
**PEDIATRIC INTENSIVE CARE NURSES
AND THEIR GRIEF EXPERIENCES**

by

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This thesis is in memory of all the children, for whom I have cared, who have died and in memory of their courageous parents who allowed me to share in their lives for a brief period. I believe I am a better person because of them. It is also dedicated to the intensive care nurses with whom I have had the privilege to work over the years. It has been their warmth, caring, and compassion that has helped me get through the tough times and made going to work a joy.

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ABSTRACT

While the phenomenon of grief has received considerable attention and has been researched at length, there is a paucity of literature that has focused on health care professionals' experience of grief. The purpose of this study was to investigate the grief experience of pediatric intensive care nurses when their patients die.

A phenomenological method was used in this study in order to obtain rich descriptions of nurses' experience of grief within their workplace. The purposive sample consisted of six registered nurses employed in an intensive care unit in a university-teaching pediatric hospital. In-depth, semi-structured interviews were conducted with the study participants in order to generate the data base. The audio-taped interviews were transcribed and analyzed for recurring themes emerging from the data according to the procedure outlined by Colaizzi. These nurses acknowledged they suffered multiple exposures to children's deaths and experienced grief. The interviews revealed eight themes that included one about their grief responses - hurting; two that described the influencing contextual factors - nurse-family unit relationship and dissonance; and five that related to coping strategies employed to manage their feelings of grief - self expression, self nurturance, termination of relationship activities, engaging in control taking activities, and self reflection. Further analysis revealed that managing grief effectively was an experiential learning process for the participants. The resultant themes were compared with the broader literature on grieving the loss of a significant other, grief and the health care professional, and the literature that addressed issues of occupational stress in the care of the critically ill, the dying, and the bereaved. The findings of this study could encourage further research that examines interventions designed to enhance the type of education and support needed in relation to the grief experience of nurses.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	.....	i
ABSTRACT	.....	ii
TABLE OF CONTENTS	.....	iii
LIST OF APPENDICES	.....	vii
LIST OF TABLES	.....	viii
DEBBIE	.....	ix
 CHAPTER 1		
Background to Study	.....	1
Purpose of Study	.....	4
 CHAPTER 2 Review of Literature		
Introduction	.....	5
Concept of Grief	.....	5
The Grief Process	.....	8
Common Reactions Associated With Grief	.....	10
Influential Contextual Factors	.....	12
Loss Outcomes	.....	17
Nurses' Grief Responses	.....	18
Intensive Care Nurses' Grief Responses	.....	20
Grief and Other Health Care Professionals	.....	23
Summary	.....	28
Research Questions	.....	30

CHAPTER 3 Methodology

Research Design	31
Methodological Assumptions	33
Setting	33
Sample	36
Eligibility Criteria	37
Method	38
Data Collection Procedure	
Pilot Study	39
Main Study	40
Characteristics of Participants	
Pilot Study	43
Main Study	43
Data Analysis	45
Enhancing Methodological Rigor	47
Ethics and Human Rights	49

CHAPTER 4 Participants' Accounts - Findings and Discussion

Introduction	51
Pediatric Intensive Care Nurses' Grief - An Overview	51
Section 1: Background	
1.1 Decisions to work with children	59
1.2 Decisions to work in intensive care	60
1.3 Critically ill children	61
1.4 The ethos of pediatric intensive care nursing	62
1.5 Rewards of working in pediatric intensive care	66

CHAPTER 4 Continued

Section 2: How Nurses React To The Death Of A Child

Theme of Hurting - An Overview	68
Sadness	74
A sense of death process accountability	77
Anger	83
Feelings of emptiness	86
A sense of powerlessness	86
Feelings of vulnerability	91
Crying	94
Physical expressions of hurting	98
Energy depletion	99
Impatience	100

Section 3: Contextual Factors That Influence The Nurses' Grief Responses

3.1 An Overview	101
3.2 Theme - The Nature of the Nurse-Family Unit Relationship	105
Sharing the lived experience of grief	108
The emotionally involved relationship	117
3.3 Theme - Dissonance	125
Personal dissonance	127
Interpersonal dissonance	135

Section 4: Coping With The Grief

4.1 An Overview	143
4.2 Theme - Self Expression	145
4.3 Theme - Self Nurturance	152
4.4 Theme - Termination of Relationship Activities	153

CHAPTER 4 Continued

4.5	Theme - Engaging in Control Taking Behaviors	157
	Establishing boundaries	157
	Distancing	161
	Fulfilling personal bereavement rituals	164
4.6	Theme - Self Reflection	167
	Coming to terms with children's deaths	173
	Finding meaning- children's deaths are not in vain	176
	Accepting grief	181

CHAPTER 5 Conclusions

5.1	Summary	184
5.2	Study Limitations	186
5.3	Recommendations and Implications for Nursing Practice	187
	Implications for educator role	188
	Implications for practitioner role	190
	Implications for consultant role	193
	Implications for researcher role	195
5.4	Directions for Further Research	196
5.5	Ending	198

REFERENCES	201
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APPENDICES	211
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LIST OF APPENDICES

A.	Trigger Questions for Semi-Structured Interviews	211
B.	Letter of Information for Research Study	213
C.	Consent Form	215

LIST OF TABLES

Table 1. Description of Informants - Pilot Study	44
Table 2. Description of Informants - Main Study	45

Debbie

What were you doing ... out so late ... and all alone?

Were you drinking? ... Were you on drugs?

Did you even know what happened? ...

It is now four days since you came to our unit ... head injury, unconscious, lifeless.

Tonight I am your nurse ...

You are so young, your body so lovely, so healthy ...

your head so bruised.

You shouldn't be here, Debbie, lying so still ... so broken ...

You're only 19 ...

I am so afraid ... of the responsibility ... of being your nurse ...

and of being touched by the fragile thread that is your hold on

life. Can you hear me? I talk and even sing to you, in the dark as

I move around ... checking ... charting ... caring ... Can you

feel me touch you? with my hands ... with my heart ...

Did you see your mother? ... hear her cry ... Her face paled, knees

buckled when she saw you. And your brother, too young to bear

such grief, circled her waist with his arms and held her up.

Watching and sensing the anguish, I felt my heart in my mouth ...

saw one of my own daughters ... lying ... like you ... myself in your

mother's place ... and I was terrified.

You died soon after ... I knew you would ... and I felt helpless ...

bitter ... and then so very hopeless ... Did it matter ... what I did?

that I was there? ... that I cared? ...

At home I cried ... laid awake, alone at night, and wondered at the

pain I felt. I thought about quitting ... never going back ...

to face again the sorrow of such suffering.

Sometimes it hurts so much to care ... to reach out ...

I never really knew in the beginning, how much it would take ...

to be a nurse.

Margaret Fenton, Winnipeg, Manitoba [as cited in Benner, P. & Wrubel, J. (1989) p. 376-377]

CHAPTER 1

Background To The Study

Introduction

My Story - The Death of Billy (a fictitious story based on true life events)

The sound of machinery labors to keep alive an almost lifeless human form. Complicated-looking equipment surrounds the individual and creates an intimidating picture. Tubes, IV bottles, wires, collection bottles, heart and blood-pressure monitors, a cardiac arrest cart, and respirator are part of the scene of life-support activity. These sights have been part of the scene on all of my working days for the last ten years in the pediatric intensive care unit. In one of the bed spots, lying quite small in comparison to the equipment and paraphernalia surrounding him, is the tiny figure of 4-year-old Billy.

To the uninitiated stranger the sight of any individual in these surroundings is disturbing, but when it is a child it becomes particularly heartrending. Multiple tubes and wires run from Billy's fragile body. Blood and intravenous solutions drip steadily into both arms and neck vessels and are connected to numerous pumps that control the speed with which they are administered. At quick glance there appears to be a least 10 such pumps. A tube down one of his nostrils drains fluid out of his body. A respirator tube down his throat stretches his mouth, creating an unnatural appearance. A blood-pressure cuff on his left arm intermittently displays results on a digital monitor above his bed. Electrocardiogram patches dot his chest and continuously register his heart rate and rhythm on the oscilloscope. Gauze pads cover each eye. A teddy bear is tucked in close to his chest. Billy has been critically unstable for two days. He has suffered two cardiac arrests in the past 24 hours.

Billy's mother looks terribly pale and haggard as she sits silent at his bedside. Billy's hand is cradled in hers, and she either strokes it gently with her free hand or examines the fingers, similar to how new mothers touch the hands of their newborn child. Billy's father stares out the window. His clothes are wrinkled and face unshaven. He has not been home since Billy's admission and has slept most of the time in a chair at the bedside. The nurse at the bedside has cared for Billy and his family for her last three shifts and has been present during the cardiac arrests. She gently lays her hand on the mother's shoulder as she responds to an intravenous pump alarm. It is apparent to anyone entering upon this scene that Billy is dying.

I have been in nursing for twenty-three years and in that time I have worked in neonatal, pediatric, and adult intensive care units. I have spent the last ten years of my professional life working in a pediatric intensive care unit as the nursing unit administrator. I have shared in the lives of many dying patients and their grieving families and I have been deeply affected by them all. I have watched as my colleagues have tended to the needs of their dying patients and cared for the bereaved families with warmth and compassion that the years have failed to diminish. I have held my fellow colleagues to give them strength and have been held by them to give me

support. The nurses of the pediatric intensive care units in which I have worked have cried together, laughed together, and shared angry words together when deaths have occurred. After the death of every child in the unit, it is guaranteed that somewhere a nurse is struggling to make sense of this world in which s/he has chosen to work and wonders why s/he has not quit long ago. But the majority of us show up for our next shift and are ready to give of ourselves to the next child and family that need us and despite our grief, I believe we do so with compassion.

Because I have known grief in my personal life, I feel confident in stating that I experience grief when the children for whom I have cared die. My feelings appear to be similar to those that my nursing colleagues are encountering. How can we experience so much grief in our lives and still reach out to others? Why do we continue to expose ourselves to it? I have always had an interest in this topic because death is part of the world of intensive care nursing and I have wanted to help the child and family to the best of my ability. My interest has grown and expanded from a focus on the family to include the grief of nurses with whom I work. As a nurse manager, I have been privy to the thoughts and feelings of many grieving nurses with a wide range of intensive care experience, from the novice to the seasoned nurse. I have found that often the grief response and the focus of their thoughts have been both different from and the same as those of the bereaved family. However, I have also noticed that the nurses' experiences have been different from each other and because of this, what they have needed from me in the way of support has been different. I have often felt inept and helpless.

While the underlying philosophy of admission to an intensive care unit is to preserve life, intensive care nurses often are called upon to provide emotional support for dying patients and their families. These nurses are vulnerable to emotional, physical, and intellectual repercussions which may not be recognized and/or acknowledged. Many years of work in intensive care units would suggest to this author that the model for normal grief and bereavement which has been documented for adult family survivors is insufficient as a framework to understand the grief

responses and processes of nurses working in these settings.

Many pediatric intensive care nurses are entering into intense, caring, therapeutic relationships with their patients and families despite recurrent and frequent experiences with the loss of their patients. If intensive care nurses are unable to grieve effectively, it may affect the way they handle future crises, may increase stress and potentially erode the nurse's self-esteem, patient and family care relationships and staff relations. How then can and do intensive care nurses resolve their grief? The nursing literature needs to document the grief experience as identified by the nurses themselves with the ultimate goal being the identification and implementation of various interventions to help intensive care nurses cope effectively with their grief.

The experience of death and dying has been addressed in the literature as to its effect on the patient and on family survival. However, its effect on the nursing staff, and particularly, intensive care nurses, who care for these patients and families has had limited attention. It is my belief that it is the intent of health professionals to understand humans, their health, and other related phenomena, such as grief, and to use this understanding to promote meaningful life experiences. It is also my belief that our patients and their families should not be our sole foci. We have a responsibility to promote meaningful life experiences for our colleagues. Nurses need as much nurturing at the time of the death of the children for whom they have cared as do the families. Grief exists, not only in the world of the family survivors, but also in the world of pediatric intensive care unit nurses. We cannot care for others without caring for ourselves. The ability to do this will be facilitated by having knowledge of the multiple contexts in which grief exists. Therefore, a study is required to explore the grief experience of nurses who work in this setting when their patients die.

Purpose Of The Study

The overall aim of this phenomenological study was to describe the grief experiences of pediatric intensive care nurses when their patients die. This was investigated by obtaining qualitative descriptions of nurses' perceptions of their grief experiences and the ways it is managed.

The findings of this study are intended to expand our understanding of the nature of the grief experience for nurses and to help focus the development of appropriate supports for them as well as generate ideas for further research.

CHAPTER 2

Review Of The Literature

Introduction

There are numerous studies that explore grief as it pertains to patients and their families. However, there is a dearth of literature that addresses the grief experienced by nurses in their working world. The review of the literature will examine concepts and theories related to grief with specific reference to the grief of health care professionals, in particular, intensive care nurses. It will conclude with a review of the effects of patient deaths on nurses.

This review was conducted in order to guide the initial focus and design of the study. In keeping with the requirements of bracketing in phenomenological method, this study was not guided by any specific expectations or frameworks. However, theories of grief are presented, not only to establish a basis for the study, but also to make explicit this researcher's knowledge based on educational and clinical experience. This allows the reader to identify how this researcher's perspective may have influenced the study (Liehr & Marcus, 1994). This is compatible with Heideggerian phenomenology as Heidegger criticizes the notion that the meaning is totally neutral and unsullied by the researcher's own normative goals or view of the world (Koch, 1995). The researcher inevitably brings certain background expectations and frames of meaning to bear in the act of understanding.

The Concept of Grief

A variety of terms have been used to describe grief. Such terms as bereavement, grief, grieving, grief work, bereavement process, mourning process, mourning, and the like, are found in the literature when discussing the loss of a significant other person. At times, these terms have been assigned specific meanings (although there is no consensus of meanings by researchers), while at others, they have been used interchangeably with grief across the literature or even within the same report and no definitions have been provided by the authors.

Since ambiguity and conceptual overlap exist, clarity will be provided by presenting the most commonly accepted definitions in the literature today.

Bereavement is the state of having suffered a loss (Rando, 1984), of having something or someone go permanently out of one's control, possession or environment (Cleiren, 1993). The term bereaved pertains to the person who has sustained a significant loss.

Grief is defined as a normal, dynamic, individualized, complex process which pervades every aspect (physical, emotional, social, spiritual) of persons experiencing a significant loss (Cowles & Rodgers, 1991; Jacobs, 1993). The grief process after the loss is characterized by changes (cognitive, affective and behavioral) in the bereaved individual.

Mourning has been described in the literature to mean the wide array of intrapsychic processes that are prompted by loss (Bowlby, 1961; Freud, 1917) or as the process of adaptation to loss (Worden, 1991) and therefore this term is frequently used interchangeably with grief with resulting confusion. Averill (1968) states that grief is elicited under circumstances where no mores or customs are prescribed and similarly, mourning, at least in its ritual aspects, may possess little or no affective component. Generally, however, the two are closely related and frequently complement one another. As applied in this paper, the term mourning refers to the culturally and socially influenced pattern of expression of the bereaved person's sorrow (Averill).

Loss is the state of one deprived of something previously or normally possessed. Losses may be physical, such as the loss of a significant other or may be symbolic, such as loss of an ideal. Loss is a specific event that has occurred which has an element of immediacy. The person perceives it and responds to it as a threatening situation (Katz & Florian, 1986-87). It is a universal human experience that can find expression in many ways and on many different levels. The individual may experience the impact only mildly and momentarily, or deeply and for many months or years. Loss is the central theme to grief.

Theoretical notions of loss and grief have evolved over time. Despite the very universal

nature of grief and the proliferation of literature describing multiple instances of its occurrence, there is considerable evidence in the literature that the concept of grief is plagued by vagueness and ambiguity. Grief has been described as a natural process, the price paid for love (Freud, 1917; Parkes, 1972). It has been described as the response to the loss of meaning (Marris, 1974); an adaptational response (Bowlby, 1961; Parkes); a disease (Engel, 1961; Volkman, 1970); an acute crisis or a series of crises (Demi, 1984); and a syndrome (Lindemann, 1944). It has been characterized by multiple listings of observable symptoms (Engel, 1964; Lindemann; Osterweis, Solomon, & Green, 1984; Parkes); yet even those authors who have ascribed to the definition of grief as a combination of symptoms have differed in their discussions of the degree, frequency, and duration of those symptoms. Grief theories have ranged from the idea of fixed stages (Kubler-Ross, 1969), linear steps (Engel, 1964), tasks to be accomplished in order to regain a new equilibrium after the loss (Worden, 1991), and phases (Parkes; Rando, 1984), to the current thinking suggesting an adaptation (Bowlby; Cleiren, 1993; Parkes; Rando; Raphael, 1983) rather than an acceptance phenomenon (Engel, 1964; Lindemann). In the latter model, successful work of mourning requires the bereaved to accept the discomfort of bereavement (Lindemann) and is indicated by the acceptance of a new love object to replace the lost person (Engel, 1964). On the other hand, it has been suggested in the adaptation model that the grief response is an instinctual response system that serves an adaptive function (Bowlby). This theory has been expanded to include the biological stress response theory based on the work of Darwin and Seyle (Parkes) and views grief as a "psychosocial transition" to loss and change. As noted by Worden (1985), the outcome of grief is to adapt or adjust to a changed environment because of the loss of a loved one.

Despite the wide variety of approaches to discussions of grief, some assumptions regarding the attributes of grief predominate throughout the current literature (Benoliel, 1985; Carter, 1989; Cleiren, 1993; Cowles & Rodgers, 1991; Demi & Miles, 1986; Haylor, 1987; Jacob, 1993; Katz & Florian, 1986-87; Martocchio, 1985; Miles, 1985; Parkes & Weiss, 1983;

Rando, 1984; Raphael, 1983; Worden, 1991). Grief is a natural, universal reaction to the experience of many kinds of loss, not necessarily death alone. It is also a "dynamic, pervasive, highly individualized process, with a strong normative component" (Cowles & Rodgers, p. 121). The uniqueness of each person's experience with grief and loss is now well recognized. But in addition, it is understood that there are similarities in the way that individuals grieve. This has led to the belief that there is a standard, expected response to grief that is considered within normal limits for a society and culture. Grief is a multifaceted experience that is manifested in the emotional, behavioral, physiological, and cognitive realms. The process of grief is not a linear or distinct one. All individuals experiencing grief do not undergo similar reactions in a set pattern. Feelings, symptoms, and behaviors may occur at any time, may occur simultaneously, and may reoccur many times during the grief process. Grief is required for healing to occur and its work is energy depleting, both physically and emotionally. Grief is a continuing development involving many changes that may occur over an unlimited period of time.

The Grief Process

The grief process relates to the phases through which the person passes in adjusting to the loss. Although phases, steps, and stages are often presumed in the literature, no assumptions are made here about its phasing or resolution. Although different professionals describe the process using different numbers and descriptions of stages, phases or tasks (Bowlby, 1961; Engel, 1964; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1972; Parkes & Weiss, 1983; Worden, 1985) a content analysis of these stages indicates that they can be collapsed into three major phases (Rando, 1984),- avoidance, confrontation and resolution. The presentation of the phases of the grief process and the grief reactions experienced throughout each phase are not necessarily sequential nor an all-or-nothing phenomenon.

During the avoidance phase, there is a desire to avoid the terrible acknowledgment of loss. All investigators of loss reported a period of shock, numbness, or despair which may vary in

intensity with the suddenness or anticipation of the loss (Lindemann, 1944; Engel, 1964; Kubler-Ross, 1969). For example, Engel stated that the bereaved is stunned and incredulous and he attempts to protect himself against the effects of the overwhelming stress by being numb, thereby blocking out recognition of the loss and painful feelings. In Bowlby's (1961) original work on loss, he did not identify a phase of avoidance. However, Parkes (1972) followed Bowlby's theoretical orientation in a study of bereavement reactions in widows. It was as a result of this research that Parkes added an initial phase of numbness to Bowlby's three phases (searching and yearning, disorganization and despair, and reorganization). It was described as a period of being stunned and that varying degrees of denial of the loss are usually present. In later writings, Bowlby supported the addition of this phase to his description of the grief process. Katz & Florian (1986-87) described this phase of shock, in technical terms, as a depersonalizing emergency reaction. A review of the literature suggested that avoidance of the pain of the loss is indispensable. It is necessary for people to mobilize the emotional strength required to face the new traumatic situation and this is expressed behaviorally by closing out the world and dwelling on oneself (Rando, 1984). Shock is most clearly observed when crisis or loss comes without warning (Rando).

During the confrontation phase, grief is experienced most intensely. Lindemann (1944) and Katz & Florian (1986-87) described it as the stage of acute mourning, while Bowlby (1961) described this period of the grief experience in terms of his two phases of yearning and searching and disorganization. Engel (1964) identified the next steps of the grief sequence as the need to develop an awareness of the loss and a period of restitution. Parkes (1972) and Worden (1991) confirmed the focus on the reality of the loss and the experience of the pain.

The resolution phase constitutes a gradual decline of grief and marks the beginning of the emotional and social reinvestment back into the everyday world. The individual learns to live with the loss as emotional energy is reinvested in new persons, things, or ideas. It includes a measure of fulfillment, quiescence, reconciliation, and even traces of personal development.

According to Marris(1974), this is a phase of adjustment which depends on restoring a sense that the lost attachment can still give meaning to the present, not on finding a substitute for the loss, while Bowlby (1961) and Glick, Weiss and Parkes (1974) described the resolution phase as the discovery of new objectives and of a new set of ideas in life. Parkes and Weiss (1983), as well as Worden (1991), further elaborated that recovery from grief will have taken place when there is intellectual recognition and explanation of the loss and emotional acceptance of the loss, along with the assumption of a new identity. This phase is an active and evolving one. Rando (1984) and Miles (1985) noted in their work with parents that this phase is not a period of recovery, for parents state that they never recover from the loss of their child but rather it is the beginning of an emotional and social reentry back into the everyday world. Parents must "grow up with the loss" in a grieving process spanning the years (Rando, 1986).

Common Reactions Associated With Grief

Effective resolution of grief is vital to both the physical and the psychological well-being of the bereaved individual. Expression of the range of feelings and emotions associated with the loss is necessary for successful "griefwork" (Parkes, 1972; Worden, 1991). Feelings that have been denied expression may come forth in full force at an inappropriate time or in a disguised manner, but almost always grief will be expressed (Martocchio, 1985).

There are numerous psychological grief reactions that prevail during certain phases of the grieving process. During the avoidance phase, a feeling of numbness is quite common (Parkes, 1972). Carter (1989), a nurse, in her thematic analysis of 30 narrative accounts of personal loss of a significant other, identified numbness as the theme of "being stopped". She stated this theme described "the interruption of life's usual flow following the death of a loved one and which is characterized by varying types and degrees of inability" (p. 355). Inability extended into many domains of functioning of the participants' lives and varied individually. A combination of being unable to feel, as though numb, and unable to believe was conveyed by the bereaved in

her study. As shock wears off, denial, either intellectual and/or emotional, emerges. Confusion and disorganization are common.

During the confrontation phase extremes of emotion are felt. Parkes (1972) states that common grief reactions at this time are related to "searching" and "mitigation". There may be a sense of panic, generalized anxiety, "pining", restless activity in which one moves towards possible locations of the lost object. Anger and guilt are experienced to some degree following a significant loss, as a natural consequence of being deprived of something desired (Bowlby, 1961; Parkes). The anger may be displaced onto other people or onto self. There may be a profound sense of injustice and disillusionment; self-reproach and a sense of worthlessness. There are acute feelings of separation, deprivation, anguish, sadness, yearning, and longing (Bowlby; Parkes) or hurting and missing (Carter, 1989). Depression and despair are other common reactions. The inability to concentrate, process information, and lack of decision-making ability causes a feeling of lack of control and heightens anxiety. A preoccupation with the deceased is another natural response to loss. This is often manifested in obsessive rumination about, dreaming about, or actively searching for the deceased. There may be obsessional review of the circumstances of the death. Individuals may have some identification with the deceased. Carter found that the bereaved go through an individual process of preserving the fact and meaning of the loved one's existence. It is during this process that the desire "to hold" by talking about the loved one or keeping the memory alive, for example, is expressed in one's behavior. She also identified "seeking" behaviors through which the bereaved searches for help and comfort as well as searches for creating some kind of positive meaning.

In the resolution phase, there is a gradual decline of the reactions to grief. However, guilt often accompanies the beginning efforts as the bereaved copes with the fact he/she continues to live and experience in spite of the loss (Rando, 1984).

There are a number of physiological reactions that accompany the emotional reactions to

loss. These have been documented most notably by Lindemann (1944) and Parkes (1972). Parkes' belief is that these result from the sympathetic nervous system in response to biological stress that occurs initially as a result of an alarm state and then may reoccur when the griever experiences "pangs of grief". Some of the more common physiological symptoms that occur in normal grief include crying, physical exhaustion, heart palpitations and other indications of anxiety, lack of energy, sleep disturbances, and headaches. Frequently, somatic symptoms are the only overt indications that grief still remains unresolved (Rando, 1984).

Socially, the experience of grief appears as a loss of normal patterns of conduct, a painful lack of ability to initiate and maintain organized patterns of activity, and social withdrawal behavior that is opposed to the establishment of new relations and the alleviation of stress (Lindemann, 1944; Parkes, 1972; Rando, 1984).

Influential Contextual Factors

Parkes (1972) maintains that in order to understand the phenomenon of grief, the influence of many possible factors must be considered when trying to explain the differences between individuals in their response to this event. Grief may be strong or weak, brief or prolonged, immediate or delayed. Many of the determinants of the response to loss are multidimensional and interrelated, rather than separate and distinct entities. For example, "a holistic view of reaction to loss and the development of relevant coping skills postulates that grief is a complex phenomenon, contributed to and shaped by a number of influences which may or may not bear a direct causal relationship to each other" (Katz & Florian, 1986-87, p. 336). It follows that management of the loss requires an understanding of as many of these influences as possible. There have been a number of psychological, sociocultural, and physiological factors identified that influence the grief process, namely those associated with individual attributes of the bereaved, the relationship with the deceased, the mode of death, cultural and familial factors, social supports, and secondary stresses (Katz & Florian, Rando, 1984).

Psychological Factors

A psychological factor influencing grief includes previous experiences with the loss of significant others, both in childhood and adulthood. Previous experience with loss tends to make subsequent losses easier to cope with since coping mechanisms have already been established and there is less fear of the unknown (Parkes, 1972). However, previous unresolved losses generally hinder effective grief resolution (Rando, 1984). If an individual has experienced too many deaths, he/she can suffer bereavement overload (Kastenbaum, 1969).

The meaning a particular loss has for a given individual, the psychological nature of the relationship severed, and the strength of the attachment will influence one's capacity to complete grief work (Parkes, 1972; Rando, 1984). Carter (1989) noted that understanding the bereaved's history; who the loved one was; what the loved one was; what that person meant to the survivor; how they were together; what their hopes, dreams, shared experiences were; and the nature of the events surrounding the death are critical for understanding bereavement (p. 357). The significance of the deceased in terms of defining the social role of the bereaved was cited as an important factor by Lindemann (1944). A number of secondary losses, such as role loss, associated with the object loss, will necessarily affect the grief process and reactions of the bereaved by increasing the demand for adaptation (Averill, 1968). Characteristically, the loss of a relationship that has been intense, highly dependent, and marked by a significant amount of ambivalence is more difficult to resolve (Parkes; Rando).

Grief will be more amenable to management and resolution if the circumstances of the death can be accepted by the bereaved. This includes such issues as the location, immediate circumstances of the death, reason for the death, sudden versus expected death, the degree of preparation for it, and the length of illness prior to death. In an investigation of parents whose children had died from cancer, Rando (1984) found that those parents whose children's illnesses were less than 6 months, or longer than 18 months reported being the least prepared for death and having the least adjustment following the death. Forewarning provided the

opportunity for completion of unfinished business, preparation for the anticipated consequences of the loss, and gradual realization of the loss, all of which tended to facilitate the grieving process. However, the extended period of preparation for the loss led to emotional and physical exhaustion and increased feelings of ambivalence toward the dying person. These consequences had the potential capability to interfere with positive resolution of grief.

