.</p> <p>“I feel like as hard as it is, being totally honest and upfront, I think is probably the biggest piece”</p>
NEGATIVE	<p>“we took it a lot harder because it was like there was no eye contact ...explain to us what’s going on. Like what do you mean she stopped breathing?”</p> <p>“I mean you had to ask questions...there were times where you would have to stop them as they were starting to walk out the door...”</p> <p>‘After he was born, I didn’t really see her [OB] so that concerned me, made me worry, like are you, why are you staying away from me right now; did you do something; is there something I need to know; ...I never saw her again and she didn’t explain anything to me...”</p>