According to Weisman (1973), timely deaths occur when observed survival equals expected survival. Timely deaths are appropriate or acceptable ones when suffering is minimal, conflict between the dying and supportive person is minimal, and the act of dying can bring relief to the parties involved. Weisman conceptualizes untimely death as having three distinguishable characteristics: premature, unexpected, and calamitous. Unexpected death can produce a serious emotional impact because it violates the inner timetable of expectation. Variables, such as the age of the deceased, the degree of fulfillment in life, the type of person, and the amount of unfinished business between the bereaved and the deceased are components of the timeliness of death. The more untimely the death is perceived to be, the greater the risk for intense feelings of guilt and the more difficult it will be for the bereaved to accept the loss.

Bugen's (1977) model of human grief asserts that if the relationship of the deceased to the bereaved is central at the time of death, grief will be intense. However, if the deceased is not a central figure in the life of the bereaved, then the initial response will be mild. Additionally, according to Bugen, the belief (realistic or not) by the bereaved that the death is preventable is the single most influential factor causing the grief process to be prolonged. If the death is perceived as preventable, survivors may feel that they contributed to the death directly or indirectly. If the bereaved believes the death to be unpreventable, the sphere of control is external and absolves the bereaved of both responsibility and guilt. Studies examining the bereaved following deaths of a child or deaths by suicide support this premise (Cleiren, 1993; Rando, 1984).

Sociocultural Factors

Sociocultural factors also influence the grief response. The individual's responses to loss and death generally reflect the norms, mores, and sanctions of the sociocultural environment (Averill, 1968). In Western society, grieving is treated by its members as if it is a weakness and a self indulgence (Rando, 1984; Worden, 1991) leading to a tendency to deny grieving. This tendency may have the effect of not allowing the bereaved persons the opportunity to work through the grief and arrive at a satisfactory resolution of it. For example, Parkes (1972) found the widows who suffered most deterioration in health felt that they had not been permitted by those around them to talk about their husbands' deaths and express their feelings freely.

In addition, the religious/philosophical training to which the individual has been exposed also can significantly affect the beliefs, meanings, and values that person holds for life, death, and life after death (Rando, 1984). This can influence the individual's grief response and methods of coping with grief. For example, the mores, norms and sanctions of the religious background may lend some meaning to the death and provide some structure to the individual's response to the loss (Rando).

Such concurrent factors as age, number of dependent children, sex, and personality characteristics of the bereaved (Parkes, 1972; Rando, 1984) also influence the grief reaction and process. For example, the importance of gender was demonstrated by Parkes. Women had less difficulty than did men expressing sadness, loneliness, or depression, emotions that are associated with effective grief resolution. On the other hand, women tended to have more difficulty with anger and with assuming control and decision-making (Rando). Other concurrent factors that can influence an individual's grief response are a person's current and past state of mental health and ego strength. Additionally, it has been suggested that a greater level of maturity, intelligence, and education level also correlate with effective coping skills and with favorable resolution of loss (Rando).

Ongoing stresses unrelated to the death may add to the hardships of the bereavement experience. Research has indicated that the presence of concurrent life crises is associated with poorer bereavement outcomes (Parkes, 1972; Raphael, 1983). For example, the individual who is unemployed, physically ill, getting a divorce, or struggling with a developmental crisis will have a relatively more difficult time coping with grief because of the additional burdens. Research has indicated that the presence of concurrent life crises is associated with poorer bereavement outcomes (Parkes).

What seems to be most important in fostering resolution and influencing the expression of grief is not whether social support is initially available, but whether social support is available and utilized "as time goes on" (Parkes & Weiss, 1983; Raphael, 1983; Stylianos & Vachon, 1993). Those social norms that promote realization and confirmation of the loss, assist in the expression of affect and memories, and offer social support to the bereaved are therapeutic (Rando, 1984). For example, it has been found that social support is inadequate or nonexistent for such losses as an abortion, a miscarriage, and an infant given up for adoption because they are not socially defined as losses. Therefore, many women have unresolved grief in these situations (Rando). The families of suicide feel socially stigmatized and have a higher incidence of complicated grief (Osterweis et al., 1984). On the other hand, it has also been reported that the bereaved may socially isolate themselves despite the availability of social supports and has hindered grief resolution (Stylianos & Vachon).

Physiological Factors

Finally, such physiological factors as drugs and sedatives, poor nutrition, lack of sufficient sleep, inadequate exercise, and poor physical health may predispose the bereaved to illness and unresolved grief (Rando, 1984).

Loss Outcomes

Positive and negative outcomes can occur as a result of loss and grief. Some people recover from grief strengthened, achieving new self-awareness and personal growth (Bertman, 1983; Downey, 1983; Martinson, McClowry, Davies, & Kuhlentkamp, 1994; Miles & Crandall, 1983). Commonly reported growth responses include having a stronger faith, being more compassionate and caring toward others, and living life more fully because of a belief in the preciousness and fragility of it. Most authors suggest that when the work of grief has been accomplished, two primary consequences are evident: the establishment of a new reality and the development of a new identity (Bowlby, 1961; Carter, 1989; Katz & Florian, 1986-87; Martocchio, 1985; Parkes, 1972; Worden, 1991). Negative outcomes include being unable to resolve the loss, having a negative meaningless view of life, and feeling that life has stopped (Martinson, et al.). Recently, researchers have investigated the long-range outcomes of the grief experience (Bugen, 1977; Miles, 1985; Stroebe, Stroebe, & Hansson, 1993). The death of a significant other is a stressor that affects emotional health, physical health and social adjustment. Documented consequences of grief have included psychosomatic illnesses (Freud, 1917; Lindemann, 1944; Osterweiss et al., 1984; Raphael, 1983); increased life-threatening disorders, particularly cardiovascular (Parkes, 1985); increased rate of consultation for mental health problems such as clinical depression, anxiety, and suicidal ideation (Lindemann, 1944; Katz & Florian, 1986-87; Parkes & Weiss, 1983); and increased natural death rate (Stroebe et al.). Parkes and Brown (1972) found in their prospective study of young widows ($N=49$), fourteen months after bereavement, that they experienced more days sick in bed and in hospitals and more use of alcohol, cigarettes, and tranquilizers than did a nonbereaved age-matched control group. Meanwhile, Parkes, Benjamin, & Fitzgerald (1969) found a marked increase in mortality in widowers ($N=4486$) during the first six months following their loss.

The grief of parents, spouses and children have been compared in the literature. It is generally acknowledged by experts that parental grief is one of the most intense grief reactions, taking from years to a lifetime to resolve (Osterweis et al., 1984; Rando, 1984; Miles, 1985; Knapp, 1986; Miles & Demi, 1986; Worden, 1991).

Although the literature review has focused on grief of family members, a few authors have identified that health care personnel experience feelings of helplessness, inadequacy, and questioning of beliefs, faith and individual well-being when they confront grief in their professional roles (Norbeck, 1985; Spencer, 1994; Vachon & Pakes, 1985).

The Nurse's Grief Responses to the Death of Their Patients

Only one reported study was found that examined the grief response of pediatric intensive care nurses. Through the use of an anonymous questionnaire, Spencer (1994) examined how 51 nurses working in two British hospitals dealt with their grief following the death of a patient in an intensive care unit and the support perceived to be given to them by their peers and their managers. Ten of the nurses were also interviewed, using a semi-structured interview. She found that sadness (100%), anger (78%), guilt (41%), shock (80%) and relief (98%) were the common feelings experienced by the nurses with no difference between male and female nurses. All but one of the nurses said that they felt relief when a patient died. "This is an interesting finding and one that does not relate to any findings in the literature" (Spencer, 1994, p.1148). Spencer identified that (a) how well the nurse knew the family, (b) the amount of discussion that had taken place between the nursing and the medical staff about the patient's care, (c) whether or not the decision had been made for no further treatment to be given, and (d) whether or not the nurse had time to care for the deceased body with what was felt to be rightful respect were the factors that influenced the nurse's grief response. She also reported that the nurses dealt predominantly with their grief by: talking to other staff members or friends and family, carrying on working, and crying. Sixty percent of the

nurses stated that the type of support they received from their peers was through informal discussions. The nurses stated that they would have found group meetings with a counselor and the presence of an informal network of one-to-one chats would have been helpful. The results of Spencer's study have face validity and intuitively are meaningful when related to this author's experience and to the anecdotal material found in the literature.

Several narrative accounts of nurses and their own grief have been presented in the literature. Price and Bergen (1977) reported themes expressed by a group of nurses working in a coronary care unit during the course of a support group. The authors believed that the nurses felt stress "because of an unconscious confusion between the feeling of being responsible for the care of a dying patient and the feeling of being responsible for the occurrence of the patient's death" (p. 235). Price and Bergen questioned whether the goal of the grief process for intensive care nurses was to resolve this conflict.

Price and Bergen's findings are somewhat substantiated from other literature. According to Eisendrath and Dunkel (1979), psychiatric and social work consultants, respectively, to adult intensive care unit (ICU) nurses over a one year period, found that these nurses were careful, attentive to detail, and had omnipotent rescue fantasies (p. 753). The potential to develop a sense of mastery in an ICU is great, but opportunity for error is also great. Consequently, ICU nurses have to deal frequently with a perceived sense of failure and its attendant guilt and come to terms with these feelings during the grieving process. Quint (1966) also found in her field observations and interviews of intensive care unit nurses that they were concerned with failure to save life because actions are guided primarily by the recovery goal (p. 53). Mount (1986) noted of health care providers, working in a medical model framework, who must deal with death and dying, that "ambiguity and role confusion may occur when the goal of cure is not attained. The task of confronting our own mortality and examining the meaning and purpose of life is clearly provoked by exposure to multiple deaths" (p. 1128). He states this potentially leads to unresolved grief, stress, and burnout. Marquis (1993), a clinical therapist, reported similar

findings in his account of caregivers experiencing burnout in their work with the terminally ill.

In anecdotal accounts and experiential commentaries, nurses and other health care providers have poignantly described their feelings of grief (Chard, 1987; Charnock, 1985; Evans, 1989; Iveson-Iveson, 1985; Kuntz, 1984; Sheard, 1984, 1990; Stowers, 1983). The following account by Wolf (1994) illustrates this.

"In my seven years as an ED nurse and nine years as a paramedic, I've seen a lot of death and suffering. After a while it takes a toll. But until today I kept my feelings inside. I've witnessed far worse things than the death of an elderly man who had brain cancer. But his was the one who brought out the sorrow. He was the one who made this man cry" (p. 29).

A common theme evident in these accounts is that to hide one's feelings and maintain a cool professional exterior is an effective coping strategy. This demeanor also was noted to be necessary because as a health care provider one is looked to for guidance and reassurance (Charnock; Evans). However, in the time following the death, the continued use of this coping strategy added to nurses' isolation and inadvertently distanced them from the potential source of comfort and support of their peers. Although grief was described as a painful personal experience, it was also noted that with resolution, grief experiences were then viewed as creating the opportunities for personal and professional growth. For example, Evans wrote of her experience of grief and loss, that she learned that needing the support of other people was not the weakness she had previously thought, personal growth was not pain-free, and even the worst experiences could eventually be viewed as life-enriching (p. 43).

Intensive Care Nurses' Responses To The Deaths Of Their Patients

Nurses working in settings where patients frequently die not only suffer the loss of their patients but also can suffer associated losses of self-esteem and support (Vachon, 1987). The death of patients, coping with resulting grief (Bailey, Steffen, & Grout, 1980; Benica, Longo, & Barnsteiner, 1992; Brunckhorst, Economou, Ranauro, Walden, & Plows, 1985; Caldwell & Weiner, 1981; Cassem & Hackett, 1972; Hase, 1989; Jacobson, 1978; McKerron, 1991;

Norbeck, 1985; Spoth & Konewko, 1987), and repeated contact with dying patients, with all the associated losses (Hay & Oken, 1972; Munley, 1985; Vachon & Pakes, 1985) have been consistently identified as stressors for nurses working in intensive care units.

In a study by Foxall, Zimmerman, Standley, & Bene (1990) which compared frequency and sources of nursing job stress perceived by intensive care ($N=35$), hospice ($N=30$) and medical-surgical nurses ($N=73$), hospice and ICU nurses perceived significantly more stress related to death and dying. When ICU nurses were compared with medical-surgical nurses, the ICU nurses were significantly higher on the death and dying dimension of the Nursing Stress Scale ($p \leq .001$). The Nursing Stress Scale is a valid and reliable tool developed by Gray-Toft & Anderson (1981). It is a 44-item, 4 point Likert Scale with scores ranging from 'never' (0) to 'very frequently' (3), which measures frequency of work-related stress in eight domains, one of which is death and dying (Foxall et al.). Cooper and Mitchell (1990) also used the Nursing Stress Scale in their comparative study of hospital based nurses ($N=80$) (adult intensive care, neonatal intensive care and oncology) to those nurses ($N=37$) working in a hospice setting. They reported that hospital nurses were significantly more stressed by the following events than hospice nurses: the unexpected death of a patient ($p = .034$), the death of a patient as expected ($p = .01$), the removal of life support systems resulting in death ($p = .013$), the patient died and the nurse did not get to know him/her ($p = .003$), and when the relationship with the patient's relatives was good ($p = .022$). Vachon and Pakes (1985) noted that staff who worked with critically ill and dying children reported that some of the most stressful deaths, ones in which they suffered conflict and had difficulty coming to terms with, were ones that were sudden or unanticipated, ones in which the mode of death prevented parents from being in attendance at the time of death, multiple deaths over a short period of time, and the death of a child who had been abused or was well known to the nurse.

Studies of nurses working in adult ICUs (Bailey et al., 1980; Norbeck, 1985) and those

working in a pediatric ICU (Benica et al., 1992) reported the number of patient deaths as being significantly correlated with stress as measured by ICU Nursing Stress Audit tools. These surveys elicited ICU nurses' perceptions of stressful and satisfying aspects of their work. Studies have also shown that adult and pediatric intensive care nurses overestimated the percentage of patient deaths (Benica et al.; Brunckhorst et al., 1985). It has been inferred by these authors that the feelings of stress and burnout are influenced by this perception that there is a high percentage of death but no empirical data exists to support this.

Why is death considered stressful by some of the nurses and not by others? Gribbins and Marshall (1982) found in their study of stress and coping in neonatal intensive care nurses ($N=24$) that death of a patient as a stressor was possibly a function of a nurse's years of experience in the unit. Nurses with less than one year's experience ranked stress related to death of the patient higher than did nurses with more than one year's experience. Furthermore, Benica et al.'s (1992) study which examined perceptions and significance of patient deaths in a sample of 66 pediatric intensive care nurses found that the greater total years of experience and the more ICU experience, the less death was perceived as a stressor ($p=.06$). Norbeck (1985) on the other hand reported in her study of adult intensive care nurses ($N=180$) that although coping with death and dying was identified as one of the five top-ranked stressors in terms of frequency of stressfulness ($p<.003$, 1-tailed), this stress factor did not relate significantly to low job satisfaction or psychological symptoms regardless of length of time the nurse was employed in critical care.

Intensive care nurses derive much of their satisfaction from seeing patients recover (Bailey et al., 1980). Therefore, it is not surprising that the death of the patient can result in the caregivers feeling anxious, frustrated and guilty. Through the administration of self-report inventories that measured mental health, Cooper and Mitchell (1990) and Quint (1966) found that if the nurses' relationship with the patient and his/her relatives at the time of death was perceived as poor or if the nurse could not anticipate the death trajectory, then there were

higher depression scores reported.

Mallet, Price, Jurs, & Slenker (1991) compared the levels of burnout, occupational stress, death anxiety and the social support in hospice and intensive care nurses ($N=376$). ICU nurses reported significantly more occupational stress than hospice nurses ($p=.001$). While hospice nurses did not indicate that deaths of patients were particularly stressing to them, ICU nurses identified that deaths of patients contributed to their stress. This was measured through the use of the Stressful Situation Scale that had the respondents identify the degree of stress experienced on a five-point Likert scale (not stressful = 1 to extremely stressful = 5). The two nursing groups differed significantly when the three components of the Maslach Burnout Inventory were compared. They found that ICU nurses had significantly higher burnout scores ($p = .004$), had more emotional exhaustion ($p = .001$), utilized the technique of depersonalization more frequently ($p = .001$), and experienced less of a sense of personal accomplishment ($p = .001$). Using the Collett-Lester Fear of Death Scale, ICU nurses reported more anxiety concerning the issues of dying and of death than did hospice nurses ($p = .008$).

It has also been reported that the stress arising from issues concerning death and dying may affect patient and family care and staff relations as well as the nurse's mental and physical health and family relationships (Cooper & Mitchell, 1990; Mount, 1986; Norbeck, 1985; Vachon, 1987).

Price and Murphy (1985) in their exploration of staff burnout in intensive care staff suggested that successful adaptation to the stress of the cumulative effect of multiple patient deaths was correlated with effective resolution of grief, while failure to effectively move through the grieving process was a possible contributing factor in the development of burnout.

Grief and Other Health Care Professionals

The theories and frameworks for normal grief and bereavement as identified in surviving family members may be insufficient in helping nurses to understand and manage their reactions

to multiple deaths. A review of the literature has indicated a paucity of information on the nurse's grief reactions and the grief process, particularly as it pertains to intensive care nursing. However, there are some studies of caregivers of the terminally ill in palliative care and hospice programs (Adams, Hershatter, & Moritz, 1991; Barton, 1977; Eakes, 1990; Harper, 1977; Munley, 1985). Similarities exist between the work of intensive care nurses and hospice workers. Palliative care nurses, for example, like nurses in the intensive care setting, are constantly confronted with issues relating to loss. Both must face the death of patients frequently and both experience cumulative losses. Given the rapid turnover of patients in palliative care and intensive care units, these nurses seldom have the opportunity to deal with and resolve the losses they experience (Mallett et al., 1991, p.1346). Caregivers in both settings have extensive contact with patients who are highly physically dependent, and they come to know the dying person and/or the family members intimately as individuals. This can result in a highly personal concern and a significant relationship.

Hospice nurses believe that their grief and bereavement is different from the previously identified models of the normal grief and bereavement response (Adams et al., 1991, p. 29). Caregivers who work in hospice programs for long periods of time often begin to feel a sense of fleetingness or have described a sense of "I want to get the hell out of here" (Barton, 1977, p. 74). They may experience a profound sense of loss of control and helplessness as well as a sense of being professionally ineffective and incompetent. Barton found that hospice caregivers are not given the opportunity to carry out their grief process. They often contain their grief and do not receive comfort normally obtained from family and friends. Rather caregiver's grief is not legitimized and the person is left to grieve in an isolated position (Barton, p. 82).

A study of in-patient hospice nurses' reactions to recurrent loss and rapid readmission of new patients in a hospice setting led to the development of the concept of "accumulated loss phenomenon" (Adams et al., 1991). From the data compiled from a survey of 100 hospice nurses, the authors found five characteristics of accumulated loss: (1) lack of closure resulting

from inadequate opportunity to deal with death of the patient and the grief of the family; (2) dying and death concerns related to personal or imagined scenarios of illness, disability and death; (3) ideals versus reality incongruity proceeding from discrepancy between desired and actual clinical practice; (4) identification-distancing as a way of separating self from pressures of clinical practice; and (5) diminished boundaries caused by a blurring of personal and caregiving commitments. These findings led them to suggest that the grief reaction and bereavement of accumulated loss results from "an overexposure to the actual and idealized process of dying and death on a daily basis ... result(ing) in a set of unique characteristics by which care-givers develop certain behaviors, both positive and negative" (p. 30). This concept may have general applicability to the reactions of nurses in a pediatric intensive care unit as they face recurrent and frequent loss of clients.

Munley (1985), from her work with hospice nurses, suggests that the flooding of emotion involved in grief from multiple losses may lead to incapacitation, rather than healing. To defend against this flooding some nurses might become emotionally numb. She reported that nurses identified "feelings of being saturated by grief" (p. 346) and "strain associated with frequent exposure to the grief of spouses, children, adolescents, and the elderly" (p. 346). Munley writes:

"Caregivers may find themselves experiencing feelings of failure with inadequate pain control or if patients did not have a "good time" before the end, being preoccupied with images of those who did not have a "good death", overwhelmed by highs and lows of emotion, burdened by a sense of responsibility for the quality of life of patients, drained of energy because of desires to reach out to multiple needs and saturated by feelings of grief and guilt" (p. 346).

Eakes (1990) in her qualitative study of five registered nurses, employed full-time in one of two southeastern American homebound hospice care programs, identified six major themes of grief resolution strategies employed by hospice nurses who effectively coped with the deaths of patients. These were the establishment of collaborative nurse-patient relationships; identification of palliative nursing care goals; open, honest expression of feelings, maintenance

and use of a solid support system; termination of the relationship with the patient and family, and a positive attitude toward the patient population.

Harper (1977) developed "The Schematic Growth and Development Scale in Coping With Professional Anxieties in Terminal Illness" from her qualitative study of nine social workers working with dying patients and their families. Using an experiential framework, her model described five steps that represent the normative sequence of emotional and psychological progress. She suggested that at each stage, there was a maturational and experiential learning adjustment to dealing with the dying and the bereaved. The stages included intellectualization, emotional survival, depression, emotional arrival, and deep compassion. She contended that it is during the first three stages that health care professionals begin to accept their own feelings of pain and grieving. It is in the final two stages of the growth process that the death of the patient is not viewed as a personal failure and that a commitment to remain within the working environment is made. Harper stated that this growth is "reflected as the health care provider gains understanding, knowledge, strength, and works through internal and external conflicts, thus adding a new human caring dimension to one's existing capacity to be helpful" (p. 21). This premise has also been reported by Marquis (1993), a therapist who has worked with health care providers who have exhausted themselves providing care for the dying. He noted that health care providers of the terminally ill "who do not get exhausted, the ones who maintain a high level of energy, dynamism, and inner peace are also those who know how to find in their relationships with the dying an inexhaustible source of gratification" (p. 31). He stated that each death for the health care provider is a means of discovery about life.

During a 6-month participant observation study of a comprehensive hospice program that included full functioning inpatient and home care components, Munley (1985) conducted interviews with hospice staff members. They revealed a number of strategies that were employed in order to reduce job-related stress. Refocusing on regenerative aspects of life, such as recreational or creative pursuits, assisted some staff members in coping with the

depletion associated with caring for the terminally ill. Still others cited ventilation of feelings, in either a formal support group setting or an informal manner, as an effective coping strategy with their grief. Physical exercise and use of spiritual means, such as participation in funerals were also identified. Another coping mechanism that emerged was distancing, or the setting of limits on intrusion of their work responsibilities into their off-duty time. Barnard (1985) identified three elements of adaptation to stress and loss in the medical setting: i) "the allowance of adequate time and energy for 'active grief and mourning' for both the literal and symbolic deaths experienced in medical care work", ii) "... acceptance of personal limitations ... a retreat away from the relentless challenges of caregiving", and iii) "... cooperativeness and a spirit of affiliation among co-workers ... which offer nurturance and assistance in the work of mourning" (p. 128).

The similarities between pediatric intensive care nurses and other health care professionals working with the terminally ill allow some inferences to be made from the studies carried out with staff working in palliative care. However, there are unique stressors to pediatric intensive care that do not permit acceptance of these results without further investigation. Nurses who choose to work in intensive care do not do so to work with the dying. The dying patient is the *raison d'être* of the service in palliative care while as previously noted, death and dying often represents failure of the service in intensive care. Intensive care nurses are oriented in the medical model genre, dominated by a therapeutic or curative role, whereas those working in palliative care are oriented to the supportive role. Despite the differences between them, the health care providers in both groups must develop personal coping mechanisms to adapt. For example, are the characteristics of accumulated loss noted by Adams et al. similar for pediatric intensive care nurses? Do pediatric intensive care nurses have a developmental process for effectively coping with their grief from exposure to multiple and accumulated deaths as suggested by Harper? Do pediatric intensive care nurses develop personal coping strategies that prevent them from becoming exhausted as referred to by Marguis?

Summary

Death and loss are unavoidable consequences for nurses intimately involved in providing care to dying patients and their families in pediatric intensive care settings. While there appears to be an increased recognition of the need for nurses to grieve in response to the deaths of patients (Sheard, 1984; Rando, 1984; Vachon & Pakes, 1984), there is inadequate information on the grief responses of pediatric intensive care nurses, factors affecting their grief response, the grieving process of nurses, and strategies to facilitate their successful movement through the grief process.

Most of the nursing research on grief has focused on the grief responses of bereaved family members. Little research was found on the grief of nurses following the death of their patients and even fewer specifically related to nurses working in the pediatric intensive care unit. Grief and terms associated with grief were not well defined in the nursing literature and frequently used interchangeably making the review difficult and confusing. The research that has been done on nurse's grief lacked conceptual or theoretical frameworks. The sample sizes of the quantitative research studies have been small and therefore the findings lack generalizability. In addition, reported qualitative studies were not subjected to rigorous content analysis.

The primary focus for authors of much of the classic literature relates to grief reactions. But it has been realized that grief is complex and varied such that an emphasis on symptoms alone is inadequate to enable identification of this response (Cowles & Rodgers, 1991, 1993). Since the concept of grief has been found to be highly individualized (Parkes, 1972; Rando, 1984; Worden, 1991), research to identify some of the factors that influence individual variations is needed (Cowles & Rodgers, 1993). As the research on surviving family members has demonstrated, it cannot be assumed that health care professionals will grieve in the same manner as families members, nor that specific populations within the health care groups, such as pediatric intensive care nurses, will experience grief similarly to others. Little information is

available regarding specific differences in response to losses other than the death of a significant other. The model for normal grief and bereavement for surviving family members may be insufficient in helping nurses to understand and manage their reactions to multiple deaths (Adams et al., 1991). It has also been noted that there is a dearth of knowledge of appropriate interventions for grief. However this step cannot be taken until the nature of nurses' grief is examined.

It becomes apparent from a review of the literature that intense involvement with dying patients and their families places nurses under considerable stress. Such immersion in death has been shown to be a source of considerable stress and is associated with an increased vulnerability to burnout (Hay & Oken, 1972; Munley, 1985; Vachon & Pakes, 1984). Price and Murphy (1985) correlated successful adaptation to stress with effective resolution of grief. Failure to successfully move through this grieving process was cited as a possible contributing factor in the development of burnout, with resulting physical and /or emotional withdrawal from the work environment.

It is widely accepted that grief must be experienced in order for emotional healing to occur and for the bereaved individual to be able to reinvest in new relationships and life experiences (Freud, 1917; Lindemann, 1944; Parkes, 1972; Rando, 1984; Worden, 1991). It seems logical, therefore, to conclude that nurses, too, need to achieve resolution of their grief in order to continue to be able to reinvest in relationships with dying patients.

This study will explore the grief experience of pediatric intensive care nurses and the strategies they use to facilitate grief resolution, so that eventually efforts can be directed toward incorporating this information into work related interventions to help pediatric intensive care nurses cope effectively with their grief.

In order not to bias my interpretation of the meaning of nurses' grief as it emerges from an analysis of the lived experience, assumptions about their grief that may have been obtained from the literature review, need to be identified so that I am aware of them and bracket them as

much as possible. These assumptions include:

1. The idea that nurses experience grief every time one of the children for whom they have cared dies.
2. The idea that grief is not only experienced when there is a strong sense of attachment.
3. The idea that nurses are sensitive human beings deeply moved by the death of a child.
4. The idea that nurses' grief is not experienced in stages or phases such as those identified for the dying patient and grieving family members.

Research Questions

In light of the analysis of the literature presented above, the following questions have been posed:

1. What are the physiological, emotional, social, and occupational reactions of pediatric nurses to the death of a child in the intensive care unit?
2. What are the factors related to a child's death that pediatric intensive care nurses perceive facilitate or hinder their grieving?
3. What are the coping strategies used by pediatric intensive care nurses to deal with their grief when their patients die?
4. Are there developmental phases, as identified by the participants, through which pediatric intensive care nurses progress in response to their accumulated grief experiences?

CHAPTER 3

Methodology

Research Design

This study used an interpretative phenomenological approach to explore the grief experience of pediatric intensive care nurses when the children for whom they care die. A qualitative research approach is appropriate when: (a) the research question is exploratory in nature; (b) the researcher is seeking to understand an emotional event, such as grief; or (c) the observations of one population are different from or contradictory to those described in other studied populations (Field & Morse, 1985). It has already been established that the literature available in the area of pediatric intensive care nurses' grief is limited and arguably different from the other populations studied.

In the realm of qualitative research there exists a number of descriptive analytical investigations of the world of human experience (Field & Morse, 1985; Liehr & Marcus, 1994; Munhall, 1989; Omery, 1983). One approach, phenomenology, has as its goal the accurate description and understanding of experience as it is lived (Colaizzi, 1978; Knaack, 1984; Lynch-Sauer, 1985; Oiler, 1982, 1986; Omery, 1983; Valle and King, 1978) and is an appropriate method to use to discover insights and meanings relative to human experience (Benoliel, 1984; Munhall, 1989). This requires understanding of "both the cognitive subjective perspective of the person who has the experience and the effect that perspective has on the lived experience or behavior of the individual" (Omery, 1983, p. 50). The phenomenological approach "guides the researcher back from theoretical abstraction to the reality of lived experience ... to arrive at the essence of the experience" (Field & Morse, p. 27) through examination of the qualities of that experience. Therefore, phenomenological methodology is considered appropriate to answer this study's question which seeks to describe the grief experience of pediatric intensive care unit nurses.

The general format for the investigation included several of the basic steps identified by

Oiler (1982) and Omery (1983). The first, bracketing, involved the researcher explicitly stating and setting aside, as much as possible, any preconceived notions, expectations or frameworks about the phenomena (Field & Morse, 1985; Knaack, 1984; Oiler, 1986; Omery; Swanson, 1990). This is necessary in order to truly approach the phenomenon afresh every time it is encountered and "to understand human experience from the individual's perspective" (Knaack; Valle & King, 1978). By acknowledging and attending to certain assumptions (as identified in Chapter 2), and then setting them aside, this researcher attempted to question "what I thought I knew about this experience and to discover what was truly being said in the interviews. Such attentiveness to self-questioning of commonplace knowledge or assumptions enabled me to uncover new possibilities that potentially enrich prior knowledge of the research topic" (Carnevale, 1994, p. 75). Of course, there needs to be recognition that these "common-sense preunderstandings, suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological questions" (van Manen, 1984, p. 9). Therefore, the interpretations that have emerged from the data have been influenced by this researcher's background knowledge and experience brought to bear in the act of understanding. The review of the literature, as presented in Chapter 2, has summarized this researcher's knowledge of grief and grieving and nurse's responses to the death of their patients at the onset of data collection. Although this information was bracketed during data collection and analysis, the reader has been made aware of how certain assumptions and pre-understanding may have influenced this researcher's findings.

The second step, data gathering, involved gathering descriptions from intensive care nurses who had experienced grief as a result of the loss of children for whom they had cared in a pediatric intensive care environment and then critically reflecting on the transcribed accounts in order to grasp the common elements and the variations in the stories. The third step was to analyze the phenomenon of grief against the background of various meanings of experience

(that is, analyze what it is like to live in the informants' world) in an attempt to determine what this phenomenon means to them. Lastly, the research findings that have been produced from the description of the phenomenon are an interpretation or an articulation of meanings as they have emerged and are in terms of its meaning for the informants.

Methodological Assumptions

The choice for a phenomenological approach was founded on the assumptions that: (1) the grief experienced as a result of the death of a pediatric patient has meaning for the pediatric intensive care unit nurse; (2) the pediatric intensive care nurse is articulate and well able to describe her/his experience; (3) the pediatric intensive care nurse would be receptive to sharing wholly her/his experience with the investigator; (4) both the informant, as well as the investigator, are being changed through this research method (Oiler, 1982; von Eckartsberg, 1971); and as a result, (5) there may be a therapeutic effect for the informant in the act of sharing her/his grief experiences (Hutchinson, Wilson, & Wilson, 1994).

Setting

Participants were recruited from a pediatric intensive care unit within a pediatric metropolitan teaching hospital. This hospital was selected as it is a tertiary care centre designated to care for and sustain life in acutely ill children in an intensive care environment. This unit, like other pediatric intensive care units, is an in-patient setting where a child (newborn through to and including adolescents) is admitted to receive medical and nursing care for an unstable life-threatening illness. High technology has a necessary place in this setting and is used to assist in the monitoring, diagnosing and treatment of the critically ill child.

The following description of the setting is based on information provided by the head nurse obtained in a ninety minute meeting which was held on completion of the interviews with the participants. Detailed notes were kept during this meeting.

This unit has the capacity to hold 12 acute care beds. Eight are in open bay areas housed in a large single space and four are in closed or single, isolation rooms, two located at each end of the unit. A central nursing station is located in the middle of the unit, and is predominantly a communication centre. Equipment, central supplies, and emergency carts are all located in the immediate periphery. In addition, a four bed, intermediate care unit is located adjacent to the acute care area and is considered part of the intensive care unit. The children in this section are considered too hemodynamically unstable to be transferred from the intensive care environment but are stable enough to be outside the direct supervision of the medical staff and can receive nursing care in a ratio of one nurse to two patients (1:2). Nurses work in both areas, although two registered nurses have been employed to work there permanently. The most senior staff work 10 percent of their scheduled hours in the intermediary unit, while the most junior staff may work up to 30 percent in this area.

At any one time, the medical team consists of a pediatric intensivist, one to four fellows, and one to three residents. The residents are scheduled to work in the unit for one month blocks. There is a physician on site at all times. There is a nurse in charge every shift who is responsible for staffing and assisting the bedside nurses, as requested, with the delivery of care.

The unit serves children from a variety of different cultural and socioeconomic backgrounds. Respiratory and cardiovascular diseases represent close to 50 per cent of the admissions for the unit as well as nearly 65 per cent of patient days. However, a full scope of medical services is offered for children with neurologic, oncology/hematologic, orthopedic, metabolic, renal, neuromuscular, gastrointestinal, endocrine, and metabolic disorders. The unit provides care for children with multisystem failure from infectious diseases or trauma, as well as respite care for children on home ventilation.

The following are the annual statistics on this unit: average census is 6.5 patients/day, (ranges 1 to 11 patients); average length of stay is 4.88 days, (range of several hours to several

months and occasionally > 1 year); average mortality is 40 deaths. It is pertinent to note that the number of deaths for the three month period just prior to the interviews for this study already had exceeded the average annual mortality rate. Children undergoing cardiovascular surgery represent the population most at risk for mortality in this unit.

This unit is staffed with 30 full time and 15 part time registered nurses to provide one to one nursing care for all patients on a twenty four hour basis in the acute care section and a ratio of 1:2 in the intermediary care section. The nurses work 12 hour shifts, with 45 percent of their master rotation scheduled for the night shift. The average nursing staff turnover for the unit has been 5 - 8 percent annually for the past ten years. Reasons for turnover have been related to parenthood or spousal transfers. Years of experience in the unit are distributed as follows: (a) < 1 year = 7 %, (b) 1-5 years = 22 %; (c) 6-10 years = 49% , and (d) > 11 years = 22%. The majority of staff are between 30- 39 years of age; 45 % have degrees in nursing and 9% have obtained graduate degrees. There are five male nurses out of the total compliment of 45.

All staff receive a minimum of six weeks orientation to the unit. New graduates undergo an additional four weeks. Preceptors assist with orientation to the clinical area. After the first 4 to 6 month period, staff are provided with additional classroom and clinical hours to orient them to the care of the cardiovascular child in the immediate postoperative period. Therefore, the novice intensive care nurse is not expected to care for these high acuity children with cardiovascular problems. A 10 day, advanced pediatric pathophysiology intensive care course is offered after the first year of service to the unit.

The philosophy of care both in the hospital and intensive care unit has a strong family orientation. Family members are encouraged to be with their child and anyone that the family has identified as significant to the child's well-being is welcome. There is no formal visiting policy and no expectations that family leave during rounds or delivery of care.

A number of bereavement support services are offered for family and staff. The hospital has a Bereavement Follow-up Program and the coordinator of same is the primary resource for

family grief counselling. This individual is also readily available to provide informal and formal support for staff. A chaplain is specifically assigned to the unit and an on-call team is available 24 hours a day, as are social services. In addition, a Family Services consultant is accessible for families with complicated grief who require further resources. Staff also have access to the hospital's Employee Assistance Program, workshops on death and dying, and the head nurse of this unit who has expertise in grief counselling.

The philosophy of the unit is to promote ethical decision making as a shared moral responsibility to the child. Partners in care include the child, as appropriate, the parents or legal guardians, and all members of the health care team. Patient care conferences are frequently held to discuss the ethical issues involved, to review the options available based on reasonable standards of care, and to decide a plan of action. Additionally, critical incident debriefings are provided for any child's death on an "as needed basis". Staff members are encouraged to initiate these sessions and are supported by all disciplines.

Sample

The qualitative nature of this study demanded that a nonprobability sample be used because informants were needed that were knowledgeable, articulate, and willing to share their experiences (Morse, 1986; Morse & Field, 1995).

It is essential that the informants be not only knowledgeable, that is, have experience with the topic under investigation (Colaizzi, 1978) but also be reflective and willing to share with the interviewer (Colaizzi; Morse, 1991; Morse & Field, 1995) in order to "maximize opportunities to obtain the most insightful data possible" (Morse, 1986, p. 183). One assumption underlying nonprobability sampling is that all participants in a setting are not equally knowledgeable about the phenomenon being investigated. Some members of the group would be considered more informative and more articulate than others owing to differences in roles, age, education, past experience, and ability to recall (Morse, 1986, 1991). Some have better observational skills,

have greater insight, and are more interested in the research topic than others. Furthermore, some members are more receptive to being interviewed and are more likely to disclose information to the researcher (Morse, 1986, 1991). Therefore, a nonprobability, purposive (Morse & Field, 1995) sampling design was used to facilitate understanding of the lived experience of grief. The researcher purposefully selected informants, via the eligibility criteria, who were experiential experts, that is, pediatric intensive care nurses who had experienced accumulated losses through the death of their patients.

The exact sample size was not determined before hand because in qualitative research, sampling and data collection cease "when the researcher ... obtains coherence and does not collect any new information" (Morse, 1986, p. 186) and the richness of the data is meaningful to report (Lincoln & Guba, 1985; Munhall, 1989). However, because of the length of the data-gathering interview(s) and the detail of the complete description, the sample size is small (Omery, 1983), ranging from a single case study to six informants for a phenomenological study (Morse, 1986; Morse & Fields, 1995). This researcher recruited six nurses as this number has been considered appropriate for such a homogenous sample (Lincoln & Guba, 1985; Morse, 1994a).

Eligibility Criteria

Ideally, the study sample needs to be drawn from a population actually experiencing the phenomena under investigation rather than reflecting back (Oiler, 1982). However, the researcher was unable to predict the number of dying children at any one time and the review of the literature revealed that grief is experienced over time. This does not present a limitation to the study as one of the basic assumptions of phenomenology is that people do act as observers and do pay attention to themselves in terms of their activities and experience (von Eckartsberg, 1971) and as "each individual's history is a dimension of the present, a past experience will exist in the present moment" (Liehr & Marcus, 1994, p. 263). Therefore, for the

purpose of this research, the participants were required to meet the following criteria:

1. to be a registered nurse currently working in the pediatric intensive care unit of the target hospital,
2. to have experienced the death of at least three children for whom s/he has cared in the pediatric intensive care unit,
3. to be able to converse fluently in the English language.

The first criterion was established to exclude other intensive care unit staff (that is, student nurses, physicians, unit secretaries) in order to maintain a homogenous sample. The second criterion was to avoid obtaining opinions from nurses who had not lived the experience of grief resulting from the recurrent and frequent deaths of their patients. The third criterion was required as this researcher is not bilingual. The target hospital is bilingual in nature and employs some nurses with French as their first language, but the participants had to be comfortable in describing their grief experience using the English language.

Method

A flexible, guided interview with open-ended questions was used to facilitate the investigation into the phenomenon of grief (May, 1991; Miller & Crabtree, 1992; Morse & Field, 1995). The same questions were covered with each participant for some consistency to allow for comparison between and among informants, but not necessarily in the same order or using the same wording. The participants were able to structure their own thoughts and how they expressed them. Each of the informants participated in one face-to-face, in-depth interview. The average length of interview was 99 minutes but ranged from 64 to 141 minutes. They were asked to discuss specific experiences with the deaths of children for whom they had cared. It was through their sharing of these lived experiences with dying patients and their families that the nature of their grief experience was understood.

The focus of the interview was based largely on the research questions of the study

which were derived from the phenomenon of grief as described in the literature. The phenomenological inquiry was guided by the research questions and initially included: grief reactions, factors influencing the nurse's grief experience, coping strategies, and changes associated with the grief experience. The interview tool was piloted and a question was subsequently added in order to solicit a portrayal of the context in which the informants experienced their grief. Additionally, the wording of prompts was changed to better reflect the phenomenological approach and to better discover the essence of their experiences (see Appendix A). Interviews were audiotaped and typed verbatim. Fieldnotes were completed immediately following the interview.

Data Collection Procedure

Pilot Study

A pilot study was conducted before the main project was undertaken for two principal reasons: (1) to give the researcher more experience in qualitative interviewing, and (2) to test the semi-structured interview tool. The success (validity) of the question put to the participants depends on the extent to which the questions tap the participants' experiences apart from their theoretical knowledge of the topic (Colaizzi, 1978).

Following approval from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and approval from the target hospital, participants were recruited from a pediatric intensive care unit in a separate pediatric metropolitan teaching hospital. This hospital was selected due to (1) its similarity to the main study's target hospital, such as bed capacity, bed occupancy, average level of acuity, patient population, primary reasons for admission, and size of nursing staff, and (2) the researcher's familiarity with the nursing staff in this unit which facilitated access and selection of prospective informants. The researcher had prior knowledge of which nurses had the experience required, would be "good to talk to", and would probably be willing to participate. Morse (1991) states that primary selection is "an ideal

method of sampling in phenomenology" (p. 136). Based on the eligibility criteria, this researcher approached two nurses who had previously expressed an interest in the study and both readily agreed to participate. Informed consent was obtained prior to the interviews. The interviews were held in a place chosen by the informants. Interviews took from 70 to 104 minutes. The audio-taped interviews were transcribed within the next twenty four hour period. The transcription was then checked against the tape for accuracy. Field notes were written immediately post interview. The transcripts were then reviewed by this researcher's qualitative methodologists and areas for improvement were identified. Alternate wording of the questions was suggested in order to obtain the desired depth of answer; areas for follow-up details were identified; strategies for exploring the subtlety of meaning were discussed; and it was noted that a redesign in the pattern of questioning was needed. A third participant was then recruited using the above selection procedure to implement and practice these strategies. The researcher was able to further develop the art of interviewing, become more comfortable with the ebb and flow nature of the interview process, and respond in a flexible fashion in order to follow the participant's expression of ideas. Upon review of the third transcript, approval was given by this researcher's thesis committee to advance with the main study. Data from the pilot study were analyzed for themes, but the cases were not blended with the main study.

Main Study

During the research proposal phase of the study, a telephone conference call was held with the head nurse of the pediatric intensive care unit of the potential target hospital. The purpose of this first meeting was to obtain consent to use the site for the study. The aims of the study and the process of data collection were discussed. Verbal support was obtained and a copy of the proposal was forwarded. Approval was then obtained from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and the appropriate research committees of the target hospital. A qualitative methodologist from one of the target hospital's

affiliating universities reviewed the proposal at the request of the nursing research committee and approval was granted with no recommendations for change.

Prior to data collection, a second conference call was held with the head nurse to discuss the recruitment process. The head nurse desired to assist the researcher with the recruitment and, to this effect, distributed to each nurse a letter (see Appendix B) explaining the study and requesting participation, as well as posting it in the unit communication book.

The head nurse reported that there was a strong and immediate expression of interest in the study among staff on the unit which has not been a common response to other research projects. Close to twenty nurses verbally acknowledged to the head nurse that they were pleased to see this topic being addressed. It is especially interesting to note that an additional five nurses reported, that although they believed the study was valuable and necessary, they requested that the head nurse not ask them to participate as they felt unable to talk about this subject. The head nurse also noted that it had been a particularly difficult past three months, as the number of deaths in that time period had already exceeded the average annual mortality rate.

A list of five names of interested staff was presented to the researcher one week following the first meeting. A sixth nurse contacted the researcher two months after the initial recruitment letter to inquire if participants were still needed. This nurse was recruited into the study at that time. In the course of the following four months, no further nurses offered to participate, although one nurse approached the researcher directly to express her interest in the study but felt she had nothing worthwhile to contribute. The eligibility criteria and the data collection procedure were reviewed with this nurse but no persuasive techniques were used given the emotive nature of the topic. She did not participate.

Contact by telephone was made with each of the subjects. The purpose of the study and the data collection procedure were reviewed and all verbally agreed to participate. At the time of the first interview, a formal written consent was obtained (see Appendix C). The interviews were

scheduled at a mutually convenient time and place. Although the head nurse offered to provide time at work for data collection, the interviews were not conducted during scheduled working hours. This researcher felt that uninterrupted interviewing time could not be guaranteed given the unpredictable nature of the intensive care unit environment and the tendency for nurses to worry about their patients for whom they felt responsible. In addition, the subjects were concerned that they would inflict a heavy workload on their colleagues for an undetermined length of time. The potential need for the participants to protect their feelings upon return to the work environment also was a deciding factor in choosing a time outside working hours. Four of the interviews were held in the respondents' homes and two were located in an isolation room in the workplace according to their preference.

Toward the end of the third month of data collection, the researcher sought any additional informants interested in the study. The head nurse determined that a follow-up letter would be posted in the communication book informing the staff of the current status of the study. Additionally, the head nurse presented a list of nurses believed to be interested in the study but who had verbally indicated that they believed that they had nothing to offer that would be valuable to the study. Personal letters were forwarded to each of these nurses requesting their participation. Nurses who had previously indicated they did not want to be approached were not contacted. No responses were forthcoming. Preliminary data analyses of the first five interviews demonstrated data saturation of themes identified both in the pilot study and the main study data set and the sixth informant did not contribute any additional themes to this. Upon consultation with members of the researcher's thesis committee, data collection was terminated.

Characteristics of the Participants

Pilot Study

The three informant's in the pilot study ranged in nursing experience from 5 to 19 years; intensive care nursing from 2.5 to 10 years; and in tenure on the unit from 2.5 to 6 years. One nurse had worked in an adult intensive care unit and had experienced the death of patients in this area. Two had experience in long term care with children who were technology dependent; both had been exposed to death in this setting. One of these subjects also had experience in emergency nursing. None of the participants had experienced the death of immediate family members. One participant identified that she had just recently experienced the death of a significant other in her life, although it was not a family relation. All three had experienced the death of a colleague in the unit eleven months prior to this study. Two of the participants were parents. All but one of the informants were female.

Main Study

The six informants of the main study ranged in nursing experience from 2 to 20 years; in intensive care nursing experience from 9 months to 19 years; and in tenure on the unit from 9 months to 15 years. The summative experience of these participants is described. Three of the nurses had previous experience with adult nursing, one in the area of intensive care, one in emergency nursing, and the other in oncology-hematology. Two of the nurses had previous experience on a pediatric long term care unit, where the children were dependent on technology for survival; one had experience with pediatric oncology-hematology; one in neonatal intensive care; one in pediatric emergency; and one had experience with pediatric medical air transport.

Four participants had experienced the death of a child prior to working in an intensive care unit. The participant who had worked in an adult intensive care unit had experienced the death of adult patients for whom she cared prior to working in a pediatric intensive care unit as well as

pediatric patients in the emergency department. This was similar for the nurse who had worked in a neonatal intensive care unit. Two of the participants had experienced the death of immediate family members. One of the participants was a parent. All but one of the informants were female.

A summary of the demographic characteristics of the pilot and main study samples are shown in Table I and II respectively. In Table 1, the participants are identified as P1, P2, and P3. In the main study, Table II, non gender specific names - Alex, Casey, Dale, Jamie, Pat, and Sean - are provided to protect their anonymity.

Table 1. Description of Informants - Pilot Study

	P 1	P 2	P 3
Age	≥ 31- 40	≥ 41-50	≥ 21-30
Highest Level of Nursing Education Achieved	diploma	degree	diploma
Current Educational Endeavors	degree		degree
Years of Nursing Experience	≥ 6-10	> 11	≥ 6-10
Years Intensive Care Experience	≥ 6-10	> 11	≥ 0-5
Years Pediatric Intensive Care Experience	≥ 6-10	≥ 6-10	≥ 0-5
Number of Children's Deaths Experienced	≥ 10-25	> 25	≥ 10-25

Table II. Description of Informants - Main Study

	Alex	Casey	Dale	Jamie	Pat	Sean
Age	≥ 31-40	≥ 21-30	≥ 21-30	≥ 21-30	≥ 31-40	≥ 31-40
Highest Level of Nursing Education	Master's prepared	Master's prepared	degree	diploma	diploma	degree
Current Educational Endeavors					degree	
Years of Nursing Experience	> 11	≥ 0-5	≥ 6-10	≥ 6-10	≥ 6-10	≥ 6-10
Years Intensive Care Experience	>11	≥ 0-5	≥ 6-11	≥ 0-5	≥ 6-10	≥ 6-10
Years Pediatric Intensive Care Experience	>11	≥ 0-5	≥ 6-11	≥ 0-5	≥ 6-10	≥ 6-10
Number of Children's Deaths Experienced	> 25 (stated > 100)	< 10	≥ 10-25	≥ 10-25	≥ 10-25	> 25

Data Analysis

The method of data analysis varies among phenomenological researchers, but the goal to remain faithful to the phenomenon in the interpretation is common to all methodologies. Data analysis was performed by the researcher according to the procedure outlined by Colaizzi (1978). In the 25 years since the appearance of his method of content data analysis, qualitative data analysis methodology has not been modified while refinement has occurred predominantly in the area of data management. Current authors (Huberman & Miles, 1994; Morse, 1994b; Morse & Field, 1995) continue to identify similar components to the analysis procedure. The

goal of content analysis was to identify the themes that would capture the essence of what it is like to grieve the loss of a child for whom the pediatric intensive care nurse has cared (Field & Morse, 1985; Swanson, 1990). This researcher chose Colaizzi's procedure because the process was viewed as logical, systematic, and coherent, strategies needed by this novice investigator in qualitative research. In addition, Colaizzi describes his procedure for analysis as being developed from Heideggerian existential phenomenology and therefore it is compatible with the interpretive approach taken with this study (p. 52).

As soon as possible following the interview, each tape was transcribed verbatim. Then the tape was replayed to check the transcription for accuracy and to add notations regarding changes in voice, significant pauses and inflections (Field & Morse, 1985). When the interviews were completed, data analysis began (Colaizzi, 1978). The data set consisted of 310 pages of typed text. The entire description of each subject's data was read through for a sense of the whole. The transcript was then analyzed with more depth so that significant words, statements, and passages that directly pertained to grief could be extracted. Notations were made in the margins and meanings (categories or common elements) were formulated as they emerged from the significant statements.

A manual data filing system was utilized as illustrated by Field and Morse (1985, p. 101-102). The interviews were transcribed with two inch margins on the right and left sides so that text analysis and initial memos could be written on the pages. Each line of the text was number coded with both a line and page number. Each page of the interview was color coded in the left margin, with one colored stripe for each participant. The major categories were written in the margins and then the relevant sections of the transcribed notes and interviews were color coded with colored markers and subsequently were cut and pasted onto a full sheet of paper (card) and filed in the appropriate folder for that category. These folders subsequently became subfiles and were divided according to the principal research questions: (a) factors influencing the informant's grief experience, (b) the informant's grief reactions and feelings, (c) how the

informant copes with grief, (d) and the learning process associated with grief. An additional file was created that was associated with (e) context. As one segment initially fit into two or more categories, multiple copies of data were made. The colour and number coding became a fast method of identifying all data, allowing pieces coded for analysis to be traced to the original source.

The above process was repeated for each transcribed interview and the resulting aggregate of formulated meanings were then organized into clusters of themes which were validated by referring back to the original transcripts to ensure no data had been ignored or added to. The cards were then sorted into piles that seemed to have a common thread, looking for patterns and relationships between cards and piles of cards. New "theme" file folders were created for the newly created groupings. Through the process of making comparisons and asking questions, connections between categories began to emerge.

The results of the analysis were then integrated into an exhaustive description of the nature of grief for pediatric intensive care nurses. As described by Bergum (1991), "the writing and rewriting, the constant search for deeper meaning, changed not only the understanding of particular parts of the study but also the totality of the study, which again required rewriting" (p. 66). This constant search for new understanding has been called the hermeneutic circle.

Enhancing Methodological Rigor

In this study, the quantitative terms of internal validity, external validity, reliability, and objectivity are referred to as credibility (truth value), fittingness (applicability), auditability (consistency), and confirmability (neutrality), respectively as renamed by Guba and Lincoln in 1981 (Beck, 1993; Sandelowski, 1986).

The informants should recognize the researcher's described experiences as their own (Beck, 1993; Sandelowski, 1986). "As in any phenomenological investigation, the validity of the findings must be assessed by its reception. If those who have lived the phenomenon can see

their own reality mirrored in the model, then the validity of the model is supported" (Swanson, 1990, p. 71). Therefore, the informants must be asked if the analysis reflects their reality and not a slanted view of the investigator. Additionally, the researcher must share the findings with others who have experienced the phenomenon under study to critique how well it accounts for their experiences. The researcher returned to the participants with the analysis of the findings to ask if the themes described their experiences. These follow-up interviews were 60 minutes in length and occurred in their home or a conference room in the workplace as selected by them. None of the themes identified were refuted by these nurses. However, due to the emotive nature of the data, the responses of the participants were limited to the verification of the researcher's results rather than a further reflection of this lived experience. Additionally, the findings were reported to a small group of pediatric intensive care nurses of the target hospital for the pilot study. These nurses affirmed the phenomenon. These strategies support the credibility, confirmability, and fittingness of the findings. The findings were not reported to the target hospital of the main study at this time. Staff were unable to attend the presentations for reasons of patient care. The findings will be presented at their annual research conference in the Fall of '96 as requested by the head nurse.

One of the committee members, a full-time social worker, expert in family bereavement, reviewed clean copies of the transcripts, in conjunction with the themes, not only to verify auditability, but to also determine if additional themes related to grief could be identified. The data collection and analysis methods were reviewed by the researcher's expert qualitative methodologists to prevent researcher bias and selective inattention (Morse, 1986). In addition a Master's level nursing student, familiar with qualitative methodology, independently reviewed the themes with clean copies of two transcripts and a copy of the themes to determine if she could, "adopt the same viewpoint as articulated by the researcher, also see what this researcher saw, whether or not she agrees with it" (Giorgi, 1975, p.96). These measures are documented in detail in this report and support the auditability of this study. Additionally, the readers have

been provided with rich excerpts from the transcripts (Beck, 1993; Morse, 1994a; Swanson, 1990) so that they can judge for themselves if they would arrive at the same or comparable conclusions given this researcher's data, perspective and situation (Sandeloskwi, 1986).

Ethics and Human Rights

Measures to assure protection of the rights of the participants began when permission to conduct the study was sought from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and all appropriate research committees of the target hospital. To ensure the participant's right to informed consent, all were given a letter of information which explained the intent of the study along with an opportunity to raise any questions or concerns. Initial consent was obtained verbally from the participants when they indicated a desire to participate in the study. At the time of the first meeting a formal written consent was obtained. The written consent form contained the following elements which Field and Morse (1985, p. 42-44) have identified as being essential in the conduct of research: (1) an explanation of the study including purpose, taping of interviews, number and duration of interviews; (2) assurance of confidentiality and that only anonymous quotes will be used in any publication; (3) a statement indicating that the study will hopefully heighten awareness about nurses' grief experiences; (4) an indication that the participant is free to refuse to answer any questions without penalty; and (5) the participant is free to withdraw from the study at any time or withdraw some or all data provided without penalty. In addition to ensuring complete confidentiality of all participants throughout the study, confidentiality of patient information has also been protected. At no time during the study have children who died or their families been referred to by name.

One condition for obtaining optimal comprehension in phenomenological research is that participants must be willing to tolerate intrusion and to share their lived experience with the researcher (Morse, 1994b, p.28). They perhaps take a risk. Therefore, the participants anonymity has been assured and they were reassured that the report would not have any

untoward ramifications for them personally. Additionally, it was appreciated by the researcher that for some, if not for all the participants, that talking about their grief would be a sensitive area. The researcher was therefore prepared to provide support during the interview and to suggest the Employees Assistance Program, Bereavement Coordinator, or other counselling resources as necessary. The researcher was prepared to terminate the interview in the event that the emotional integrity of the nurse would be compromised.

CHAPTER 4

The Participants' Accounts - Findings and Discussion

Introduction

This chapter describes the essential structure of the grief experience of pediatric intensive care nurses when their patients died. Each section explores three elements of the participants' grief, namely: (1) grief responses, (2) influencing contextual factors, and (3) coping strategies. While each participant provided a distinctive account of the experience, in-depth comparative analysis of the interviews revealed themes woven throughout the described personal experiences specific to each element. Further analysis within each theme revealed a multitude of variables. The participant's own words are used to support the identified themes and build an exhaustive description of the experience. All of the names of the informants have been changed to protect their anonymity. Non gender specific names have been selected and the female gender is used when necessary throughout the findings. No children, or their families, have been identified by name. A discussion has been incorporated into this chapter as is common to phenomenological writing (Wolcott, 1990). As described by Lofland (1974), the presentation and discussion of qualitative results is a blending of results, "frame" (conceptualization or description), and discussion:

"Frame and qualitative materials coexist as one whole, each depending upon the other for the 'interest' a reader has in the frame or in the qualitative material. . . . The frame taken separately is dull because the reader has little conception of the concrete empirical reality to which the frame might refer. The 'data' alone are dull because the reader has no notion of what sort of social structure or process might be involved. But interpenetrated through minute and continual alternation between data and frame-elements, the whole is more than the part" (108-109).

Pediatric Intensive Nurses' Grief - An Overview

The majority of the interviews were highly emotional both for the participants and the researcher. Their distress was both audibly and visibly evident. The participants' voices would often break as they discussed the children's deaths. Their tone of voice would soften and at

times become almost inaudible. Frequently there were long pauses in their descriptions and occasionally they stopped telling their stories when they were having difficulty coping with their emotions. They would resume their stories later. All participants were teary during the interview and most of the participants broke down and cried several times. It was necessary to break for a short time for all but two of the interviews. The participants needed time to regain composure before they felt they could continue.

Nervous laughter also predominated all the interviews. It appeared that it was used at times to replace other expressions of emotions such as crying or anger or to hide their embarrassment. It also seemed to occur when the participants expressed thoughts they felt might not be acceptable to say out loud. For example, the participants would give a slight laugh when discussing the removal of the child's body from the unit or when feeling a sense of release at the time of a child's death.

Many of the participants were faced with suddenly remembering deaths or events of deaths that they had previously thought had been forgotten. These often triggered a more intense emotional response. However, no one requested to end the interview prematurely. Despite the vulnerability the participants faced, all of them stated it had been beneficial to them. Some expressed a sense of emotional relief at having said out loud many of their thoughts and feelings. Some stated they felt glad they remembered these children because it helped them to see that they were still caring human beings. Several described feeling good about sharing information that they hoped would be helpful to other nurses. Another described that it had helped her gain a new perspective about her grief. One participant's words poignantly expressed what all the participants stated at the end of the interview:

"I was happy that I'm able to do it because it just, it "fait le vide" [catharsis] and uh. I think in general we should, nurses need to do that. ... We talk about it at lunch but nobody really spills their guts out."

Perhaps the highly emotional nature of these interviews partially explains the discrepancy between the nursing interest in the study but the limited participation.

The participants confirmed that pediatric intensive care nurses do experience multiple, accumulated losses as part of their working life. They all stated that not only had they been exposed to many deaths, but they had often been exposed to several deaths at one time or within a short period of time.

Pediatric intensive care nurses' grief was a complex phenomenon. Even though there were common patterns in the grief of nurses, their grief was a personally lived experience. The death of a child was uniquely lived by each participant and each death was unique in and of itself. The participants made it clear that the death of each child was different and therefore their grief was different for each of the deaths. Nurses who had the same child death exposure did not necessarily share the same grief experience. The meaning that each individual placed on the death of the child was different due to such factors as age of the nurse, and personal and professional work experiences. Individualization as an attribute of grief is not unique to these participants. Cowles and Rodgers (1993) reported in their meta analysis of the current and classic literature, that the general consensus was that grief is a highly variable phenomenon among individuals. Cody (1991), in his phenomenological study of four persons who were grieving the loss of a close other through death or separation, stated that "the meaning of any loss is determined individually, subjectively, and situationally by the person experiencing it" (p. 61).

Consistent with the current research and writings on grief (Demi & Miles, 1986; Katz & Florian, 1986-87; Parkes, 1972), the participants' grief was also multifaceted and multivariate, that is, their grief had many interwoven elements. The elements identified in the analysis were grief responses, influencing contextual factors, and coping strategies. Within each of these elements there were many variables. First, the participants described a variation in their feelings of grief with each death, such as sadness, anger and guilt, and how these feelings could be manifested in a variety of ways. The participants described how they lived through different combinations of feelings of grief and how the intensity and duration of the emotions varied from

one death to another. As the participants shared each of their stories, it became evident that their grief responses were influenced by a myriad of contextual factors. They identified such factors as the mode of death, reactions of the family to the death, the meaning the child and family had for the nurse, age of the child, the number of deaths recently experienced by the nurse, available supports, concurrent personal stresses, and available coping strategies. Thus, the participants' grief was both personally and contextually driven. These influencing factors were different for each death. As Alex said: "But every death is somewhat different," and therefore, the participants' grief was different for each death. Also significant, the nurses were not able to predict their responses to the death of a child because these variables changed for each child's death and most were not within their influence to control.

There was no habituation to the nurses' grief. There appeared to be no acclimatization to their stated behavior or feelings at the time of the child's death. This is in contrast to the habituation that seemed to have developed for other stressful situations in the unit, such as their fears of being unable to care for any child in the unit or to be able to function at a cardiac arrest. All stated that they "would never get used to the death of children". Even those nurses with ten to twenty years of pediatric intensive care experience continued to grieve when the children for whom they cared died. They described how their grief could be as intense and of as long a duration after many years of intensive care experience as it was the first time they were exposed to the death of a child. However, the experienced participants appeared to continue to derive great satisfaction in pediatric intensive care nursing despite having been exposed to many children's deaths during their tenure in this setting. The participants described how they learned to manage their grief by learning to cope and this was another element to the lived grief experience of pediatric intensive care nurses. The nurses learned, through a process of trial and error, to develop a variety of coping strategies, such as the development of death rituals, sharing their experience with others, and creating a personal philosophy of illness and death. The development of coping strategies to manage their grief is similar to the finding by Vachon

(1987, 1994) and Vachon and Pakes (1985). In their research of occupational stress, these authors found that health care professionals developed and utilized a similar variety of strategies to cope with the stress of caring for the critically ill, the dying, and the bereaved.

The nature of pediatric intensive care nurses' grief was an experiential one and was the essence of their lived grief experience. For example, as the participants had more exposures to death, they began to learn what contextual factors surrounding the child's death affected their grief response. The more experienced participants had learned to perceive each death as a whole, used past concrete situations (of both those children who had survived and those who had died) as paradigms, and moved more quickly to the specific coping strategies that they had learned would be the most helpful in managing their grief for the particular contextual factors of the child's death. In contrast, the participants who were inexperienced with the death of children felt overwhelmed when their expectations and preconceived notions related to life and death were disconfirmed by the actual situation.

As defined by Kolb (1985), experiential learning is "the process whereby knowledge is created through transformation of experience" (p. 38). In the process of experiential learning, ideas are formed and continuously modified by experience. The process of learning is the individual's desire to resolve the conflicts between the interplay of one's expectations and concrete experience. It involves the integrated functioning of the total organism - thinking, feeling, perceiving, and behaving. Central to this learning process is self reflection. Boud, Keogh, & Walker (1985) state that "reflection in the context of learning is a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations" (Atkins & Murphy, 1993, p.1189). Experiential learning is a continuous, lifelong process. It was through constantly reflecting upon some of the children's deaths that the participants had learned, or were learning, how to manage their feelings of grief and cope with multiple, accumulated losses. In the following account, Pat describes this experiential process.

Pat: "... I think in a sense I've learned to first of all cope, in many different situations, positive and negative. And I'm sort of able to carry on now. ... I think just dealing with different people and dealing with the grief process over and over again, I've learned basically how I can make it better for me, and how I can learn to live with it, for me. And uh ultimately hopefully make it the best for the parents and the baby and whoever." (5 plus years intensive care experience)

The participants did not achieve mastery of their grief through a single exposure to the death of a child for whom they had cared. Pediatric intensive care nurses, inexperienced with death, could not know the breadth and depth of each of the elements of the grief experience from the death of only one child. This was because they had not yet learned that the grief experience was not limited to a single form. They had not yet learned that the contextual factors of a child's death changed each time and that this would affect their grief responses. They had not yet developed a variety of coping resources to help them manage their grief. The only two constants for the nurses were the hope that each child for whom they cared would live and the threat that a child for whom they cared would die.

Therefore, managing their grief was a learned and a learning process. No one was able to tell the nurse how s/he would grieve and no one was able to make the nurse an expert griever. As noted in Benner's work, "knowing that" and "knowing how" are two different kinds of knowledge. Reading about or being told what to expect at the time of a child's death and being informed of the coping strategies that are helpful to manage one's grief are not the same as learning "how" to manage one's grief through experience. Just as "expertise develops when the clinician tests and refines propositions, hypotheses, and principle-based expectations in actual practice situations" (Benner, 1984, p. 3), experience with death was a requisite for expertise in managing one's grief when living multiple, accumulated deaths. The participants who appeared to be successful at managing their grief had learned from being exposed to different deaths and by reflecting upon all the elements of the grief experience. They did not appear to isolate themselves. Rather, they worked with others to receive the support they needed to survive this painful experiential process.

As a result of this learning through multiple experiences with death, the nurses' lived experience of grief underwent change and also created change. Their grief responses varied in quality and intensity from time to time due to the changing contextual factors associated with each death. Their grief responses also changed over time because of the development of coping strategies that helped them manage their grief. For example, a factor such as organ donation may have caused considerable grief at one stage in their career, but appeared to change for some participants when new meaning was assigned to it when they later had experiences with transplantations. The nurses also stated that they had changed over time due to such factors as normal maturational development and personal life experiences such as marriage, parenthood, or the death of a significant other. These findings are consistent with the grief literature that states that the maturational processes of age, experiences with losses, and emergent life opportunities, such as parenthood, determine one's responses to death (Parkes, 1972; Rando, 1984; Worden, 1991). Several of these findings are also consistent with those of Eakes (1990) in her exploration of how hospice nurses effectively resolved their multiple experiences of grief. She too found that personal family relationships and personal experiences with death influenced the nurses' grief reactions at different times in their career working with the terminally ill.

Even the nature of the pediatric intensive care setting changed over time and these changes influenced the participants' grief. For example, constant advancements in technology resulted in ever-changing bioethical issues. Procedures, such as organ donation and transplantation, the use of extracorporeal membrane oxygenation, or innovative cardiovascular palliative surgical interventions had sometimes caused the participants to question the "right" balance of holistic care in the unit. When is enough, enough? When is a dignified, peaceful death the preferred choice to quantity of life? However, how these changes would affect their grief could not be anticipated prior to the death of a child. These bioethical issues also contributed to there being no habituation to their grief.

The nurses' lived experiences of grief also created change. The participants stated that their lives had been altered. The more experienced participants described how their exposure to multiple deaths and the grief they had experienced changed the way they viewed life and death, how they defined their philosophy of nursing, and even how they coped with problems in their personal lives, findings that are consistent with other research on the grief of hospice nurses (Eakes, 1990) or coping with the occupational stresses of critical care nursing (Vachon, 1987, 1994; Vachon & Pakes, 1985).

Consistent with the definition provided by Cowles & Rodgers (1991, 1993), grief for pediatric intensive care nurses is defined as a highly individualized phenomenon which pervades every aspect (physical, emotional, social, spiritual) of their being when a child for whom they care dies. It is a complex phenomenon that requires a holistic view of the multiple contextual factors that interact with the deaths of the children and the development of relevant coping skills over time, both of which influence the grief response. However, unlike the definitions provided in the literature, the nature of their lived experiences of grief is an ongoing experiential learning process. This is because pediatric intensive care nurses are exposed to many deaths on an ongoing basis. Therefore, the experience of the nurses is characterized by cognitive, affective and behavioral changes following exposure to multiple children's deaths.

The following sections provide a more in-depth view of the complexity of pediatric intensive care nurses' lived experiences of grief. The elements of their grief and the multiple variables within each element, as described by the participants, is presented. In the first section, the context of pediatric intensive care is described to provide insight into how these participants experienced their grief. The second section describes how these nurses have reacted to the death of a child for whom they have cared and presents the theme of hurting. The third section describes the contextual factors that have influenced their grief responses. Two themes have been identified: the nature of the nurse-family unit relationship and dissonance. The final section describes how these nurses managed their grief. Five themes related to coping have

been identified. They are (1) self expression, (2) self nurturance, (3) termination of relationship activities, (4) engaging in control taking activities, and (5) self-reflection. An overview of the findings and discussion is followed by presentation of data in full.

Section 1: Background

This section presents information related to the context of pediatric intensive care, or the world in which these nurses work. This description helped to provide insight into how these participants experienced their grief. To reiterate, the names of the participants are Alex, Dale, Pat, and Sean, who, for the purposes of this study, are considered experienced nurses with five plus years of pediatric intensive care experience, and Casey and Jamie, inexperienced nurses with less than five years of the same experience.

1.1 Decisions to work with children

All the participants had chosen to work in pediatrics because of their love of children. They described the nature of working with children as different from that of working with adults and as a result the rewards they experienced were different. Working with children was described as "more upbeat", "more fun." They were described as more resilient; they "bounced back" from their illnesses "faster" than did adults. Additionally, they perceived that children fought harder to live; did not give up on life when faced with the challenge of a life-threatening illness. Working with children was described as working with "the beginning of life".

The participants also described children as more open and honest in their communications and thus the nurses felt they knew where they stood at any one time. They stated that children, understandably, became angry when the nurses hurt them, but they described how children quickly forgave them the hurt. They stated that children were very demonstrative with their affections and they, the nurses, were permitted to physically show their feelings of affection and empathy with the children and families.

All the participants felt they had made a difference in the lives of the children for whom they had cared. They stated that most families showed their appreciation of the care provided in a variety of ways. The nurses who had worked in adult settings stated that they had frequently questioned if they had really made a difference in their patient's care. The adults were perceived as more verbally abusive and often the patients and/or their families complained about the care they had or had not received.

1.2 Decisions to work in intensive care

The reasons the participants cited for entering this work environment were varied. For Alex and Pat, it was an opportunity to have one-to-one patient care and to be able to have the time to provide holistic care to the child and family. They stated that workload issues in the non-critical care environments had prevented them from "getting to know their patients" and from providing total patient care. For example, they stated they had felt frustrated at the end of a shift that many of the needs of the patients and their families had not been met and described feeling a lack of control over the delivery of their nursing care. Dale and Sean expressed the fact that they had wanted to work in intensive care since graduating from nursing school. They perceived that clinical knowledge and skills could be expanded to enhance one's sense of competence. Jamie, as well as several other participants, identified that they had not wanted to work with chronically ill patients and perceived that the children in the intensive care environment recovered more rapidly from the acute phase of their illness and were then quickly transferred to another unit. Casey's reason for seeking employment in intensive care was related to the fact that she had heard that the unit manager was highly supportive of the nursing staff. She transferred from a unit where she had not received support in her grieving the deaths of the children for whom she had cared.

Neither Casey nor Pat had had a burning desire to work in pediatric intensive care. In fact, both expressed that they had had serious doubts about their abilities to work in this

environment. They said they "had not been ready" for this type of nursing and did not "consider themselves an intensive care nurse." While Pat stated that now she would never work anywhere other than intensive care, Casey still expressed much reservation about her abilities to work in this type of setting.

The wide range of age groups and the enormous scope of childhood diseases was an attraction for some of the participants. The nurses who had worked in adult or neonatal intensive care areas stated there was more predictability in the trajectory of the patients' illnesses and so they had no longer felt challenged. They perceived this was due to the more limited number of patient diagnoses seen in these units. They wanted the challenge of the perceived less predictable nature of events in the pediatric intensive care environment.

1.3 Critically ill children

The children in the pediatric intensive care unit were described as being seriously ill and "unstable" and dependent on the nurses for essentially all of their needs. As described by Carnevale (1994) in his research on the nature of intensive care nursing, and confirmed by these participants in their description of the patients for whom they have cared, this meant that the children were vulnerable to sudden, sometimes fatal, changes in their status. It has also been well documented that children are even more vulnerable than adults to sudden changes in their condition due to the anatomical and physiological differences of their body systems (Hazinski, 1992; Shoemaker, Thompson, & Holbrook, 1984). The participants also described dealing with life-threatening problems. In this context, nursing mistakes were perceived as more likely to cause significant injuries, if not death, to the child than those made in situations that were not life-threatening. This is very similar to the findings by Vachon & Pakes (1985) who noted in their research that "the ICU nurse is expected to function at a high level of professional competence. There isn't much room for error in this setting" (p. 157). During the acute phase of their illness, the majority of children were described as frequently not aware of their

surroundings and could not express their own needs. This was due to their illness, level of cognitive development, or interventions. The participants described that all these factors placed them at the front line for anticipation, early detection, and swift management of these life-threatening problems. They stated that PICU nursing required advanced expertise that was acquired through experience. They expressed how nurses, new to intensive care, often felt overwhelmed by the situations confronting them. The participants remembered that it took many months to feel that they would be able to care for any child that "might suddenly roll through the doors."

The patient was described as including more than the child for whom care was being provided; the family or legal guardians were described as being part of the unit of nursing care. All of the participants described valuing close relationships with the families and working with the family was identified as a strong attraction to working with children.

1.4 The ethos of pediatric intensive care nursing

Pediatric intensive care nursing was described as both sophisticated and diversified. The participants expressed how the skills and pace were frequently accelerated. Therefore, they described a strong need to feel in control of the situation in order to facilitate meeting the needs of the child and family. Observation, assessment, and evaluation of life-threatening conditions preceded appropriate interventions based upon a thorough knowledge of the dynamic interrelationships of body systems. They stated they needed to control the patient's condition by "assessing appropriately" and "hopefully intervening before the child's condition deteriorated." Therefore, they felt this required a broad scientific base of knowledge as well as specialized skills. They discussed the need to control the environment in order to be able to influence their practice. Even during crisis situations, the chaos remained controlled because the physical setting was purposely designed to facilitate control. For example, the use of technology was described as enabling the nurse to feel a better sense of control over the

child's physiological status at all times. As Alex said, she would find it very difficult to work in a setting where she did not have the child hooked up to all kinds of machines and equipment and other personnel very close in case something were to happen to the patient. The participants also described how they needed to be in control of self, cognitively and emotionally, so that they could make appropriate and rapid decisions as necessary. They described that to be out of control would leave them "feeling totally helpless", "sort of incompetent" and "unable to function," feelings that were personally unacceptable to them in this setting.

The nurses discussed how the team approach to the care of the child was an integral part of this practice. They described how in a crisis they needed to know that they could count on the person next to them, to know that when they said "help", the person "would be there" to "back them up." The participants stated that part of their successful adaptation to intensive care nursing was building relationships; learning "who one could rely on," "who one could trust."

Associated with this specialized body of knowledge and skill was an obligation to a high standard of care. This was not just a personal expectation for these participants. It is reinforced by such influences as the Standards for Critical Care Nursing Practice by the Canadian Association of Critical Care Nurses (1992) and the Standards for Acute Care Organizations by Canadian Council on Health Services Accreditation Standards (1994). Unit policies and procedures are based on these specialized standards.

All the participants stressed how important it was for them to integrate the comfort and supportive components of care with the cure or therapeutic goals of the intensive care unit. They described how the survival of the child with a good quality of life was the ultimate goal of the intensive care unit. Therefore, they valued scientific knowledge and high intervention. They stated that the provision of high quality physical care was a necessity for the child's survival, but at the same time, they saw the child as "more than just something you do things to," but rather as someone who had "feelings and a life with wishes and wants". An holistic approach to the care of the child was equally as important to the participants as the physical safety of the child.

For example, they told of their anger and frustration when the physicians viewed the child only as the organ or system for which they had been consulted. They stated that a prime focus of their care was the child's and family's "physical and emotional comfort." They described a strong desire to eliminate their suffering. In addition, a collaborative approach to care, with parents as members of the team and having shared decision-making responsibilities, was also cited as very important to them.

They believed that being with the child and family at all times afforded them the opportunity to meet not only the physical needs of the child, but also the psychosocial and spiritual needs of the child and the family members. Therefore, the nurses stated that although they valued providing the necessary physical care to the child and understood that "the physical needs had to be a priority" under most circumstances, they wanted to do so while meeting the concerns of the family. They believed it to be a large part of their role to help the family cope with the crisis of their child's illness. The nurses "liked the opportunity to follow the same child and family" and "strongly supported continuity of care" as this facilitated them getting to know the child and family, their needs, and how best to help them. They stated that having a relationship with the family made caring for the child "less technical," "more personal" and "more humane."

The participants also described how there was a strong parental surrogate role to their nursing care. Sometimes parents and other families members were not present and therefore the nurses provided the "affection" that parents would have given had they been present. Hugs, cuddles, and kisses were offered even when parents were present. Whenever possible, the nurses described playing with the children as part of their nursing care.

Learning how to integrate supportive nursing care with the cure aspects of the medical model required experience that only time allowed. Nurses had to learn to deal with the technology that had the tendency to separate them from the child. They had to learn to combine instrument manipulation with hands-on care and with meeting the emotional needs of the child and family. In fact, many of the participants stated that they "weren't thrilled about

technology," but recognized that it was "part of the setting," "part of the job," and were "tools to help them do their job." The participants identified that it "took them a good long time to get integrated." They described living with the fears of "missing something in their assessment" and "not being able to react quick enough when need be." Consequently, in the early stages of their work in intensive care, their nursing practice predominantly focused on the provision of the child's physical aspects of care. They described feeling frustrated and guilty when they could not provide holistic care. These findings are highly consistent with Benner's work on moving from novice to expert (1984) and the work of Benner and Wrubel (1989) on caring and coping with caregiving.

However, even the experienced participants discussed ongoing struggles to find the appropriate balance of medically driven cure interventions and nursing support and comfort measures in their practice in this environment. They described how dissatisfied they felt at the end of a shift when they had not been able to meet the needs of the family because the instability of the child's condition had kept them constantly focused on the physical aspects of care. The following account summarizes this integration of care.

Pat: "Okay, taking care of basically of the entire child and the entire body systems. Looking at everything at the same time while trying to make the child as comfortable and the family as comfortable as possible going through it. ... The turning, the positioning, the basic nursing things. Um that to me is more critical care than just suctioning Q4H and uh measuring ins and outs and you know watching heart rates and stuff. It means a lot to me that I give the best care possible and more of the actual nursing types of things. That to me is critical care. But I mean you also have the machines that you're dealing with and you have to watch and be alert. You have to um any changes in vitals or anything, be alert to what might be going on before hopefully it happens. So you've got the basic basic nursing needs and you also have the medicine medical part you know. If you think your ventilator's not working or whatever I get the appropriate people. So you've got everything kind of all into one." [more than 5 years intensive care experience]

Moreover, the participants identified how complex patients and complex technology had led to ongoing dilemmas in the ethics of health care delivery forcing them to deal with the moral distress that comes from ethical issues. Through the telling of their stories, they inferred that they frequently faced such issues as: if the technology is available, does it have to be used,

and if not, who should make the decision to withhold treatment? When is enough enough?

The ethos of pediatric intensive care nursing, as described by these participants, resulted in strong feelings of responsibility, individual professional accountability, or ownership for the child's and family's care, as an integral part of their practice that persisted throughout their career in intensive care. This had profound implications for their responses to grief when children for whom they had cared died and also contributed to there being no habituation to their grief.

1.5 Rewards of working in pediatric intensive care

The major rewards in pediatric intensive care nursing that were identified by the participants were the nature of the direct patient care, interpersonal relationships, and the acquisition of knowledge. The nurses described how exciting it was to watch a critically ill child progress and recover, especially when the nurse felt partially responsible for that recovery. They stated it was gratifying to visit children after they had been transferred from the unit or to have them visit with their families on their way home from hospital - to see the child who was close to death now resuming normal activities. They expressed that they had been able "to see a lot of miracles" working in this type of setting. When a child lived that was not expected to survive, it filled them with "happiness". To save a child was described as "a good feeling", "a joyful moment", and "worthy".

Pat: "So to me I feel like I'm doing something worthwhile. It's not like working in palliative care or something where they all wind up. I mean I guess each person has their own thing but for me it's, you know, every little kid that I can help walk out of here and that I know I've done the best of my ability to either make comfortable or whatever, then I get pleasure out of that. At least I've done my share." (5 plus years intensive care experience)

The nurses stated it was highly satisfying to be able to deliver total patient care and to have close involvement with one or two children and their families. As previously noted, they realized this was not always possible with large numbers of patients in less acute nursing care units. The participants described it as rewarding to sit down and talk with a mother and father and know that they had done something positive for them. They also described it as highly

rewarding to assist children and their families through an extremely difficult and sometimes devastating experience and to be allowed to share very personal, intense feelings.

The nurses described being able to take more initiative and to make more independent decisions in the intensive care setting. In actuality, it was an expectation of them once they had developed the knowledge and skills to be able to do so safely. They found this rewarding. They stated that they were usually recognized for their specialized knowledge and competence by their peers and by other health care professionals. They described how this increased level of knowledge and technical proficiency enabled them to influence others, such as the physicians, in the care of the child. This increased their self esteem. At the same time, they acknowledged that this feeling of responsibility and accountability for the child's well-being was at times also a major negative stressor. This occurred when they felt they lacked the knowledge or skills necessary for the situation or when they perceived they had made a mistake.

The close working relationships among nurses, physicians, and other co-workers in intensive care was also recognized to be rewarding. They described that the doctors and nurses usually worked well with and supported one another.

Jamie: "...And we support each other so [emphasized this word] much. I find the support we have within each other in a critical care unit is very important, and that's why we work so well. Because it's such stressful situations, that you need to know that you can count on the person next to you if you're in dire need of help. If you say help you know that a person will be there. And I guess that's why I really like working there." (less than 5 years intensive care experience)

The challenge, fast pace, excitement, stimulation, and opportunities for learning were all identified as positive aspects of the pediatric intensive care setting. The nurses described "the incredible adrenaline rush" they experienced in a life and death situation as long as the outcome was life-saving. The rewards identified by these participants have also been noted by Quint (1966) and Vachon & Pakes (1985) in their studies of positive and negative stressors for intensive care nurses.

In summary, it can be said that work on a pediatric intensive care unit involves constant

exposure to critically ill infants and children and their distraught parents in an atmosphere of ever-increasing technological changes requiring constant professional learning. However, the nurses strong desire to provide holistic care to the child and family and the high value they place on their emotional connectedness to the child and family are striking features of the ethos of pediatric intensive care nursing and helps create meaning for the nurses' experiences of grief. There is a perception commonly accepted by non-critical care personnel that this environment is a dehumanized one. This has evolved from the belief that technology destroys human dignity by reducing people to objects and that technology minimizes the nurse's role as empathetic toucher, only touching the patient to obtain objective information (Allan & Hall, 1988, Sandelowski, 1988; Walters, 1995). Given that high technology has established an inevitable and necessary place in the intensive care setting, it has been assumed that the nurses in this setting have objectified human life. If that were the situation, then perhaps the nurses would not have experienced grief. But as the following section describes, it hurts them when a child dies. These pediatric intensive care nurses did not appear to be dehumanized.

Section 2: How Nurses React To The Death Of A Child

Theme of Hurting - An Overview

When describing their stories, the participants used a wide variety of expressions, such as, "they were the most difficult," "were just awful," "were tough ones," "was a horrible, horrible, experience," "couldn't be a worse scenario," "that really touched me," "that really hit home," "were particularly hard," "was a good death experience," "an overwhelming death," and "really marked me." These expressions helped the researcher to identify that different grief responses resulted from different factors involved in each child's death. But in addition to this, the way in which the participants described their grief through the use of the above statements suggested it might be difficult for them to articulate more specifically what their grief was like. A

striking feature of each participant's accounts was that these expressions, used to globally summarize a specific story of the death of a child, were the same expressions used to describe their feelings of grief associated with that death. Repeatedly, participants spoke of how difficult it was, even impossible, to find the words to truly convey how they reacted to the death and the state of their emotions at the time of the loss. For example, when prompted to explain her feelings of helplessness at the time of the child's death, Sean said that you feel it, but it was difficult to put into words. Throughout the interviews, the participants struggled with their words as if searching for the right descriptor, paused for long periods, or changed their thought processes when the words failed them. So they resorted to stories that were meaningful to them, but helpful only by inference in building an understanding of how the loss of a child, for whom they had cared, affected them. For example, when asked what grief was like for them, all the participants alluded to their grief by describing the context of the child's death and thus the aspects within that situation that influenced their grief responses.

Casey: "I guess the one that really stands out for me the most was a little girl, she was thirteen. And she had a um, she had an AV malformation and she came in and she was basically, she was basically, um, brain dead when she , when she came to the unit after going to the OR. And it was, I took care of her for over a period of two days as they did the whole process of, you know, establishing brain death [voice cracks and she begins to tear]." (less than 5 years intensive care experience)

Difficulty in describing one's grief is a finding that has been reported in the more current literature. Inexpressibility was a meta-theme identified by Carter (1989), a nurse, in her thematic analysis of 30 narrative accounts of personal loss of a significant other. Inexpressibility, like "hard to find the words" in this study also referred to the felt inadequacy of words to describe the experience of personal bereavement. Knapp (1986) reported a theme he called "impossible to find the words" for those parents who had lost a child to sudden and unexpected death. In contrast, he found that in the case of death after a long illness, the parents were usually better able to verbalize their reactions. He stated that due to the months of anticipatory mourning, the parents appeared less disorganized and confused at the time of death, and therefore were

better able to scrutinize and analyze their grief experience. As a result, they could describe their anticipated feelings and emotional reactions. For the parents of children who had sudden deaths, there was no time for a careful accounting of the events and even after many years of reconstructing the sequence of the happenings, they were still unable to fully describe their emotional responses. Knapp suggested that the inability to recall precisely their reactions was a protective mechanism, since their reactions at the time of death were so debilitating to their psychological stability (p. 69). The finding of inexpressibility in this study may be related to the fact that most of the deaths experienced by the nurses were of a sudden and unexpected nature. Even when deaths were anticipated, the time frame that nurses had to prepare themselves for the loss was usually only several hours to several days. Therefore, there was limited time to take account of one's feelings in either situation. However, there may be a simpler explanation for the difficulty in describing one's feelings and reactions at the time of the child's death. Frequently, deaths that occur in an intensive care unit are so dramatic that they almost defy description. In this society, one that under normal circumstances refuses to discuss death, there are simply not the words available to the nurses to truly convey their feelings that would provide for a shared understanding. Therefore, there was the need to reconstruct the death for the researcher.

Unlike the works of Lindemann (1944) and Parkes (1972) who reported a numerous array of somatic and psychosocial reactions to the loss of a significant other, there were not a wide variety of reactions and emotions identified by the participants in response to the death of a child for whom they had cared. But the cluster of emotions that were described caused a feeling of hurt. Typical expressions of hurting included: "... it left me with a really bad pain," "I felt so rotten," and "... tore me apart for a couple of weeks."

A feeling of acceptance was the antithesis of hurting and it was this feeling that the participants strove to find through the use of their coping strategies. This finding has some similarity to the work by Worden (1985). He stated that to learn to accept the reality of the death

is a task that must be completed in order to successfully grieve a loss. This did not mean that the participants' feelings of grief continued to dominate their lives if they had not achieved a feeling of acceptance. From the description of their stories, it appeared that their feelings were not manifested overtly, nor did it appear that there was a conscious effort required to cope with their feelings on a day to day basis. Rather, as Dale said, memories of the children who died are put in "the back of my mind," "somewhere in the back of my brain" and under certain circumstances and on certain occasions the memories were brought to the surface. Sometimes the participant purposely recalled the memories of the child and family. On other occasions, something involuntarily triggered them to revisit the loss. The triggers were as innocuous as a song that reminded them of the child or news that bereaved parents were doing poorly. Or, they could be as devastating as the death of a significant other in their personal lives or the death of another child in their professional world. As Dale said of three particular children's deaths that continue to haunt her, every time she sees somebody else die, she seems to go through the process of just lying in bed and thinking of those three deaths.

The memories were described as always being accompanied by a feeling of sadness and with other feelings such as anger, if those feelings had been part of the original experience. The participants stated the events surrounding the death were remembered with some kind of emotional reaction, regardless of how mild the reaction. The recalling of their stories, some experienced many years ago, in such depth and detail and in a highly emotional way, was in itself indicative of this fact. It was as if they were being forced to relive those scenes again through the interview. Therefore, instead of indicating an end or finishing with their feelings of grief, the participants talked more about seeking and gaining an acceptance of the child's death. Words such as "coming to terms with," "learning to live with," or "resigning oneself" were used to describe their grief. As Sean simply stated, the step that she needs to pass to once she has felt her sadness or anger is to accept the child's death.

Sean: "... To accept it, the kid's dying [whispers the last two words]." (5 plus years intensive care experience)

This revisiting of the losses appeared to be a normal part of their grief and had continued throughout the nurses' lives. This finding is consistent with the current research and writings on grief. A trend emerging in the literature suggests that grief is possibly limitless with regard to time (Carter, 1989; Demi & Miles, 1986; Jacob, 1993; Rando, 1986; Worden, 1991). This trend in thinking is more compatible with this study's findings than the classic grief literature, where suggested time frames for grieving the loss of a significant other range from six months to two years (Bowlby, 1961; Engel, 1961; Averill, 1968). Descriptions of how certain events and confrontation with reminders of the loss cause a resurgence of certain aspects of grief are now found in the literature and considered to be a normal component of grief (Cowles & Rodgers, 1993; Rando; Worden).

However, the participants also described how over time the feelings of grief that had been resurrected had changed and were now relived in a different and more manageable form. The experienced participants described how they had learned to cope with their feelings of grief. It was through the development of coping resources, such as sharing their feelings with others and implementing closure seeking activities, that they had learned how to lessen the intensity and duration of their feelings. For example, as a result of one child's recent death, Pat described how she had felt a deep depression for nearly a month. But now, when there was a trigger which caused her to revisit this loss, it did not affect her as much. It caused more of an "on the spot horrendous feeling" and then she was able to "put it away" and "forget about it." She described having taken time to reflect upon why she felt the way she did by reliving the events of the child's death. She compared her feelings to the death of another child where her grief reactions had been different, a death she considered more positive for her. She discussed having developed a new coping strategy to help her manage her grief based upon her reflections.

The experienced nurses even described how they had learned to control and/or shut off their feelings as was necessary to the situation. They identified how they had learned to set

limits on the expression of their feelings of grief. They stated this helped them to cope. In the same vein, some experienced participants also described learning how to "go through their grief quickly". As Sean said of the number of deaths to which she had been exposed during the summer, she could not grieve for ten children at the same time. However, she accepted that she was not going to stop all her bad feelings from happening when a child died. Therefore, she had to "go over her grief fast" because she could not "bring all her grief together."

The more experienced nurses described how they had learned to accept their feelings of grief. It appeared that if they wanted to continue to feel the joy and satisfaction that came with saving the life of a child, then they had to be willing to experience the pain of the death of a child. Indeed, it continued to hurt just as much when a child died, for whom they had cared, even after twenty years of experience. There appeared to be no habituation to their grief responses for these participants. For example, Sean, a more seasoned intensive care nurse, had been crying throughout the sharing of her stories. When asked toward the end of the interview how she was feeling right at that moment she stated:

Sean: " It's just that remembering all these kids together makes me sad for sure [crying]. I think it's of living all these deaths is really the worst that we can live here. You know? Like when we save a kid there is no feeling that can be better than that. When we lose one it's the opposite [sobbing and tone of voice is very low and soft]. So right now I feel sad about thinking of them.... So just in thinking about them, particularly the second one, I sure do find it hard." (5 plus years intensive care experience)

However, it appeared that, for the more experienced nurses, their grief reactions were more discriminating. They were better able to identify the contextual factors of the death that influenced particular responses. Their multiple experiences permitted them to view their feelings of hurt and pain on varying levels. Multiple experiences allowed them to compare their feelings from one death to another. Rather than viewing the death of a child as "just bad", they began to view the death of a child in levels of "badness." In fact, some deaths could even be viewed as a "good death." In contrast, the inexperienced nurses appeared to have a more global reaction to the death of the child. This seemed to be associated with not having "come to

terms with" the death of children.

In the following account, Pat's words demonstrate the strong link between learning to cope with death and how her grief is experienced. Her words also help to confirm that there is no finite point to all of their feelings of grief.

Pat: " I have to kind of go through it and come to terms with it and be able to live with it. So that every time I hear the music or hear the names that I not fall apart. 'Cause a lot of those kids too that I've taken care of, their plaque is outside the unit. Every time I go by that thing I see their picture, so I've got to learn to be able to cope." (5 plus years intensive care experience)

Sadness

Feelings of sadness and sorrow were expressed on all occasions of a child's death. Because of their involvement with the family and having cared for the family as part of their nursing practice, the sadness that they felt was also related to their empathy for the family. Feeling sad occurred because of the value the participants had for human life and particularly for the life of children. As Alex said, the sadness she felt was augmented simply because it was a child's life that had been lost.

" Well no death is easy and I think especially with children, because they haven't had a chance to lead their lives and fill their lives and have a life. [voice has begun to slow in tempo]. I think that always intensifies their death. ... I think I find them all sad." (5 plus years intensive care experience)

This response was not an unexpected one given the meaning that children have within the North American socio-cultural context. Children in our society are highly valued today (Rando, 1984). "The value we place on children is not derived from their practical, economic usefulness, as once was the case, but from their esthetic, emotional, or symbolic value and great effort goes into their care, development, and protection" (Knapp, 1986).

Additionally, feelings of sadness resulted from the participants' beliefs that children were not supposed to die. As Garfield wrote (1979): "We fear for our children as we fear for ourselves . Never have we lived or loved enough. Death always comes too soon" (Knapp, 1986, p. 13). In earlier times, when infectious diseases were rampant, the death of a child was a rather frequent

occurrence. But, with the growth of modern medical technology and the implementation of childhood immunization programs, and the consequent reduction in the death rate, child death occurs less frequently in North America. Although accidents and unpredicted chronic diseases do strike today's youth, most deaths occur quite naturally and expectedly among the older segment of the population, those who have served full lives. Children are not expected to die before their parents; it defies the natural order of things. Therefore, youthful deaths, particularly of infants and young children, are regarded as "ultimate tragedies" (Knapp, p. 14).

The participants described degrees of sadness. The depth and duration of that sadness was dependent on the situational history, such as the level of attachment to the child and/or family or how visibly and audibly distraught the family members were at the time of the child's death. The intensity and duration of feelings of sadness also appeared to be related to the participant's level of experiential learning. Casey, a nurse with less than 5 years intensive care experience, described how she felt overwhelmed with sadness for all families who had lost children in the unit. She observed the behaviors of the other nurses and compared her feelings to those who were more experienced. She perceived they were more at peace with the process of death because of how they provided their nursing care to the child and family at the time of death. She believed that they were not as "overwhelmed" by their feelings of sadness. Casey strongly identified with the families and had not yet come to terms with death. She felt overwhelmed by her sadness and stated she did not know how to cope with this feeling.

"She seemed, seemed so much more comfortable with the whole process.... She was very kind and very uh, loving towards towards the family and [child's name]. Whereas I, anytime I went to say anything, my voice would catch. [pause]. I think the bad feelings were all just about how not right it was. Just it was, it was such a huge loss for these people. [long pause] Whereas she seemed so much more kind of at peace with the whole thing. [long pause] ...[I feel] just sort of this overwhelming feeling of sadness. And loss, I think [voice low and distant]."

Casey also stated that at times she felt concerned for not feeling more sadness for the families at the time of the child's death. As she said, she felt almost that it should affect her more. Casey had not yet learned that it is permissible not to feel a profound sense of sadness for every child

who dies. She had not yet learned to know what degrees of sadness would be normal for her to experience and how to manage her sadness.

On the other hand, the more experienced nurses were able to describe levels of sadness they felt when comparing one child's death to another. As Alex said, she found all the deaths very sad, but some more than others. They were also able to identify other feelings they were experiencing at the same time, particularly feelings that appeared to reduce or balance their feelings of sadness. For example, when the more experienced participants shared their accounts of those children's deaths that were not as difficult for them, they described that although they still felt sad at the time of the child's death, they sometimes experienced a sense of relief, or felt good, because the child had not died in pain. They also acknowledged this feeling when they perceived that the child had had no quality of life or when the death had been prolonged and they had watched the long emotional suffering of the family. This sense of release or relief appeared only to be felt by those participants who had learned to come to terms with death. In fact, acknowledging a feeling of release seemed to help them accept the death of the child for whom they had cared. The inexperienced nurses did not express this sense of release in any of their stories. In Spencer's study (1994) that explored the grief of adult intensive care nurses, all but one nurse stated that they had experienced feelings of relief when a patient had died. Unfortunately the questionnaire did not give the opportunity to describe these feelings further and no correlational analysis was completed on years of experience in this setting to the expression of this feeling.

From this core of hurting radiated variations of other painful emotions dependent on the context of the death: a sense of death process accountability, anger, feelings of emptiness, feelings of powerlessness, and feelings of vulnerability.

Sense of death process accountability

A sense of death process accountability was another painful emotion experienced by all the nurses. A sense of death process accountability is defined here as degrees of guilt ranging from feelings of regret or remorsefulness to feelings of culpability concerning care given to a child who subsequently died. A sense of death process accountability was not perceived to be present for all deaths. However, it appeared to occur more frequently, be more pervasive, and of greater duration when the nurses were inexperienced to intensive care. This is consistent with the findings of Eisendrath and Dunkel (1979) in their work with adult intensive care nurses. The participants realized that often their feelings of guilt did not make sense. They could intellectually understand that they were not to blame for the child's death. However, they did not emotionally feel the same way. They felt it was their fault. As Jamie said, she took it personally and felt responsible when she lost a child whom she had been caring for.

A sense of death process accountability resulted when the participants perceived that they had caused the death, either directly or indirectly, or when the child and/or family had not received what the participants felt was the best care possible during the dying process. This is similar to the findings reported by Price and Bergen (1977) who stated that the coronary care nurses felt stress because of a confusion between the feeling of being responsible for the care of a dying patient and the feeling of being responsible for the occurrence of the patient's death. For the participants of this study, feelings of guilt, of culpability, are a direct outcome of the degree of responsibility and accountability that nurses carry when caring for acutely ill children. Although the nurses stated they felt tremendous satisfaction from being seen as an expert and having the responsibility for independent decision-making, this sense of professional accountability also made them feel responsible for the child's death.

Jamie: "And I feel good when people can ask me questions and I can answer them. ... But it makes me feel bad in a sense that what if I do something wrong? And this is my fault? And it might. And you use your judgment and you do everything in the best way you can but you could be wrong. Anybody can be wrong. Anybody can make a mistake. But in the ICU your mistake can be life-threatening. As on the wards, I find if you give like one extra pill or something, it's not necessarily life threatening. You're not put in that situation

every single minute that you're on the job." (less than 5 years intensive care experience)

Guilt was not just associated with feeling that they themselves had caused the death of the child. The participants also felt guilty when they believed that they could have prevented the death by intervening at some point or if they had better control of external events. If they perceived it was within their control to do so, the participants felt guilty for not having intervened when others in the team interfered with, or caused less than, the best delivery of care to be offered. This was best illustrated by a story told by Jamie. The child's death occurred when Jamie was new to intensive care, but despite the time that had elapsed, it continued "to haunt" her. She had cared for an infant who had died suddenly and unexpectedly following open heart surgery. The baby had momentarily dropped her blood pressure and oxygen saturations for no apparent reason. No other clinical signs of a problem were evident. However, Jamie had developed a "gut feeling", that "there was something very bizarre" going on with the baby. When she reported the event and her feelings to the physician, she "felt that nobody was doing anything about it." It left her feeling "very out of control." When she returned for her next shift, 12 hours later, the child had died. She described feelings of guilt for not having been more forceful with the physicians.

" And I came back to work and I go to the corner and she was gone. [pause]. And I felt so bad. Because I felt, you know, I should have called the staff person more. I should have waited until she called back. I should of [pause]. You know I remember calling the resident, the chief resident. And he just said okay I'll be in soon. Nobody [pause]. I was so worried. And call it just a gut feeling and maybe clinically, they were saying - 'well, okay so she desaturated and her blood pressure bottomed out. But now she's okay, so what's the big deal.' And clinically I guess if you look at it as a clinical point of view, they're probably right. But it was just my gut feeling I guess. And I felt so rotten. For about a week I felt so rotten going into work because I thought I must have missed something. I kept thinking it's my fault. I must have missed something. It was so awful [voice very low, soft and slow in tempo as she described the last part of the story].

A sense of death process accountability was experienced no matter how many years the participants had worked in pediatric intensive care. However, feelings of culpability seemed to be expressed less frequently when the nurses were more experienced. This appeared to be

associated with the increasing level of confidence that they had in their own knowledge and skills. Feelings of competence and self assurance came with experience. Yet, even after years of experience, the nurses continued to question their own culpability in the death of the child for whom they had cared. However, they seemed to be able to more quickly and legitimately let go of the feelings of responsibility for the death. The participants described that, as part of their professional responsibility and accountability, it was imperative that they always ensured that the situation could not have been handled better, especially when the primary goal was to save the child's life. As Alex summarized:

"Did I do a good job as an ICU nurse? Was I technically skilled? Did I assess? Did I pick up? Did I respond? Was I fast enough drawing up drugs? Was I able to effectively give CPR? Was the team good? Did we do everything as a team?" (5 plus years intensive care experience)

Verifying that they had not failed to meet the needs of the child also included the psychosocial aspects and extended to the care of the family. This was not surprising given the strong orientation toward family centered care and the constant striving to provide holistic care, to integrate comfort and support with the cure goals of intensive care nursing. As Dale said, for the next day or two after the death of a child, she always thinks about what more she could have done to help the child, how did the family react, and what more could she have told the family to support them." And as Alex explained, if she felt that she had done everything she could and the best she could have done, then that was a good death. There was no reason to feel guilty.

Feelings of guilt were closely associated with feelings of attachment to the child or family and to sudden and unanticipated deaths of the children. This demonstrates the influence of the contextual factors on their feelings of grief and the complexity of their grief. When the nurses were strongly attached, then feelings of guilt arose that were difficult to release. This feeling of guilt intensified and lengthened the grief experience and required the nurses to utilize coping strategies not normally used for other death experiences. This was illustrated in a story by Sean,

a nurse who has been exposed to many children's deaths over her years of nursing in the unit. On a more recent death of a child to whom she felt particularly attached to the mother, Sean stated that she had felt very guilty about this child's death. She stated that if she had influenced the transfer of this child to another center of care, then the child might not have died. The child had died suddenly and unexpectedly from a cardiac tamponade following the removal of external pacemaker wires, just prior to her discharge home. It was because of her feelings of guilt that she felt a need to continue her relationship with the mother for months after the child's death. Family follow-up had not been a normal nursing practice for her, nor an activity she had previously used to cope with other children's deaths. It was not until the mother indicated to her that the child would have eventually died from the underlying heart defect and demonstrated signs of acceptance that Sean was finally able to release her own feelings of guilt. When asked how she had finally been able to accept this child's death, Sean stated:

"Because of this particular feeling of guilt that I had with this particular child, I think that following the feelings of the mom over the months, as she was feeling better, and also, like telling me, like even if I didn't ask her all these things, like that she would have died anyway." (5 plus years intensive care experience)

Sean's story also illustrates how the more experienced nurses are able to manage their feelings of grief through the use of a variety of coping strategies. For example, the more experienced participants, Alex, Dale, Pat and Sean, described how they had learned what was within their control, or realm of influence, at the time of a child's death because of their many different experiences. As a result, they were learning to "let go of" that which they could not control. Even though they never stopped evaluating the care they had given, they were able to "put the death aside" once they had verified they had not caused the death and that they could not have made it a better death experience for the child and family. It also appeared that they were able to "put it in perspective", even if they believed the death process could have been a better one. Instead of experiencing feelings of guilt, they expressed feelings of regret or remorsefulness. Then, they described how they would make changes in their nursing practice

for the future. Learning from their reflections became a means of coping with the death of the children and managing their feelings of a sense of death process accountability. As Dale said, always thinking over and over, for two or three days, about what just happened, and about what she could learn from this child's death, helped her put her feelings of guilt in context, helped to create meaning, and helped her to "slowly set it behind."

The difficulty that seemed to arise for the less experienced intensive care nurses was that they had not yet learned how to cope with their feelings of guilt. The following account demonstrates how one nurse has continued to feel responsible for the death of a baby to whom she had been deeply attached when she was new to the unit. There was no sound reason for having taken the blame for the death. In her story, she compared the grief for this baby with her grief for another child (S) to whom she had not been as emotionally connected. In both cases the children's deaths were sudden and unexpected. There were feelings of responsibility in both cases. For the baby to whom there was a deep attachment, she felt a direct responsibility for his death. In the other case, she felt responsible for not having better met the needs of the parents. Thus, the influencing factors in the situation are similar to those described by Sean earlier. However, in this participant's account, she poignantly described the despair she has continued to feel in not knowing how to cope with her feelings of guilt. Her feelings of guilt, compounded by sadness, are highly pervasive.

Casey: "He was very important to me. And he went home and within four days of being home, he died. And uh I guess it's similar to S.'s experience because I, there was this, all wrapped up in my sort of feeling of sadness and loss was this, this feeling of responsibility that I couldn't shake. That there was something, something I could have done. Something more. And not that I know or think that as a nurse I could have done anything to change the course of S's situation. But just to have made it easier or better or whatever for the family. But in the case of the little baby, I felt like there was something I missed. I could have stopped the discharge or something if I had been able to catch something. [voice has dropped off and almost inaudible]. And logically and rationally I can sort of you know argue that there was nothing. But I just couldn't shake that feeling. That sort of [crying]. I don't know, I guess it's like this responsibility that kind of makes the process easier, or better or whatever [sentence said very slowly; voice low; crying]. ... And I'm not really sure what I'm so supposed to do about it." (less than 5 years intensive care experience)

Casey appears not to have yet developed the knowledge and skill proficiency necessary to assure herself that she was not to blame. She was consumed with her feelings of professional inadequacy. She was in need of external assurances that she was not responsible for the death of the child and that she had delivered good care to the dying child and grieving family.

Casey: "... I want, I guess I wanted to say, I wanted someone to say that um [long pause] I was doing, I was doing an okay job I guess [voice low and distant]. But you know that's probably what I wanted to hear [voice cracking]."

It also appeared that the inexperienced nurses' feelings of guilt were compounded by multiple foci. As well as feeling responsible, directly or indirectly, for the death of the child, as described by both Jamie and Casey, their guilt was also augmented by feeling that they had failed to meet the needs of the family. Jamie described how her guilt over the baby's death, who had died suddenly and unexpectedly after open heart surgery, also extended to feeling that she had let the family down. She felt like she had given them a feeling of false hope

"... and I remember telling the parents - 'Oh well you, she'll see you in a few days. ... And I was telling them how great it would be. ... I let these parents down because I told them their child is going to be okay. ... I just felt like I really let them down.'"

Feelings of guilt and responsibility made her afraid to return to work for a period of several weeks. It is understandable that the inexperienced nurse cannot provide the full scope of holistic care with the same proficiency as the more experienced intensive care nurse. However, they still have the same expectations of themselves.

Unfortunately, external reinforcement alone will probably not release the novices' feelings of guilt, which is not to suggest that positive reinforcement should not be provided. However, just as one cannot tell or show another how to grieve the death of a child, one cannot give inexperienced nurses a sense of confidence in the knowledge and skills they have not yet mastered. As Benner (1984) has said, knowledge and skill is embedded in expertise, and expertise is developed with experience. Experience becomes the teacher. Jamie expressed this feeling when she told of her feelings of guilt about the infant who had died unexpectedly

after open heart surgery. As noted earlier, Jamie was new to intensive care when this child died. She stated that it had been explained to her that the child had died from a problem that "even the best of people" could not have done anything to prevent or cure, and she was not to blame for the child's death. There was nothing that she could have done. Despite these assurances, she still felt responsible.

A sense of death process accountability, or feelings of responsibility, were not only common to these participants. In a four year study, in 14 health care settings in Manitoba, Barton & Degner (1990) reported on their findings of how patient deaths affected nurses and how nurses responded. They too found, that although nurses realized they were powerless to prevent the death of a terminally ill patient, they nonetheless felt responsible for the conditions under which the patient died. When nurses perceived that a patient had died under less than favorable conditions, they believed they had failed both the patient and family. Feelings of guilt and self recrimination were often expressed. Even though the circumstances may have been beyond the nurses' control, they still felt they had broken their trust with the patient and let the family down.

Anger

Anger was another emotional response to the death of a child that was painful. This feeling did not occur for all deaths but rather appeared to be associated with specific contextual factors. Like feelings of guilt, the participants' stories described how much harder it was for them to accept the child's death when they felt angry.

The participants' stories indicated that feelings of anger resulted when they believed that the child's death could have been prevented, deaths they often described as senseless. It also occurred when the child's death was not as they expected it should have been. That is, feelings of anger occurred when they were not able to provide the type of care that they believed the child and family deserved. Instead of feeling a sense of satisfaction and pride in the care they

had delivered, or a sense of release at the end of a long, difficult and anticipated death, they felt angry because their goals for the child and family had not been met. For example, the nurses described being angry when the child's death was not a peaceful one because a decision had not been made to say "enough is enough". Or, they felt angry when they were not given time to provide the rituals of care at the time of death that gave both the family and the nurse time to say good-bye to the child.

Sometimes their anger was directed purposely at the person or persons who they believed were responsible. This could have been towards self and therefore guilt and anger were closely associated feelings of grief. Or, sometimes it was directed toward other health care professionals, the system, or the parents. Burning anger, even to the point of hatred, was reported by several of the participants. For example, Pat said, of a physician colleague who had insensitively remarked to her at the time of the death of a child that "now she would have a pretty easy day now that she had gotten rid of her patient," that she would always hate him no matter what he did or said in the future. Other times, the anger was non specific. It was described as the anger that comes with the injustice and senselessness of the death of a child.

Guilt and anger at self and others were feelings that were often intertwined. It was these deaths that the participants often found continued to haunt them even many years after the loss, the deaths they found hard to come to terms with. The following account describes this.

Pat: "... When it shouldn't have [occurred] I feel anger. Or I feel guilt. Did I do something? I, the typical um. Did I miss something? Could I have made a difference? Should this death have happened the way it happened? [pause] Should I have spoken up 5 hours earlier and been more aggressive and said enough is enough? [words said emphatically, voice risen in angry tone]. 'Stop this ridiculousness. Do you see what we are doing? Do you see what we are perpetuating here?' Then I feel anger. I feel frustrated. I feel self-recrimination from the fact that, you didn't speak up. You didn't get aggressive. You didn't call the shots. You didn't do what you could have done. Whether it could have made a difference or not is a moot point. It's what I felt. That's those things I hang on to." (5 plus years intensive care experience)

Similar to grief, anger was felt by all the participants despite their years of experience. However, it was expressed less frequently by the inexperienced staff and tended to be more

non specific in nature. In contrast, it appeared, that as the nurses became more experienced, their guilt changed to anger when they no longer felt responsible for those deaths that were outside their control. This change appeared to be a product of developing self confidence as they acquired more knowledge and skill with experience. It also appeared to be a coping strategy to help them manage their feelings of guilt and the anger they had previously directed at self. As a point of illustration, one participant recalled an experience ten years earlier with the death of a child that occurred when she was in charge. She described arriving at the bedside of a young child in cardiopulmonary arrest to discover that the medical resident and intensive care nurse were ventilating the child with the face mask upside down. The child subsequently died. In hindsight, she understood that the death of the child had not been caused by the mismanagement of the team at the bedside. However, the best care that the intensive care team should have been able to deliver had not been provided and she was not able to assure herself that the death could not have been prevented. She said how "we didn't do it right" and, by using the collective pronoun, demonstrated the strong sense of collective responsibility that the intensive care team carried for all the children in the unit. She became angry at herself for not having prevented the mistake. This nurse stated that when she believed that the team had done the best they could do, then "it was not meant to be; the child was not meant to be around." Then she was able to accept the child's death. However, the story did not end here. She described how this experience had begun to change her nursing practice. She stated, that as part of her job as a staff nurse, she had learned it was also her responsibility to make sure that everybody who was working in the unit had the skill set they needed. If they did not, she showed them the way to get that skill set. Taking control in this manner, helped alleviate the sense of guilt she was feeling. In addition, she also stated that over the years, she had been learning not to take responsibility for others' actions if she had done all she could to enable her colleagues to deliver the best care possible. Instead of carrying the guilt around, she had learned to direct the anger appropriately. This is one means by which she had learned to cope

with her feelings of grief.

Feelings of emptiness

Jamie: " And I just felt that there was such an emptiness on the unit because he wasn't here. It was awful."

A feeling of emptiness, another aspect of feeling of hurt, was described by a few of the participants. Although this feeling has been frequently reported in the grief literature on the loss of a significant other (Parkes, 1972; Rando, 1986), it has not been noted in the literature on the grief of health care professionals. It appeared to be associated with strong levels of attachment as was described by Jamie when a child for whom she had had a strong emotional attachment died after several years in the unit. It was described as one of "feeling empty inside." On the other hand, some of the participants, such as Sean, also described "an empty feeling" that was associated with the feeling of guilt, particularly when a child died suddenly and unexpectedly. When they looked over at the spot where the child had been, where the child should be lying, and saw that it was empty, they felt empty inside and this feeling then augmented their feelings of guilt.

The feeling of emptiness was described as lasting for several hours to several weeks. They described how the feeling gradually went away with time and that they just finally "didn't feel empty anymore." A common strategy utilized to cope with this feeling was to engage in ongoing contact with the child's family.

A sense of powerlessness

A sense of powerlessness, as described by the participants, included feelings of helplessness and feelings of loss of control. It was described as a feeling of inadequacy to meet the needs of the child and/or family. Jamie poignantly described what was happening to her when a child, for whom she had had a strong level of attachment, suddenly arrested. She said

she was feeling helpless, feeling out of control. She was feeling like there was "not a damn thing she could do to make this thing better." She described how all her emotions took over and that she couldn't function any more. In contrast, as Pat said, it was easier for her to deal with a child's death and her feelings of grief when she felt more in control of the situation, more able to do something and do it to the best of her abilities. It appeared that when the participants described these latter feelings, they were better able to accept the death and the memories of the child's death were more positive and those positive memories became part of their coping strategies.

The experienced nurses were more apt to describe these feelings of loss of control without an associated sense of guilt. It may be, that with more experience, just as with feelings of anger, they had learned to let go of the feelings of guilt when the events of the death were not within their control. For example, Pat told a story of a child for whom she had cared who she had had to transfer to the operating room for organ donation. The receiving physician spoke insensitively about the situation and was disrespectful to the child. Initially, Pat felt "bad" for 'whose hands she had placed her in'. However, after some reflection, she had been able to let go of her feelings of guilt, although the anger remained.

... And it was something that was beyond my control. I mean if he was the anaestheologist, he's the anaestheologist. I have no control over that. So I was able to get over it a little bit better." (5 plus years intensive care experience)

On the other hand, the less experienced nurses described a feeling of having no control over the situation or feeling very out of control, and, as both Jamie and Casey said, also felt bad, felt responsible, because maybe they should have had control over the events leading up to the children's deaths and therefore could have prevented them.

Jamie also described feeling out of control when she had heard that the child for whom she had become strongly attached had died. In this situation she felt that she might not be able to handle her emotions; that she might totally lose control. Loss of control of one's emotions at the time of the child's death was a concern for all the participants.

Casey's feelings of helplessness were more pervasive, but this again appeared to be associated with the fact that she had not yet had the time and experiences needed to find the coping strategies that would help her manage this painful feeling. She felt a sense of helplessness and powerless to help herself manage her grief. As Casey described, when a child dies, "something huge and terrible has happened," and she couldn't do anything to change it. She felt like she should be doing something more yet she didn't know what to do. The power of death appeared to have contributed to their feelings of powerlessness.

In some instances, the feeling of helplessness appeared to be of short duration. For example, the participants expressed that they had feelings of helplessness when grieving family members were present, but these feelings dissipated when the family left the unit. Likewise, when colleagues were being insensitive or interfering with the delivery of care, their feelings of powerlessness often were not as pervasive when these colleagues left the bedside.

The participants described a feeling of helplessness when a child died within just a few hours of admission. Sean said it was like feeling that you couldn't do anything. She stated she did not feel the same if the child died after several days of interventions in the unit. If they had tried everything and the life just seemed to be slipping away, then for Sean, God did not want this child to live. Under these circumstances, she could more readily achieve a feeling of acceptance. Pat said that when a child died suddenly and unexpectedly, she felt like it was going too fast; she did not have time to think about sedation and pain interventions. She had no time to think about much of anything.

A feeling of powerlessness is in direct opposition to the feeling of empowerment they described as a reward of working in intensive care. Helplessness and feeling a loss of control were contrary to the very nature of their expectations about how they should feel about their practice in this milieu. Perhaps these feelings of powerlessness were a direct result of the dissonance, or the clashing, of coexisting beliefs and values that they experienced within themselves (personal dissonance) when the reality of the child's death contradicted their

expectations about death and the dying process.

Alex: "... I remember thinking this was so weird. That [chuckle] I'm used to people dying from diseases, not from murder. ... Like having cancer, or heart disease that develops and ... in most cases in kids, it's not as easy as it is in adults.... I think I was just so shocked that this baby died. And as I mentioned before a lot of the kids that come through emergency are, they're sick but... they're not sick enough to die [voice raises and sounds incredulous]. And suddenly there was a child who was very sick and actually died. And so it didn't sort of fit into the sequence of daily routines. And so it was very much as a shock I guess." (5 plus years intensive care experience)

These feelings have been noted in the research on intensive care nurses caring for the patient who is brain dead (Borozny, 1990). In contrast, the more experienced participants described feeling a sense of satisfaction (even though there was a feeling of sadness), or, said the child's death was a positive grief experience for them, when they were able to meet all their nursing goals for the child and family during the dying process. What they valued and what they were able to provide were in harmony. They did not have feelings of powerlessness because they felt in control of the situation to help the child and family to the best of their abilities. This required a belief that sometimes death was a more preferred option to living. It also meant that the nurses had a philosophy of intensive care nursing that integrated valuing the care of the dying child. Then they could derive a feeling of satisfaction from this type of nursing practice whenever it became necessary in this setting.

A lack of control has been described in the critical care nursing literature as a significant job related stressor (Vachon, 1984; Vachon & Pakes, 1985). In these studies, control was associated with autonomy and generally referred to the control a worker had over his or own time and activity and to issues of authority. These findings are congruent with the feelings of powerlessness that these participants expressed when they perceived there had been organizational or interpersonal conflicts that had interfered with their care giving at the time of the child's death. However, sometimes the nurses felt helpless because of the lack of control that comes with not being able to prevent death or to take away the emotional suffering of others. This mechanism for the feeling of helplessness and lack of control as an emotional grief

reaction was not identified as a job related stressor in the work by Vachon and Vachon & Pakes. In the grief literature, it has been noted that feelings of helplessness and feelings of being out of control have been identified during the confrontation phases (Rando, 1984) or searching phases (Parkes, 1972) of grief. The bereaved have expressed that they feel like they are losing control because they feel confused and lack the decision-making abilities and incisiveness they once had. Again, although the feeling is similar, the cause for the feeling seems to be different. For these participants, it appeared to be related more to the human side of our nature, even stronger in the helping and caring profession of nursing, to want to reach out and help those who were in pain. When the nurses saw the parents grieving, they wanted to go to them with words and actions that they hoped would both soothe and comfort. The nurses wanted to supply an answer or provide a remedy for the bereaved parent's pain. Instead, they experienced the painful feeling of helplessness when there was the realization that no words would help. However, it appeared that a few participants had learned the power of their own presence as a source of comfort for the parents and paradoxically, being present for the family became a way to soothe their own pain at the time of the child's death. The sense of satisfaction that it gave them provided some comfort. As Pat said, even though she felt a lot of grief for the parents, she also felt good that she had done what she could for them and made it the best that was possible.

The participants described managing this feeling of helplessness by engaging in task-oriented behaviors. For example, Sean described having the sense that she needed to fill this emptiness, to keep herself busy, and so she would help the parents or seek support from her peers to share what she was living. Alex said she dealt with her feeling of helplessness by intellectualizing the event. This coping mechanism has also been reported by Barton & Degner (1990). They stated that justification helped the nurses cope by decreasing their sense of personal culpability, especially when something went wrong (p. 22). Casey and Jamie described that they managed this feeling of helplessness by being with other children, being involved in

life-affirming activities, such as reading to the children or holding them. Again, Barton & Degner (1990) reported that many nurses in their study had difficulty talking to families about their feelings of grief following the death of the child because they were caught up in trying to cope with their own emotions. It left these nurses with feelings of inadequacy. To help cope with these feelings, some nurses focused on other aspects of care because it was easier to deal with than the patient's or family's emotions.

Feelings of vulnerability

Nurses who face the death of children and see the grief of the family are forced to imagine what it must be like to lose, through death, one of their loved ones. Projection of the families' loss onto oneself was a common result of sharing the grief experience with the parents. It affected the grief response of these participants and resulted in feelings of vulnerability. To project another's experience onto one's self (how would I feel; what if this were my child?) seemed to be both necessary to be empathic and yet anxiety producing for the nurse. Seeing and hearing the grief of the family members forced the participants to face and reflect upon what it would be like to lose someone they loved and to fear that they would have to experience this excruciating pain, pain that they saw as almost beyond human endurance. Sharing the grief gave the nurses a glimpse of what this pain could be like. Every participant made statements throughout the sharing of their stories that demonstrated that they frequently projected the events of the child's death onto themselves and questioned what they would have done in a similar situation.

Pat: "Like I'm still sure to this day I would never have been able to extubate him. Never. I would have been able to turn off the drips. I'm sure I could have. But I couldn't, if it was my baby I don't think I would have [extubated him]." (5 plus years intensive care experience)

For one participant, sharing the lived grief experience of the family resulted in fears of loss of loved ones in her own life. This form of identification appeared to have overwhelmed her with fear and anxiety. Casey said she had never lost anybody really close to her, although she

described that she felt horrible for a month after the break up of a serious relationship due to his relocation to another city. Because of this personal experience and her identification with the grieving parents, she said that the idea of losing somebody, who she really cared about, like her grandmother or parents, permanently from her life, terrified her.

It has been noted previously that Casey has had few experiences with death both in her intensive care and nursing career. Casey appeared to be in the beginning phases of the experiential process of learning to come to terms with death and to find ways to deal with her feelings of grief that occurred when a child died. As Casey continued to speak about her fears of losing a significant other, it appeared that how she had chosen to cope with these overwhelming feelings, that occurred each time she has had to face a child's death, was to avoid these feelings.

Casey: "I don't know how I would survive. So I think that if, if I do avoid dealing with my grief [voice shaky] I think that's probably one of the reasons is because it really scares me, the thought of losing somebody that important to me [crying]." (less than 5 years intensive care experience)

Casey's comments also appeared to reflect that she had not yet learned to limit the degree to which she lives the parents' emotions of grief. Although the more experienced nurses stated that their own feelings of grief were more intense because of sharing the lived experiences of the other family members, these same participants appeared not to have overidentified with them. The more experienced nurses made statements that appeared to suggest that they had learned to make a distinction between a momentary projection of parental grief onto oneself and overidentification with the family. However, Casey appeared to have overidentified with the parents and their loss. The pain she was carrying appeared to be related both to her identification with the parents of the children who had died and to her own fears of how she would cope with the loss of a significant other in her life.

Casey: "And that's how I look at some of these families and I think you know, how are you going to manage? How are you going to, you know, wake up a week from now and cope with the fact that your child is not in the next room? [pause] It just amazes me that, sort of day in and day out stuff that they have to deal with for the, you know, forever. [pause]. I

was actually out for a run and I saw [child's name] mother. And, you know, I stopped and we kind of chatted for a few minutes. But she was, this was about a month later, and she was, she looked so, so empty and so uh so sad [voice low] [pause]. So, I mean I don't know of any grief [deep sigh] experience outside of my nursing ones that [pause] has really played a role except for this fear I have of losing somebody that important [voice almost inaudible, crying] [long pause]."

Projection of the death onto self or fear of the loss of others has been reported in the grief literature of health care professionals and has been termed death anxiety. The concept of death anxiety is ambiguous and presents multidimensional concerns such as denial of death, fear of dying for self and for others, avoidance of death, and reluctance to interact with persons who are dying (Mallet et al., 1991, p. 1348). In her review of the death-related literature, Benoliel (1983) found that anxiety was the strongest predictor of attitudes toward death and that the nurse's age was viewed as a critical variable, that is, younger nurses had higher anxiety levels when faced with death and dying than older nurses. Therefore, maturational development may be an important variable to this feeling of vulnerability when a child dies. She also found that direct exposure to death had an important influence on the death anxiety of nurses. It was found that there was an inverse relationship between death anxiety and the number of exposures to death. That is, the more experiences with death, the less death anxiety was reported by the nurses. However, the confounding variables of age and the type of dying to which they had been exposed could not be overlooked, and therefore exposure to death had to be considered a multidimensional variable (p.111). Benoliel's work helps support the findings of this study; that is, the nature of the nurses' reactions to grief, such as feelings of vulnerability, is an experiential one and that it is a multivaried phenomenon.

It is important to reinforce that although each participant reported some form of hurting, not all experienced the same emotions and not all emotions were experienced on every occasion of a child's death. How the nurses expressed their hurting also varied from participant to participant and were different for different deaths. Expressions of their hurting included crying, physical hurting, being energy depleted, and being impatient.

Crying

"Tears are a release of rage or bitterness, or an expression of despair and exhaustion" (Hart, 1995, p. 47).

Participants expressed that feelings of sadness were always accompanied by either tearfulness or crying. In general, the female nurses felt more comfortable expressing their sadness with tears than did the male nurses. The need to cry and having difficulty controlling their crying appeared to relate to the intensity of the grief they were experiencing for the child who had just died. For example, Jamie described how she did not feel the need to cry when a child for whom she had not been strongly attached had died.

"When I went to this patient's funeral that, the child who got hit by lightning, I left there and I thought about it you know a little bit. But it wasn't like I sat down and cried about it. ... So it was more like I was sad. ... and I felt bad for the parents. ... But it doesn't come from deep inside and make you cry." (less than 5 years intensive care experience)

However, Jamie described that she cried a great deal for a child to whom she had been strongly attached and she had continued to cry for him even months following his death, although less frequently.

" But I went to his funeral and everything and I would come home, and I still do this, if I think about him too much, I'll start crying and crying and crying."

The participants perceived that the expression of their sorrow through crying was an appropriate and acceptable behavior in the unit. In fact, Dale said she thought that it was probably a wonderful way for nurses to grieve when they could have a really good cry while at work, when they had the need to. The participants described how their colleagues would often offer them the opportunity to leave the bedside for awhile, so that if they wanted to have a good cry, they could. However, all of the participants voiced concern that they would not be able to control their crying while in the work place. Crying seemed to be perceived as the trigger mechanism for the letting go of all their emotions of grief which would result in not being able to meet the needs of the child and family. There was a fear that once they started to cry that they

would find it hard to stop

Jamie: " ... It sometimes feels like it's quite possible to, you know, cry and cry and cry with them. I don't actually know if that would be helpful. I think the last thing in the world I would ever want was a parent supporting me." (less than 5 years intensive care experience)

This was implied by the participants' statements that described how necessary they felt it was to "stay in control" and feelings of "being out of control" when their feelings of grief were strong. For example, in the following account, Pat compared her feelings of grief for a child whose death was a "more positive experience" to the death of a child that was "really difficult" for her. The more difficult death had caused her to have "a strong physical hurt." She stated that she wanted to cry with the pain she was experiencing, yet also felt a strong need to remain in control of her crying. This account demonstrated how tenuous their feelings of control over the expression of their emotions were and how strong their need to remain in control.

"I still felt grief. I still felt very sad for the family but I didn't have the pain where I could have just about sobbed. That was what I had with the other one, that I think if I had been left there, or somebody would have pushed me just a little bit too much, I would have just burst into tears with the wailing you know." (5 plus years intensive care experience)

There was also a fear that they would not be able to perform their job. As a point of illustration, when Jamie was asked what she perceived would happen if she lost control, she stated that she feared she would not be able to function. She feared that if she became overly emotional, she would not be able to think.

And so they frequently chose not to cry while at work. The participants stated that being in control of their crying was one of the ways in which they coped with their feelings of grief in the work place. As Pat said, she just made it a thing with herself that it was not a good time to cry when the child died. She said that over the years, she had decided that not letting herself cry at work was the way she coped. This was the way she got through the day. She had learned to manage or control the expression of her feelings of grief in the work place.

Similar to anecdotal accounts in the literature (Charnook, 1985; Evans, 1989), each of the participants expressed that it was their personal expectation that they should be able to

continue to meet the needs of the grieving family, to be able to support and comfort them despite their own feelings of grief. As Sean said, there was a need to "be strong for the parents," to be able to help them. Although it was appropriate to openly express how much they cared for the child by crying with the parents, the crying had to be controlled or within boundaries. They said they needed to be able to support the parents, to give them the words they needed at this time of their grief. And so, as Sean continued to say, nurses needed to be able to "swallow their own sadness."

Attempting to remain in control of one's crying sometimes prevented the nurses from being able to reach out to others and support them in their time of grief. This was more apparent with the inexperienced intensive care nurses, but was not limited to them. For example, the intensity of the participants' feelings of grief at the time of the child's death also influenced the amount of emotional energy needed to control their crying, despite their years of experience. However, being unable to help their colleagues or to give themselves emotionally to the grieving parent augmented the inexperienced nurses' sense of guilt for having failed those who needed them. Casey described how she felt badly for not being able to support a colleague who was crying at the time of a child's death because she was trying to prevent herself from crying. Jamie described how she had had a hard time holding it together and therefore how difficult it had been talking with the parents about their child after the child's death. The more inexperienced nurses described how they had seen other nurses who seemed to be able to cry with the family a little bit, but could still control their crying so that they could support the parents. They said they wanted to get to that point too. They acknowledged that it had not been an expectation of their colleagues that they provide the emotional support needed by the grieving family. They said their colleagues had helped them with the emotional care, allowing them to focus on the physical care of the child at the time of the death. It was easier to manage their crying when they remained focused on specific tasks.

Therefore, the participants needed to learn how to control their crying. This was

something that required experience. As Jamie said, it was a hard thing to get good at if you did not see very many deaths. Several of the more experienced nurses described how they had learned to "be strong" through a variety of coping techniques. For some, it was removing oneself from the situation until they felt better in control of their emotions. As Sean said, just talking with someone, or going for a coffee to get away from "all the emotion in the air", would enable her to face the situation better. For others, they described how keeping busy helped them to stay in control of their emotions.

Dale: "... I'll probably come along and my eyes will be red but I try not to cry. That's me. I have a lot of emotion. As soon as the parents leave, and things go back to normal then I'll just work. We have to work [long pause]." (5 plus years intensive care experience)

The participants also described how they preferred to cry in private. This reinforced the impression that grief was a private experience. Pat described how the worst thing for her had been fifteen people sitting and watching her rock a baby who was dying. The most important thing to her was to be alone so that she could feel free to cry if she wanted to. Although the participants acknowledged that the staff were not ridiculed for openly crying, they also acknowledged that it was difficult for the nurses to observe their peers grieving and therefore staff often left the unit for a short time to cry. Dale described how it was difficult to see another colleague cry and therefore the nurses would prefer to cry in a small room by themselves. Once they had cried, they felt ready to continue on with their work. Therefore, there may be ambivalence about the acceptability of crying publicly in the unit. On the one hand, there is acceptance of this form of grief expression by their colleagues. On the other hand, there appears to be a personal expectation that crying be done privately. This may be related to the cultural norms and mores regarding the expression of grief. Traditionally, persons raised in the cultures of Western civilization have been taught to control their emotions and there is a more reserved or stoical nature to the expression of grief in this society (Knapp, 1986).

Not crying helped to get the participants through their shift. But the participants also stated that crying did help when they allowed themselves to do so. Unfortunately, it was not

always possible to cry later. As Jamie said, not crying might get you through the shift, but it is unfortunate that when you really need to cry, you don't feel you want to cry; but when you feel that it is all right to cry, you may not be able to. Unfortunately, triggers often caused them not only to relive the feelings associated with the death of the child, but also to have "break through tears," often at a time and in a place they did not want this to happen. As Pat said, she can be working away and suddenly hear a song that reminds her of a particular child, who she had cared for more than two or three years ago, and she will just start to cry. Thus, there was a timelessness to their feelings and expression of grief.

Crying and controlling one's tears appears to be common to nurses in other settings as well. In an article of their analysis of personal inventories of 300 oncology nurses attending the authors' bereavement workshops, Saunders and Valente (1994) stated that due to professional standards, nurses may hesitate to cry in front of the family. As a person, the nurse feels sad and tearful, but as a professional it is important to stifle those tears.

Physical expressions of hurting

Several people stated that they experienced physical feelings of hurting associated with their grief. The characteristics of the physical sensations they experienced were very diversified. The male participants in both the main and pilot studies described the difficulty they had in expressing their emotions through crying, although they recognized that their "eyes were cloudy" or "red" upon the death of a child.¹ They perceived that their inability to express their grief by crying was culturally determined. Therefore the physical symptoms they described appeared to result from their attempts to control their feelings.

"I wasn't really brought up that way but my mind was a man should not cry. And then you're surrounded by people that cry a lot, you're there and you have to take a deep breath [takes a deep breath] and you have to be a man. So I tend not to cry but it, it hurts [voice softens] so much inside it's incredible. [Makes a fist into his stomach] ... It's so hard and

¹ The excerpt has not been referenced to protect the anonymity of the male participant. Pilot study data has been included here to demonstrate that the male nurses had similar responses.

you look around and of course all the women are crying but not most of the men ... and all us guys are just standing there, and our eyes are totally red, but not a tear is coming down. But we all feel the same thing. It it hurts right in the throat [grasps throat with both hands, one hand on top of the other]. It's, I find it hard."

On the other hand, the only other participant to describe somatic sensations at the time of a child's death, a nurse with many years of intensive care experience, told of physical symptoms that were of an intense quality and of much longer duration than those described above. She said she experienced pain and heaviness in her stomach and chest. She stated that these physical symptoms have occurred for all those children with whom she has been directly involved, but the intensity and duration have varied depending on the context of the child's death. This participant also described other physical manifestations of grief such as headaches, sleep disturbances and profound physical fatigue when she had been exposed to a number of "very negative deaths" in a brief period of time. This nurse described how she had experienced all these physical disturbances as signs of burnout just prior to her decision to transfer from adult nursing because she felt no sense of satisfaction from her work. Based on her prior experience, she interpreted these feelings as a warning that she was not coping well with the deaths of the children in the unit. She understood her own personal limitations and requested patient assignments for the next few shifts where it was anticipated that the children would survive. A vacation then allowed her time to "find new strength" to help her better manage her grief in the future.

Energy depletion

The participants all expressed some degree of emotional fatigue or depletion of energy resources. This tended to be implied through such statements as "I needed to get my strength back" or "I came back feeling re-energized." As Dale said, when a child dies for whom she had cared, she could not go home and do things that she had to think about. She had no energy left.

"You just don't walk out after your 12 hour shift and say I'm going home and I'm going to read a book or going to study. I can't do that. I can go home and do things that I don't have to think about you know. ... But I can't [pause], it just blocks me from doing anything where I need concentration because I can't concentrate. The only thing I have in my mind is that [the death], you know. Because trying to concentrate, it just, it just drains you. It just takes all your concentration energy and you don't, I don't have it any more, you know." (5 plus years intensive care experience)

Dale described how it could take a few days, to feel the need to be actively engaged in more mentally challenging activities again. Some of the participants stated that, if they had to go back to work for another shift immediately after the death of one of their patients, then they sometimes needed to emotionally distance themselves or to limit their degree of attachment to their next patient. They felt they still gave good care to the child, but they did not have the emotional energy to open themselves fully to another child. Distancing themselves for a short time helped them to cope with this manifestation of their grief. Once they had several days off work, they felt they could once again give of themselves more fully.

Impatience

One participant noted that she had expressed her feelings of intense grief when one of the children for whom she had had a strong attachment died, complaining about everything at work, a behavior she stated was very unlike her. She said that she complained about her work schedule and even about the garbage not being taken out. This participant noted that due to her feelings of grief, she hated going into work and was even thinking about a new job. As her feelings of grief began to hurt less, she again began to view her job as a good one and she no longer was bothered by the small frustrations of day to day work life. Parkes (1972) has reported that feelings of powerlessness, anger, and profound sadness can have their expression through impatience with activities of daily living. Limited energy reserves also can aggravate this.

Each of the participants shared stories that were very different from each other. However, when all the stories were analyzed and compared, it became evident that the participants had identified common factors surrounding the children's deaths that tended to influence their grief responses. These included such conditions as the integrity of their relationship with the child and family, suddenness and unexpectedness of the death, preventability of the death, number of deaths to which they had been exposed, and the support received within the work environment. The next section examines in more detail the contextual factors of the death that influenced the participants' grief.

Section 3: Contextual Factors That Influence The Nurses' Grief Response

3.1 An Overview

What is essential to understanding the nature of the nurses' grief response to the death of a child for whom they cared was an understanding of the contextual factors of the child's death. Participants began their discussions with a lengthy history filled with details about events surrounding the death. It was as though the participants were saying 'before I can help you understand how I felt, you must understand what happened and what the child and family meant to me.' Therefore this section will discuss those factors that the participants described as influencing their grief response to the death of a child.

Every death was different. Therefore, every time a child died, the participants experienced a different grief response, although there were common elements. Their stories told that there was no pattern to their reactions to the deaths because there were always different contextual factors involved with the period before, at the time of, and following the death. Therefore, there could be no habituation to their responses to the death of a child. There were also personal factors that influenced the participants' grief responses and these could be different for every death. For example, several nurses described how they had been

exposed to three or more deaths in a row and they found their grief responses to be more intense and "harder to deal with." They stated they wanted to see just one child live and do well in order to feel a sense of joy again. They all described how the morale of the nursing staff also affected their own general mood while at work. They described how they tended to carry the emotions of their colleagues, such as their sense of gloom and sadness or even their guilt or anger. Then, if they experienced the death of a child during this time, they felt a more intense grief response. The degree of support by staff was also diminished when the unit had been exposed to a large number of deaths in a short period of time. It was perceived that the staff would not have the emotional energy to help others as each nurse would be trying to manage his/her own grief during these times of multiple deaths in the unit.

The personal events in one's life, such as the recent death of a significant other, was another example of a personal factor that influenced their grief response when a child for whom they cared died. As Alex stated, her grief responses now were "definitely harder" since she had experienced her own personal losses. She stated that she had had to fortify her social support system outside of work and had redefined her personal limits of coping in order to manage the feelings of grief in both her personal and professional lives.

These findings are consistent with the research on health care providers stress and coping with multiple losses (Adams, et al., 1991; Benoliel, 1983; Eakes, 1990; Munley, 1985; Vachon & Pakes, 1985). It is interesting to note that the perceived non availability of support systems and/or other recent losses in one's life which occur concurrently with the death of a significant other are considered factors that place the bereaved at high risk for atypical or complicated grieving, current terms for pathological grieving (Katz & Florian, 1986-87; Parkes, 1972; Rando, 1984; Stylianos & Vachon, 1993; Worden, 1991). These personal factors, particularly the non availability of support systems, may be present for many of the deaths to which nurses are exposed in their working life.

The contextual factors that influenced the participants' grief in a child's death were

different for each individual. This explained why nurses who had the same child death exposure did not necessarily share the same grief experience. For example, the inexperienced nurse may have had strong feelings of culpability at the time of a child's death due to her lack of knowledge and skill, while the experienced nurse may have felt a sense of relief that the suffering of the child was now over. The meaning that these individuals placed on the death of the child was also different due to the differences in their experiential learning. In addition, it appeared that the participants "weighed" the variables within each situation of death according to their own value system. As a point of illustration, Alex stated that she felt more sadness when the family's choice of how the child would die was not congruent with her own. But the sadness "wasn't long lasting" because the family's choice had been respected. Respecting the parent's choice was of higher value than meeting her own expectation of the best way to die. Therefore, her feelings of grief were not of long duration. Each person's value system appeared to have developed, or was developing, based on both their personal and professional experiential foundations.

It appeared that the presence of particular variables potentiated the participants' grief responses. The findings of this study have similarities to Bugen's (1977) theory. In his 2x2 matrix, Bugen suggested that, if the bereaved perceived the death was preventable and the deceased was considered a central person in his or her life, then the grief experience would be intense and prolonged. The opposite would be the bereaved who had only a peripheral relationship with the deceased and believed that the death could not have been prevented. Then, the grieving process would be predicted to be both mild and brief. Just as has been suggested by Bugen's theory, the closeness of the relationship and the perception of preventability of the death appeared to have increased the intensity and duration of the participants' feelings of grief. However, in Bugen's theory, preventability refers only to "the general belief that the factors contributing to the death may have been sufficiently controlled so that the death might have been avoided" (p. 199). Although the preventability of the child's

death was a component of this variable for these participants, the perception of preventability also extended to the dying process. That is, if the participants perceived that the death could have been a better one, then the intensity and duration of their grief responses were increased. Additionally, Bugen's matrix appears too simple, because it appeared that a sense of predictability of the child's death was another critical factor that contributed to both the intensity and the duration of their grief responses. For example, it appeared that when there was no sense of personal loss at the child's death and no sense of preventability and/or the death was a predictable one, then there was no anger or guilt and the feelings of sadness did not linger. On the other hand, if there was an intense emotional connectedness with the child and family, in addition to feelings of preventability, and/or the death was sudden and unexpected, then feelings of anger and guilt augmented their profound sense of sadness and their grief was more difficult to manage. In contrast, it appeared that if there was a strong sense of attachment to the child and/or family but no perception of preventability and/or the death was anticipated, although there was intense feelings of sadness that may have been of long duration, these did not seem to be compounded by feelings of guilt or anger. Feelings of acceptance appeared to be easier to achieve.

However, their feelings of grief were even more complex than the above matrix suggests. For interwoven through each of these variables was the variable of experience. For example, as the participants gained knowledge and skill, there was an increased ability to let go of the feelings of culpability related to the perception that they could have prevented the child's death. In addition, some of the participants had learned to establish boundaries around the type of relationship that they would develop with the children and their families. Therefore, their grief responses changed over time as they gained more experience and learned about what helped them to manage their grief and what variables influenced their grief responses. As a point of illustration, Casey, a less experienced intensive care nurse, told a story of a child that had continued to haunt her many months after the child's death. She had had a strong sense of

emotional attachment to the child and also felt that the child's death could have been prevented. She believed that had she been able to find some indication to delay the child's discharge home, the child would not have died. In addition, because of her lack of experience with death, she had not developed coping strategies to help her manage her feelings of sadness and guilt. She described her feelings as being overwhelming and her only way to cope at present was to avoid the painful feelings. It appeared she had not yet come to terms with this child's death.

"The one that so affected me, it was a little boy who, he was a BPDer and he was my primary patient. And I had taken care of him for about 2 months. And his parents lived quite far away so I was, they, I really, I mean I don't know how healthy it was, but I really felt like he was, you know, my little baby. I mean I sincerely think I loved this little baby. [tempo of voice very slow and voice cracks at this point] He was very important to me. And uh, he went home and within 4 days of being home, he died. ... And all wrapped up in my sort of feeling sadness and loss was this feeling of responsibility that I couldn't shake.... I felt like there was something I missed. That um, [pause] you know, I could have stopped the discharge or something, if I had, if I had uh, been able to catch something [crying]." (less than 5 years intensive care experience)

Two themes have been identified that describe the contextual factors that were common to all the participants and that have influenced their grief responses. They are: (1) the nature of the nurse-family unit relationship and (2) dissonance.

3.2 Theme - The Nature of the Nurse-Family Unit Relationship

Being involved with the child and family appeared to have affected how the nurses felt at the time of the child's death. As was described under the ethos of pediatric intensive care nursing, these participants highly valued being involved in and committed to the nurse-family unit relationship. The participants described a strong sense of satisfaction from having shared in their lives and having been able to help the child and family cope with this life crisis. The development of a trusting relationship helped them to be partners with the parents in care of the child and being empathetic helped them to provide support and comfort to the family in crisis.

Forming a "close relationship", becoming "emotionally bound", "becoming attached", or having a "connectedness" were words introduced by all the participants in the study. The type, quality, closeness, intensity, and importance of the relationship appeared to affect the duration and intensity of the nurses' grief. The participants appeared to be involved in a range of relationships with the child and family, similar to those that have been described by Morse (1992) in her exploratory studies on the development of various types of nurse-patient relationships. For example, the participants stated that on occasion there was no sense of connectedness at all. Their relationship with the child and family was strictly related to the physical care given to the child. They stated this had happened when a child came into the unit and died within a few hours of admission or when the participant had peripherally assisted another nurse with the physical care of a child during a crisis situation. For example, Dale described one death where the child had been in her care for less than half a shift and therefore she was able to "easily overcome the death." Jamie described that, although she felt sad when the child died, she was not as affected by the child's death in those situations where she did not have time to get to know the child and family because the circumstances of the child's dying process had kept her very task orientated while the team attempted to save the child's life. She stated that in these cases "you don't even have time to look at the face of who is there." She acknowledged that if another nurse had cared for this child and family during the days prior to the death, that nurse might have been devastated upon hearing of the death. However, the death did not affect her as much. There was little personal emotional involvement and therefore the nurses rarely remembered these children's names or the details of the child's death, as long as there were no other contextual factors that had influenced the death in a negative way, such as feelings of preventability.

A few participants had worked with adults and were thus able to compare their feelings of grief when a patient for whom they had cared died. They stated that feelings of emotional connectedness were not as prevalent in their adult nursing experiences and as a result, their

feelings of grief were less intense and of shorter duration. The following account suggests that this less intimate connectedness enabled the nurse to continue to function effectively for the remainder of her shift because it was not difficult for her to manage her feelings of sadness.

Pat: "It's very different [in reference to her grief for adult patients]. I don't find you get as close to the patients. You're not as close to the family. ... I mean I felt sad for the family, ... but it's not the same kind of impact lets say. I mean after you take care of the patient afterwards it's just - 'Okay. Keep going. Do your day.' [in reference to children] I think it's because here you're so close to the family. You're so close to this one baby or child or whatever. You in a sense get attached. In a sense develop a really much stronger relationship." (5 plus years intensive care experience)

However, for the most part, the participants described having what Morse (1992) would refer to as a connected relationship with the child and/or family. This connected relationship appeared to have occurred at two levels. In the first, the nurses described having had an emotional connectedness to the child and family in which there was not a personal sense of loss when the child died, but rather feelings of having shared the lived experience of grief with the family. In the second, they described having had more connected relationships that involved feelings of personal loss when the child died. This stronger sense of "attachment" occurred with either the child, the family, or both. Bugen (1977) would refer to the former relationship as a peripheral one and the latter as a central relationship. The degree of emotional connectedness that the participants felt for the child and/or family affected the intensity and duration of their feelings of grief and is illustrated by Alex.

"Certainly the ones that I've actually cared for have, I would say, have a greater impact on me. Particularly if it's a child and family that I've looked after for a while and had some time to develop a relationship with. As compared to someone who comes in, and a child comes in and dies within a couple of hours. It presents a different type of grief I guess. In terms of the children who died in the unit that I haven't directly looked after, I think there's a certain element of sadness that goes along with that. I guess the easiest level would be children who I haven't looked after, but I'm aware of their death in the unit. Another level might be children who I have looked after. Not a lot. But have developed some relationship with the child and family. Who die when I'm not there. And then there would be a group of children and families who I've developed more of a relationship with, who may or may not die when I'm looking after them. But it would affect me more. And then there's a group of kids and families who I guess I've developed a stronger relationship with. And they would die on my shift, when I'm looking after them. And then there's also the factors that somehow get put into this and I'm not sure how this all relates." (5 plus years intensive care experience)

Sharing the lived experience of grief - the empathetic relationship

Being connected to the families through an empathetic relationship was highly valued by these participants. The participants stated that being able to meet the needs of the family and being able to comfort them meant that they must truly "be with" the family. As Jamie said, "being with" the family meant that she needed to live what they were living in order to make it easier for them and to make it easier for her to work in partnership towards mutually shared goals for the child. The rewards of an empathetic relationship were seen as positive. They stated that it made them "feel good", "feel great about" themselves, or that they felt "a sense of satisfaction" when they knew they had helped the parents and had eased their burdens for a short period of time. The participants had found it rewarding to be allowed to share very personal, intense feelings.

These participants have expressed what Liehr (1989) has noted in her work on the value of presence in nursing. She has written that:

"true presence is an experience of genuinely engaging with another, perhaps for only a fleeting moment, perhaps intermittently for an extended time. The person with whom one is engaging moves to the foreground with all the anger, joy, fear, or pain the shared moment will hold. To attend in this way, the nurse's sensitive awareness of the other extends beyond a facial expression or beyond the content of verbal interchange. The nurse's sensitivity is expressed as a shared feeling. ... To share another's loneliness is to touch one's own and to stay with it, channeling energies to understand the meaning of the moment" (p. 7).

Being involved in an empathetic relationship helped these participants provide the comfort and supportive component of their nursing practice. The more experienced nurses had learned that emotional closeness and sharing the lived experience assisted families through the grieving process and protected them from institutional depersonalization. These findings are similar to those found in other literature with the terminally ill. Martocchio (1987) has written of her work with nurses caring for the terminally ill, that they have learned "to engage in empathetic relationships because during chaotic life experiences, loss is changed to gain when there is a feeling of understanding" (p. 23).

The value of this type of relationship for these participants is congruent with other

findings in the literature. In an exploratory-descriptive study by Eriksson (1992) , she examined the ways in which nurses communicate caring to the patients and families. From both the patients' and nurses' point of view, the experience implied "the ability to cry with those who cried, laugh with those who laughed, grieve with those who grieved and be happy with those who were happy" (p. 93). Demonstrating that they cared for the patients by sharing the patients' and families' experiences were said to have positively affected the healing process for the families and had eventually led to a feeling of joy and satisfaction for the nurse. The nurses in her study stated that they felt they had matured as human beings and that their own life values were involved. Eriksson found that time as a quantity was of no great significance, but the experience of sharing time was important. Communicating caring implied choices which included both joy and pain (p. 93).

Williams (1982) has written that successful enactment of the supportive professional role, perhaps even more so than the therapeutic role, requires the capacity to empathetically experience with the patient or family. Empathy involves mentally imagining oneself in the role of the other and experiencing the associated emotions. Therefore, an outcome of sharing the death with the family was that the participants also shared the families' feelings of grief and these shared feelings became part of the feelings of grief experienced by the nurses. For example, Pat stated that the presence of the family in pediatric nursing had made her feelings of grief more intense than they had been when she had worked in adult nursing. Although she acknowledged that the level of attachment she had developed with the children had influenced the change in the intensity of the feelings of grief, she also stated that her grief had been exacerbated by seeing and sharing the grief of the family. Although meant to facilitate meeting the goals of the child and family, sharing the family's feelings of grief and becoming "part of them" resulted in sharing the loss of the child with the family. She had not established this type of empathetic relationship with the families in the adult setting and therefore found her grief with adult patients less difficult.

" I think it's just um a feeling that you're kind of part of them. You feel like you're part of them. And you feel like the loss, you're also having the same kind of loss. And ultimately you're all, we're all working towards the same thing which is the best for the baby or the child. I guess that's why you, I eventually end up feeling like I'm part of them. I see what they're going through and I try and make it the best I can. ... Definitely makes the person real. Whereas I found when I worked with adults it was, it didn't seem as real to me because it seemed like nobody was grieving and nobody really gave a hoot. So it makes it a heck of a lot more uh a reality.." (5 plus years intensive care experience)

Sharing the family's grief did not necessarily require a deep sense of emotional connectedness to the child or family. In the following story, Dale stated that she had not developed a deeper level of emotional connectedness to the child or family due to the short period of time that the child was in the unit. However, the intense grief lived by the parents, particularly those emotions expressed both visibly and audibly by the mother, "marked" her. In addition, the emotions displayed by other health care providers intensified her feelings of sadness. This story has "haunted" Dale for many years even though there appeared to be no personal sense of loss of the child.

"The first time it really marked me was a little 21/2 year old that drowned in a pool. ... And the mother was just basically crying and crying and [saying] 'This is it. I'm losing my whole life. I'm losing my only daughter.' And a lot of the family, she invited her whole family members over to be with her and they were all really grieving. ... So I was really in the midst of the family members that would come and walk by and kiss her and hug her. And she even told her [other children] once to 'Well this is it. Just say good-bye. This is the last time you'll see her.' You feel so weird inside. And then they look up at me, the chaplain was in front of me looking at me, his eyes were red, tearing. I myself was trying to uh hold back a lot. Which is difficult. ... Having all these emotions go through you and just try to keep a straight face. Be [long pause] Try to be reassuring as much as possible. Yet you feel you're falling apart inside." (5 plus years intensive care experience)

Dale also described how once the family members left the unit, their feelings of grief were taken with them. Therefore, the energy that she had used to share the families emotions with them became available to help her cope with the death of the child.

"As long as the family members are around, I find it very, very difficult. They carry all the emotion. When they leave, it seems all the emotion goes with them. Then I could be alone with the child. I feel very sorry but I'm able to regain my strength after that and be able to continue on. But during that moment of time it was extremely difficult. Just to be there and seeing all these people walk one after the other." (5 plus years intensive care experience)

In contrast, when families were not present or when their emotions were not displayed, the nurse's own grief experience was perceived as easier. Dale described a situation in which the child's death did not haunt her that much because there was no requirement to share in parental emotions.

"And the parents did not carry that much emotion. They walked in and they see the child. We did not even see a tear from the parents, neither the father or the mother. And they walked back out and they were gone. And for us well, if they don't carry much emotions, you don't have that much yourself."

Pat's account also illustrated that although painful feelings of grief were still experienced at the time of the child's death, the duration of those feelings was less because she did not carry the additional burden of the parent's feelings of grief.

"That's why too I guess in a sense the baby that uh died when he was alone, I was able to get over it even though it was very painful at the time, because I didn't see the family. So if whatever grief they were feeling, I didn't end up carrying it around basically and feeling for them, like feeling bad for them, because to me, I don't even know what they look like. So it can definitely affect your grief. Definitely." (5 plus years intensive care experience)

The participants stated that how the emotions were expressed by the family had had a profound effect on their grief responses. For example, the nurses' own feelings of sadness and feelings of helplessness appeared to have been less intense and easier to manage when the parents' feelings of sadness, helplessness, and hopelessness were shared in a more controlled and reserved manner. In contrast, the burden of grief carried by the participants as a result of sharing the family's lived experience appeared to be greater when the parents had expressed violent emotion. It was as if the amount of grief carried was greater when more of it was released by the family members.

The participants also described how they shared the parental feelings of anger and non acceptance of the child's death. The sharing of these feelings of anger influenced the participants' own feelings of grief which were described as "harder", often longer, and it was more difficult for them to achieve a sense of acceptance. These thoughts were expressed in the following account by Dale. An adolescent had chosen to have heart surgery for which

chances of survival were poor. The father had not been able to accept his daughter's decision and the anger he felt was directed at the caregivers. Despite this, Dale had developed a trusting relationship with the family. She understood that the father's anger was an expression of his grief. Dale described how she carried the father's anger and the siblings feelings of grief.

"And things did not go well at all. It was getting worse and worse. We had to sedate her for her not to feel anything. She arrested many times. And it was difficult. The family was very mad at the medical system. And basically I had been taking care of the child so much, that I was the only person that the family could really relate to. And all the anger was thrown partly, well, at me. They told me: 'We're not mad at you, we're mad at the system.' But being that I was always with them, all the anger was like channeled through me, and back to the medical people. So it was extremely difficult. ..." (5 plus years intensive care experience)

The sharing of the family's feelings of grief intensified Dale's own grief response and still "haunted" her even years later. The sharing of their anger had made it more difficult to accept the child's death.

Even when anger was perceived as a normal part of the grieving process, and the participants stated they were able to understand this response, they were affected by the anger and had difficulty coping with it. But they also described situations when parental anger turned to blame and as a result the nurse's own feelings of grief were further intensified. Under these circumstances, they not only had great difficulty accepting the children's deaths, but they also expressed having feelings of anger, guilt, and powerlessness. Even the experienced nurses, who felt more confident in their knowledge and skills, stated they had these feelings as part of their grief response. In the following account, Pat described how being exposed to extreme parental anger and blame resulted in feelings of responsibility for the child's death, even when she realized that it was illogical thinking. Sharing the anger of the parents caused her to relive the circumstances of the death in order to find someone or something to blame. She became angry with the system, others, and self.

"Basically the one I'm talking about was very negative. They [in reference to the parents] were very negative. And it just uh it made me carry it around that much longer I think, because like it really became questioning what we were doing. It really had me look at - did we do all we could? And it also made me a lot more like, think a lot more that I didn't do what I could. And you know I could have done this, this, and this that would have been

better or made it more. It wouldn't have been better. It's a bad experience and that's it. You know? But it could have maybe helped." (5 plus years intensive care experience)

She stated she was not able to readily accept this child's death and it caused her to question her previous understanding of life and death and her role as a nurse.

In studies that have examined the stress and coping in adult and neonatal intensive care nursing, families' grief, reactions to families' grief, parental anger and guilt were considered stressful for neonatal nurses (Caldwell & Weiner, 1981). Similarly, pediatric hospice nurses have reported that certain negative responses of families, especially anger (hidden or overt), helplessness, and criticism of staff are difficult to cope with (Woolley, Stein, Forrest, and Baum, 1989). Although these studies have identified that these feelings are considered stressful for the nurses, they did not examine why this would be so. The participants in this study have possibly given an explanation as to the reason. Sharing of these feelings, makes their grief experiences more difficult.

Certain factors in the participants personal lives also appeared to have affected the meaning of the shared experience and thus influenced the intensity of their own responses. These variable were: (1) becoming a parent and (2) the death of a significant other. In the main study, the one participant with children commented that she now shared more of the parent's grief because her understanding of what it might mean to lose a child had changed for her when she had become a parent. She stated her feelings of sadness when a child died were now more intense. These thoughts had also been expressed by the participants with children in the pilot study. It was as if they were saying: 'Now that I truly know the feelings of love a parent has for a child, I am closer to understanding what the loss of this child would mean to me. I can empathize even more now.'

Dale: " I think the big difference was when I had my children. I had a. [pause] I felt before, but I couldn't really know how a parent would feel losing a child. ... I just can't imagine myself losing a child. ... It's hard. I see and I feel a lot more. Before that I was sad for them but there was something missing. I could not really fully comprehend what it was with the child, that bond that we have. And now I do know. And I would have an extremely difficult time if I had to lose a child. And I feel a lot more for these parents that go through this [big intake of breath]." (5 plus years intensive care experience)

However, an experienced participant with children from the pilot study stated that she believed that the intensity of her grief was not just a product of being a parent, but rather having shared the grief of numerous parents over the years.² She described her current feelings of grief when she was exposed to the death of a child as more intense than they had been in her earlier years of intensive care (although she stated she had learned to manage her feelings better). She saw that the intensity of her feelings of grief was a direct result of the learning that came from her numerous experiences with death and having shared the intense emotional pain of these parents. This participant's experience confirmed what the grief literature states, that is, parental grief is one of the most intense grief reactions, taking from years to a lifetime to resolve (Demi & Miles, 1986; Rando, 1984). This helped to discriminate between sharing the lived experience and projection of the child's death onto self. The participants described sharing the parents' feelings of grief more intensely, not having increased feelings of vulnerability.

P2: "It is a very different situation when a child dies, as opposed to when an adult dies. So by virtue of that I probably project that into this situation is that I can't imagine that there is **anything** [tone of voice strong, emphatic on this word] worse for parents than a child's death, their child's death. I can't imagine anything worse. And so to me it is the ultimate grief that they feel. Where as when I was a new nurse in PICU I didn't have that appreciation [in reference to the fact that she had come from an adult ICU]. Is that a product of being a parent? I don't think it is. I think it's a product of seeing parents lose children. That's where I think that comes from. As much as I have seen the physical pain. I have seen parents hurt. I have seen it go on. I have seen the fact my learning of what is a normal grieving period and it's not 4 months. It's not 8 months. I mean we're talking **years** [tone of voice strong, emphatic on this word]." (5 plus years intensive care experience)

In addition, those participants who had experienced the loss of a significant other in their personal life, after they had started to work in pediatric intensive care, stated that the sharing of the families' feelings of grief was now deeper because they had a different understanding of the parent's pain and what this loss might mean to them. They recognized that the death of a child and seeing the pain of the family caused them to relive some of their own emotions of their personal loss. However, they also felt they were more empathetic and shared more of the

² Pilot study data has been included here to report the variance in the meaning that two nurses had ascribed to their grief experiences as a result of becoming parents.

families' grief. Both of these factors resulted in feelings of grief that were more intense.

Sharing the lived experience of the family did not always result in the more painful feelings of grief, such as sadness or anger. Sharing parental feelings of grief sometimes helped the participants to manage their own grief when the feelings of the family were ones of strength, courage, and acceptance. They helped the nurse to see that grief could be endured, faced with a sense of control, and that survival was possible. This was reflected in the following participants' account. Despite many exposures to death, this was the only positive death experience to which Pat had been exposed. Pat had had the privilege of sharing the lived experience of parents who demonstrated strength in the face of adversity and who had been able to come to terms with their child's death while the child was still in the unit.

"Strength of the parents. The overwhelming strength of the parents. I find they were very brave, strong, and admirable people. It was just unreal when to go and even think of buying a tuxedo for their son for his funeral and then you know. She was telling me things like what she'd planned is on their first Christmas, father and son would be dressed the same, in the same tuxedo, in the same colors, in the same way you know. I found I shared more in their lives because of that. ... And to go right around to accepting it and being strong enough to be able to go out and buy something for the baby for his funeral and for after he died and thinking of these things. I would never even think of that. Like I don't think I would have the strength to go out there and do it. ... And it was just seeing their remarkable strength and their togetherness. It was just unreal. I think that's what stands out more than the others. The others kind of grieved and did it more privately I guess. I wasn't in [voice punctuated this word by getting louder and stronger] as much with their feelings and stuff. But this family I guess really made me a lot more part of it than others have. And I think that's why it was more positive and it really sticks out." (5 plus years intensive care experience)

The child in this story died from multi-organ failure following open heart surgery for a complex congenital heart defect. Despite having this physiologic rationale for the death, Pat still needed a deeper understanding of why the child had died. It was through sharing the lived experience of the parents and their strategies for creating meaning and memories around his death that she was able to create something positive from the death. Although her grief experience still consisted of profound feelings of sadness, she was able to accept this child's death and find meaning in the positive feelings she had experienced with the family.

Other participants expressed similar feelings when they were able to share the

experiences of families who had "strong beliefs in another power." They found deaths "easier to grieve" when the family prayed together, sang at the child's bedside, or were involved in rituals that appeared to provide the family with a sense of comfort. Sharing the lived experience of the family in these circumstances helped them cope with their own feelings of grief and they felt "less sadness".

When the participants were able to continue to share in the experiences of families where there was a perceived sense of growth through the grieving process, the nurses similarly shared the same feelings and this helped them to achieve an acceptance of the child's death. This is reflected in Sean's comments about being with the parents of a child for whom she felt attached and who had died many months previously.

"I saw them last weekend and uh they were at a wedding with me for a girl from here. And I saw them with a smile and dancing and so. In a way to see them a bit more happy that also makes me more happy. To see that they were feeling a bit better [crying]. I felt better because the both parents [both refers to another mother she had previously described] are growing in their grieving." (5 plus years intensive care experience)

One participant shared the experience of the death of a child for whom she has continued to experience grief, not because she had not accepted the death of the child, but because she has continued to share the grief experience of one of the survivors through frequent contact with that individual in the work setting.

Dale: "That was hard because that was a member of the personnel and every time I see her also it's, I find it hard because I always think of her brother. It's her brother and I try to talk to her just in a neutral way as like we used to before, but in my mind, I don't know. Every time she's going to look at me she's probably going to see her brother. And I find that hard. Even though I was so. The time I spent with them was short and I was able to overcome also the death. But now it's. I have more problem with the, this person than I did with the brother. That I do find hard." (5 plus years intensive care experience)

To help clarify and prevent a misunderstanding of her thoughts, Dale continued in her account to compare this death to another colleague who had also lost a child in the unit. The emotions that this peer displayed have been different and thus Dale did not share the same grief experience. This father visually and audibly projected a picture of acceptance to the staff and

thus Dale had been able to also share in these feelings of acceptance.

The emotionally involved relationship

The emotional connectedness that these nurses developed with the children and families often created a sense of personal loss when the child was dying or at the time of death. The participants stated that forming an emotional connectedness that resulted in a sense of personal loss when the child died, usually required time together. The participants stated, that in general, the greater the length of time that they cared for the child and family, the more they were able to get to know them. As Pat said, the more time there is to get to know them, the more there is to miss. Alex described:

"The ones that I've become attached to, I guess it's, um (pause) I'm trying to think of the right word to describe it. Perhaps it's a deeper level of grief. Because I know them more. I mean I guess the more I know people, the more difficult it is for me to experience the loss. When I don't know someone that well there's certainly an element of loss but it's not as strong. And I guess it reflects the type of relationship that I have with the individuals. The closer the relationship, the stronger the grief experience." (5 plus years intensive care experience)

Time, however, was a relative term because the process of getting to know the family was usually accelerated due to the child's or family's extreme needs. The participants also identified that the quality and intensity of the relationship also had to do with "the chemistry" that occurred between them. As Alex said, "there are those children or parents that for whatever reason are more appealing, just like in any relationship." In the following account, Dale described the complexity of the establishment of the nurse-family unit relationship. She stated that on various occasions, she had established an emotional connectedness with the child directly, with the child indirectly through the family, or with various family members. The variables of time and "chemistry" influenced the degree of attachment she felt. For those children and/or families to whom there had been the establishment of this degree of closeness, she stated that it was like losing a part of her life when the child died.

"It really depends on my direct involvement with the child. How much of an emotional attachment I have with them. [long pause]. ... Patients can come into your life so briefly and be gone and sometimes they can come in for days and weeks and are gone. Sometimes you'll have a patient for weeks and it doesn't upset you as much as sometimes you'd have them for a couple of days. You know that's not a true rule, but I would say for the most part, the more I've had them, and the more I get to know them, and quite often you don't get to know the patient verbally, but you can get to know them through pictures and what the parents tell you about them. And you get to know the parents and the siblings and all the extended family [long pause]. And so when you lose them you sort of feel, you know, you could have lost a friend or you could have lost, you know, not a part of you, but a um a part of your life. And um [long pause] But I would say for the most part, that the emotional attachment just depends on the people and the patients. And I guess more on the length of time that you have them, although like I say that's not a true rule, but often. It's the patients you've had over several days." (5 plus years intensive care experience)

It appeared that the intensity and duration of the participants' feelings of grief were greater when the emotional connectedness had been made directly with the child than if the nurses became connected to the child through the family. For some, it was the age of the child that affected the nurses' relationship with him/her. For three participants, the death of child in the older age groups resulted in more intense feelings of grief because it had been easier for them to get to know the child. As Sean said, although she found the death of babies really difficult, she found the older children even harder because they had just had more time to become a person, to develop their own personalities, had been involved in their own decision making regarding their care, and because their parents were full of stories about them. On the other hand, others stated that they became more emotionally attached to the infants for whom they cared. As Pat said, she felt a strong sense of satisfaction when the infants responded to her voice by smiling or when their oxygen requirements were reduced when she soothed them. She felt it was easier to form an emotional connectedness to the infants because they were totally dependent on her for all their needs. She found that her grief responses were often more intense when a baby died.

The degree of attachment to the children varied, but in some cases, the attachment became so strong that the participants described having felt a deep and abiding love for a child, almost as if the child were her/his own. In these stories, the nurses had become surrogate

parents and the bonds were strengthened by the reactions of the child to the nurse. This usually occurred when the parents were infrequent visitors and the child was in the unit for more than a few days. As predicted by Bugen's (1977) theory, the nurses described an acute grief reaction that was of long duration and great intensity when the child died because the child had become a central figure in their lives. Jamie recounted just such a story. She felt profound sadness and feelings of emptiness that were expressed through crying that lasted for many months. She stated that although she had been exposed to other children's deaths prior to the death of this child, this was her first experience with a child to whom she felt a strong emotional attachment that resulted in a sense of personal loss when the child died. As this story demonstrated, the contextual factors in the situation were complex. Jamie had not experienced this type of emotional connectedness to a child before, and therefore had not developed the strategies necessary to cope with the intense feelings of grief that she experienced at the time of this child's death. While others had described having learned from their experiences with loss to establish boundaries on their emotional connectedness with patients and their families, Jamie had not had to face this problem in the past and so had not learned how to set limits to her relationships. She stated that she did not know why this strong attachment had occurred with this child and not with another before him. But, it was inferred from her story that it may have been his personality, the reciprocal nature of their relationship which was unusual in this environment, the length of time he had been in the unit (more than 3 years), the fact that his mother had not been present throughout much of his hospital stay, and the gratitude the mother expressed to Jamie for giving her child the love and care he needed in her absence.

"He was on our unit for so long because he had pulmonary hypertension. This child was very alert. ... And he was so manipulative but he was so funny. He wouldn't eat because, let's say if you couldn't spend time with him, if you were very busy, well then he wouldn't eat. He would only eat if you sat there with him. He was very, very cute. And almost every shift I worked, I had this child. And he's so beautiful. And we got very attached to each other, this child and I. And I would go in and I would kiss him and I would rock him. To the point where I would go in on my days off to see him. And I know, when people tell you you shouldn't get attached to these kids. And I think. And I put myself through hell and when he died it was awful. It was the most awful thing in the world. But, if I had to do it all over again I would. Because just to see the smile on his face when I would walk in the door

would be enough. ..." (less than 5 years intensive care experience)

Many of the children within this setting are not fully responsive due to the nature of the illness or the treatments being administered. Therefore, it was not possible to form strong emotional attachments to the child directly. The participants described that it was through their attachment to the family, that they were able to establish an emotional connectedness to the child. The family made the child real to them through their stories of past events and through sharing their hopes and dreams for the future. Pictures of the child within the family unit displayed at the bedside or the playing of family video recordings facilitated this attachment.

Dale: "And like I said, some of these kids can be unconscious, paralyzed and everything else and this child never even opened his eyes for me. But I got attached to him, because I got attached to the family. ... The family knew that this wasn't just a number for me. This was a child with a personality and. [pause] That's why we ask them to bring pictures of this child when they're well and so we can see a little bit of what they're like. And you get attached to the child through the family." (5 plus years intensive care experience)

Sometimes, it was the attachment that the participants developed with the family members that could cause intense grief reactions when the child died. As Dale said, "you do become within that family." She described how often she had been able to get to know parents well during their child's illness because they had a strong need to open up and share many aspects of their personal lives during this crisis. As a result, she became part of the family and then when the child passed away, she felt sadder and sometimes it was more difficult to cope with their child's death. Jamie described the death of a child to whose family she had been very attached. Because of this attachment, she had found it difficult to manage her own grief with the coping strategies she had previously used. For this child's death, she chose to go to the child's funeral which was something she had never done before because she felt a strong need to find a sense of closure with the family. Pat also described a deep relationship she had had with the parents of a terminally ill child. This strong emotional connectedness had been formed in the course of only three shifts but due to the urgency of the needs of the parents, it had been established quickly. Pat described how she had entered into the nurse-family unit relationship

cautiously and with some anxiety because she had been informed that the parents had blamed the staff for the child's condition. However, she stated that in order to meet the needs of the child, she needed to earn the parents trust and within the first shift they had established a bond that developed into a strong emotional connectedness over the remaining two days. She described how the parents stated they were grateful for the care she had given to them and their child. It had also been a positive experience for her because she believed that her care had made a difference to the child's dying process and to the family. Although the relationship did not continue following the child's death, Pat stated she would not forget their relationship. She said that she felt a great sadness at the time of the child's death, but her positive feelings about their relationship was one way that she coped with her feelings of grief.

"We definitely got closer. We were able to speak fairly on a very open level. We attained I think a deeper relationship than I've ever had with a lot of other parents. We got down to the basics of what you did last summer just about [chuckle]. I got to find out a lot about them as a couple and how hard the pregnancy was and how she went through and they didn't even know at first when the baby was born that he had a defect and all the things she went through, how difficult it was and how she had felt kind of mismanaged in the fact that nothing was figured out until he was quite sick. So we went through a lot of changes in three days." (5 plus years intensive care experience)

Sometimes the degree of emotional connectedness to a family member appeared to be as strong as those that had been formed with the children. The variables for how these strong relationships developed with the family were described as similar to those for the child and "the chemistry" between the nurse and the family appeared to have been a strong influencing factor. Sean described just such a relationship. She stated that she did not normally form friendships with the families for whom she cared. She stated that she had learned over the years to establish boundaries on the type of relationship and degree of closeness she established with the families and children. She had learned that controlling the level of involvement had helped her manage her feelings of grief and the emotional pain she experienced when the child died. However, despite these boundaries, she had formed a strong emotional connectedness to the mother of a child for whom she had cared over a period of one month. She stated that she had

enjoyed a type of friendship with this woman, and although it had not extended beyond the work environment, they enjoyed talking with one another and shared their concerns with each other. When the child died, Sean experienced a profound sense of guilt, which she believed was related to the type of attachment and feelings of closeness she had for the mother. Although she acknowledged her feelings of guilt were illogical, the attachment resulted in a belief that maybe she could have prevented the death of the child. As predicted by Bugen's (1977) theory, her feelings of sadness and guilt were of long duration and she described how she had difficulty managing these feelings with her normal coping strategies. She intentionally continued her relationship with the mother until she was able to come to terms with the child's death.

For the nurses, being deeply attached to the children or the family was a fairly common experience. Attachments were rewarding. They brought a sense of satisfaction and facilitated the meeting of the children's needs and their families' needs. In most cases, however, the more experienced participants had learned to control the level of involvement and the extent to which their attachments carried over into their personal lives. Jamie, a less experienced nurse, described her current struggle to find the right level of involvement for her with the children and families. Jamie described how she had not allowed herself to get close to another child since the death of the child for whom she had a felt such a profound sense of personal loss. She stated that she had been trying to protect herself and therefore had not even hugged a child because she was "so afraid of getting back into the same thing." But at the same time, she had begun to realize that her attachments with the children and families were an integral part of her job. She had discovered that attachment brought her a deep sense of satisfaction. She had also learned that limiting attachment, as a strategy for coping with her grief, was not beneficial to her on a long term basis.

"I try not to attach myself by, for example, not going in the room, uh, you know, to just spend time with the child. Where normally I would. And I think nurses should do that. I mean we're there for that. That's why we have one to one nursing. So as much free time as you have you should be spending it there. So I've been very, you know, on guard

about doing stuff like that. But to really not get attached I don't think it's possible. I don't think I'd enjoy my work if I couldn't get attached. I think you do whether you want to or not. You can't control your feelings. ... I don't know why I get so attached to these kids. I wouldn't say I'm more attached than others, but I think everyone has their own little pattern they go through. Some people maybe get more attached than others and if I were to describe myself I would say that I do. I get more attached than most people in general. But what's led me to be that way I don't know. Like I said I just. If it was my child in the hospital that's the way I'd want it to be. And that's just my personality I guess. ... And like I said after this thing happened with [child to whom there was strong attachment] sometimes I was trying not to give the maximum that I could give. Just trying to hold back. But I'm slowly finding myself going back into it." (less than 5 years intensive care experience)

Jamie's chronicle of this child's death also provided evidence that she had learned that she could cope with the most painful emotions of grief she had experienced to date. Because of this, and because she had not experienced a sense of satisfaction since distancing herself from other children, she had decided that she would be willing to feel the pain of grief again. She wanted to experience the joys of truly "being with" the children. Jamie stated that now that she was beginning to come to terms with this child's death, she believed she would begin to become more involved again with other children in the unit. She did not perceive that her feelings of grief would be any less if one of these children should die. She just believed that she would survive the pain.

"... as much as you try to go into work and not get attached and be different, I can't. I just can't. So I'm not sure that it would be different. I think the experience I have would in the back of my mind say: 'okay, as bad as you feel now it'll get better.' And if this happened again for example like with [reference to the child to whom she was strongly attached], I didn't want to go to work any more and I had this empty feeling when I went to work. Well now that feeling is going away. I don't feel empty any more. So I guess in that sense my experience would say it will get better. Certainly make it easier to move on. But other than that. No I think it would be the same thing."

Jamie also described how in an attempt to manage her feelings of grief, she had kept in contact with the family. She had not been ready to "let go" of either the child or her relationship with the parents and felt the parents also needed her support. However, Jamie had begun to question whether this coping strategy was beneficial to her or the parents. She had never experienced these profound feelings of grief before and had no other experiences with an ongoing family relationship after the death of a child to which she could compare her feelings

and thoughts. Jamie appeared to be ready to accept the child's death and to establish a new level of involvement with the parents. She also acknowledged that this new type of relationship could possibly be beneficial in managing both her feelings of grief and those of the parents over the long term. Jamie had used self reflection and experimentation with different coping strategies to help her manage her feelings of grief that had resulted from this strong level of attachment with this child.

"I don't know which is better for her and which is better for me. I think I'm going to call her again. ... But I don't know if I want to go over there. I want her to move on with her life as well. ... If you hang on to something, you're trying to hang on to something that's not there. And I'm saying: 'Am I friends with her because of this child? Well obviously. Or am I friends with her because I really care for her as a person and how she's doing? And I think it's a bit of both I guess. I don't know. ... So I'm thinking is this a good thing or? And I'm thinking you know maybe we can still communicate and maybe it won't be so sad each time. You know? Maybe it'll get better and maybe we do need to support each other through this because she knows how I felt about this child. And I knew that he was a very important part of her life as well. And we can reminisce about this child and maybe we'll reminisce and it won't always be a tear jerker. Maybe we'll think happy things."

In summary the following account by Alex eloquently describes the theme of nurse-family unit relationships, its complexity, and its influence on the participants' grief response when the child dies.

"What makes the attachment? I'm not sure. I mean it just evolves. It just [long pause]. I guess a certain type of connectedness with the child and family. I mean I don't expect that I have to like all the children and their families that I look after, nor do I expect that they have to like me. But I'm there to do a job and so I, it's nicer if I happen to like the group that I'm working with. I guess the ones that for whatever reason are more appealing to me, I tend to get to know them better and um, a sort of relationship develops. It's just like any relationship. You share some things and I guess again these type of patients I have some time to develop a relationship with. ... And when I say some time it doesn't necessarily have to be a long time. ... And so just get to know the parents and the child and it's nice. It's not just a little kid lying in bed who has had heart surgery. It's a child with a name and who has brothers and sisters and a dog at home and likes to do different things. It just makes it less technical. It's more personal. It's more human. So I guess in some ways I don't see becoming attached to a child and family is that much different than meeting individuals outside of work. However, there clearly is a difference. Uh, as I've said before, I've never developed friendships outside of the hospital with any of the children or parents. I'm not sure if that's something I've really made a conscious effort not to do. Or if it's just that you know our lives go different ways. The ones that I've become attached to, I guess it's um [pause]. I'm trying to think of the right word to describe it. [long pause] Perhaps it's a deeper level of grief. Because I do know them more. I mean I guess the more I know people, the more difficult it is for me to experience the loss." (5 plus years intensive care experience)

3.3 Theme - Dissonance

The participants stated that they worked in pediatric intensive care because they valued and received great satisfaction from saving children's lives. This was the goal of the unit. However, when it was not possible to save the child's life, then the nurses' wanted a good death for the child. Unfortunately, the stories they shared demonstrated that dissonance was one of the most powerful contextual factors affecting the type, intensity, and duration of the nurses' grief responses. Sometimes, this dissonance resulted from a conflict between their ideals about death and the dying process and the realities of life and death in an intensive care unit. Sometimes, it was an incongruity between their expectations of what would happen and the actual outcome of the situation. Sometimes it was a personal dissonance. Other times, it was an interpersonal form of dissonance which occurred between the nurse and the child's family, one's colleagues, or the "system". As previously identified, dissonance refers here to the clashing of coexisting beliefs, values or expectations within themselves or others when the reality of the child's death contradicted their expectations about death and the dying process. Alternatively, a personally held belief, perception or opinion sometimes contradicted the participant's knowledge or actions.

The participants implied, from their stories and comments, that they all perceived that there was a right or ideal way to die. This ideal death scenario included the individual dying at the right time, in the right place, and under the right circumstances. It also implied that it be the right time for the nurse and that even the right nurse be present at the child's death. The participants identified numerous contextual factors that interfered with what they perceived as the right way to die. These factors increased the complexity of the situation and prevented the participants from ever being able to develop a sense of control over the deaths in the unit or to become habituated to children's deaths.

From these participants' stories, the characteristics of an ideal death seemed to be timeliness, painlessness, consciousness, and preparedness.

Firstly, death would come in later years; it would not be premature.

Dale: "I worked, remember working with adults and I had a patient pass away, but the patient was 70 some years old. I don't accept anybody dying, but you can say at least that person had a chance, had a life, did things. Uh. Kids may have had 10 years, might have had 5 years, might have had a couple of months." (5 plus years intensive care experience)

It is understandable that this would be an expectation held by these nurses. North American society is reluctant to acknowledge and accept death. The attitude is that death is antithetical to living and that it is not a natural part of human existence (Rando, 1984). Intensive care epitomizes our society's death defying and death denying nature. Not only do the children's deaths violate the natural order, children are not expected to die in this setting. As Dale said, this is not geriatric or palliative care. Therefore, the death of a child, for whom they cared in this environment, became the first expectation to be shattered.

Secondly, the participants held ideal expectations about the dying process. Death would not occur suddenly but rather eventually, and the child (as appropriate to age) and the family would have time for both spiritual and emotional preparation. The child would be in control of his/her faculties, be alert and able to communicate. There would be time for closure, and there would be a quiet dignity both to the child's death and to the expression of grief by the loved ones. These perceptions about the ideal death had then been translated into expectations they had for their nursing practice. For example, the participants reported they felt they managed their grief more effectively when they believed they had helped the child die a good death, which included the following conditions: (a) the nurses had relieved the child's and family's emotional and physical suffering; (b) the nurses believed that they had delivered the best quality of care possible for the child and family; (c) the family had a chance to complete some unfilled dreams with their child, thus creating positive memories for the survivors; and (d) the child's death was contextually appropriate. The participants' beliefs are comparable to those of other nurses reported in the literature. Hospice nurses have described similar expectations in their nursing practice of the terminally ill (Adams, et al., 1991; Cooper & Mitchell, 1990; Eakes,

1990; Munley, 1985; Saunders & Valente, 1994) while conflicting expectations, such as changes in the trajectory of illness, the death of young patients, and sudden and unexpected deaths, have been reported as stressors for nurses in neonatal, pediatric and adult intensive care settings (Caldwell & Weiner, 1981; Vachon, 1987; Vachon & Pakes, 1985).

Personal Dissonance

The participants' grief responses were strongly influenced by the personal dissonance that resulted from the contextual factors impacting on the death of a child for whom they had cared. These included (1) the participant's beliefs about the ideal death, (2) their philosophy of what intensive care nursing is and how the provision of care to the dying child conformed to this philosophy, and (3) the nurses' professional responsibilities and their own emotional needs.

From the interviews, it was evident that all the participants' grief reactions were influenced by their inability to reconcile their personal beliefs about the right way to die with the reality of how children sometimes died in this setting. Their grief reactions were more intense, longer in duration, and often included feelings of anger and/or guilt and thus became more difficult to manage. For example, a "senseless" or "preventable" death was the one aspect of children's deaths that all participants identified as hard to accept. Children who died as a result of child abuse, drownings, being run over by cars and trucks, and from not wearing their bicycle helmets were a few examples of senseless deaths. The difficulty with these deaths was that they did not meet the nurses' expectations of why a child should die and as Alex said, all of these deaths could have been prevented so easily. Alex described how the first child's death she experienced was an infant who had suffocated in the plastic from dry cleaning. This was a "needless" death and one she did not "find particularly very easy to deal with." Her prior experiences with death had been in the adult population. In the telling of her story, it became clear that why this child had died had not fit into her previously created understanding of why people died. This child's death did not fit her expectations that she had created from the adult

deaths she had experienced. As Alex said, people died from disease, not from murder.

"I'd never experienced this type of death before. Most of the deaths that I had experienced in working with adults were as a result of heart attacks and disease and stuff like that. ... And in certain ways they'd contributed to their own heart disease and things like that. And I guess I was able to justify their deaths. It was really hard for me to justify the death of this little baby who got tangled up in plastic because the mother left it on the bed." (5 plus years intensive care experience)

These types of deaths also resulted in feelings of anger that prolonged the nurses' grieving. Sean stated that because she was not able to understand these types of deaths, she had to think about them for a longer period of time and they made her angry. As a result, her grief was more intense, of longer duration, and more difficult for her to manage. As her words and tone of voice so poignantly portrayed when she talked about children dying from near drownings or from being hit by cars when they had run out the front door:

"Close your door or do something with your pool [crying but firmly and emphatically stated]. " (5 plus years intensive care experience)

Sudden and unexpected deaths were also incongruent with the participants' expectations of the right way to die. They conflicted with their definition of timeliness of the death. Frequently, these types of deaths were associated with those that were senseless and preventable. But sometimes, they were associated with sudden and unexpected deaths of children already being cared for in the unit. For example, the participants described deaths where it was not anticipated the child would die. They also told stories in which the child had died before the expected death trajectory. These types of deaths often resulted in feelings of guilt, even if only briefly, until they had proven to themselves they were not responsible. This is illustrated in the following account. Dale described a child for whom she had cared following complex cardiovascular surgery. The prognosis prior to surgery had been poor and it had not been expected that the child would survive given the development of sepsis and multi-organ failure. However, Dale stated that it had not been anticipated that the child would imminently die. Because of this, information about the child's current condition was presented to the parents in

such a way as to offer some hope of stability for the next few days. When the child died suddenly and unexpectedly, Dale felt guilty for having given the parents a false sense of hope. Not only had the child's death been sudden and unexpected, it had resulted in a violent and graphic one. All these factors had been in conflict with this nurse's vision of how a child should die. This death has continued "to haunt" her even years later.

"... Surgery went well but within 48 hours started to have more and more problems. Went on ECMO. And came back and then just lingered on and on in the ICU. And never really recuperated with all the other problems that came afterwards. ... Then we seemed to be getting in that better mode where things had gotten better. And uh the day that she passed away, I felt very bad. I had this child and in the morning the parents called me and I basically told them well uh things are getting better. I just put an NG down and we are going to start to feed the child. So she was getting strength back. I think I hung up the phone, I turned around, and looked at the child and um [long pause] the bed was full of blood. You know. Like 'Oh! [incredulous tone of voice] What happened?' ... We found out later on there was an esophageal-aortic fistula that ruptured, had opened." (5 plus years intensive care experience)

This is similar to the findings in the grief literature. Lindemann (1944), for example, identified that the bereaved often had prolonged and complicated grief when the loss was sudden and unexpected. This finding continues to be confirmed by others, both in the grief literature on the loss of a significant other (Osterweis, et al., 1984; Parkes & Weiss, 1983; Rando, 1986; Raphael, 1983) and in the literature on caregiver's grief or stress both in the palliative care setting (Adams, et al., 1991; Eakes, 1990; Munley, 1985; Vachon, 1987) and in the intensive care setting (Bailey, et al., 1980; Cooper & Mitchell, 1990; Quint, 1966; Vachon & Pakes, 1985).

In contrast, anticipated deaths were more congruent with their values and therefore, their feelings of grief were "not as hard" to manage. Once again, this is similar to other researchers' findings in the intensive care literature (Cooper & Mitchell, 1990; Eakes, 1990). It was easier for the participants to achieve a sense of acceptance with anticipated deaths.

Dale: "I thought it wouldn't haunt me that much. It was my first death ... Probably because from the very beginning I knew this child would die. As soon as we had the CT scan it was kind of obvious that it is only a matter of time. Everybody has time to prepare." (5 plus years intensive care experience)

When a death was anticipated, the nurse could better control the events of the death. As Casey said, "when you know a child is going to leave you, it is very special to be able to define that process." The participants commented that anticipated deaths were easier to grieve because there was time to help the parents and other family members to resolve their own feelings and say their farewells. These thoughts were best reflected by Alex.

"... I find that when this child finally passes away, the parents do have a lot of time to prepare themselves. ... They [the parents] are sad but the emotion they carry is different from a sudden death. Because they are prepared and they know, well, now the child is probably resting more peacefully. So that's probably one way I probably find those deaths a lot easier than ... [when] the death is unexpected." (5 plus years intensive care experience)

It might also be suggested that the same was true for the nurses working with the child and family. They had been able to psychologically prepare themselves for the death of the child and put strategies into place that had helped them cope with their feelings of grief. As Sean stated, when the deaths were anticipated, they could begin their grieving process. For this type of death, it was implied, from their stories that, they had had time to reassess the situation and create a new set of expectations that would be congruent with the actual outcome. They had been able to create a sense of control over the death.

The participants not only had expectations related to why children die but also to how a child should die. As part of their values and expectations of the death experience, the participants had created a picture of the right way to die. As stated by Sean, "peaceful or uneventful" deaths were easier to grieve. However, the very nature of the intensive care unit often interfered with this. The technology and need to intervene at any cost to save a child's life often conflicted with the desire to offer the child a peaceful and comforting death. All participants discussed the same issue, but Alex's account best articulates their thoughts.

"Probably most kids who die are hooked up to all kinds of equipment and probably are not aware either because they're not cognitively developed to that level or they're sedated to such an extent... Does that bother me? I guess it comes back to I don't think that's a nice way to die. ... But it clearly reflects the environment which I work in. And it reflects the type of health care system that we have. ... I don't think being hooked up to 52 different pieces of equipment is a nice way to die...."

Alex further described her perceptions of how a child should die. Similar to all the participants, she identified it was easier to accept and grieve the death when the child was held and cuddled by loving parents, unencumbered by all the technology. The feelings of satisfaction, that resulted from having facilitated the meeting of this goal of a peaceful death for the child and family, helped her to cope with the child's death.

"I think it would be nice if we could offer the parents and the child something more [pause] pleasurable. And I guess from my perspective that would be not having them hooked up to all kinds of things and allowing the parents to hold the child if they want, before the child dies, not after. But that's not usually the way it is. ... And I guess maybe it's a bit of a fantasy. Maybe it presents a nice little rosy picture, to have the child feel comfortable in the mother's and father's arms. It's harder to envision that when they're hooked up to a respirator and that. ... I guess it's [pause] to see, you know, the child and the parents cuddling, is somehow comforting. I don't know. You know it's a nice picture. It's a nicer picture than seeing parents kind of leaning over a bed where their child is lying. You don't get to see that on Hallmark cards you know [sarcastic tone]. I guess it's my perception that it would, it's better..." (5 plus years intensive care experience)

But Alex also acknowledged that her expectations of the best way that a child should die was not necessarily the same way that the family would envision it. She was able to reconcile this through a stronger belief that the family's grief was facilitated by being able to choose what was most important for them.

Alex elaborated that her feelings of grief were then affected in different ways. She stated that she felt more sadness when the family's choice of how the child would die was not congruent with her own. But the sadness wasn't "long lasting" because the family's choice had been respected. However, her grief reactions were more intense and she felt angry when the child did not die in the best way envisioned by both herself and the parents because the parents had not been offered this opportunity or given choices by the staff. She found it more difficult to come to terms with the child's death when she knew the death could have been better for the child and parent.

"I guess I experience a little more sadness. But that's because it's my perception that it would be better. I don't know if it would be better. And clearly for families who aren't able or don't want to or whatever, if the child remains hooked up to everything, that's the way they're coping, and that, you know, I can respect that. It's not how I would want it. I don't know, I never had a child die. So I don't know how I would want it. And so I have to go by

what I kind of perceive and think I would want. Yeah, it affects me a little bit but you know if I am aware of what the parents want and if it's different from what I want, that's a little easier than seeing kids die who we're not aware of what the parents want. ... But I think in most cases the parents would want to be given that opportunity and that's probably because we don't offer it."

Violent or graphic deaths also did not fit into the preexisting representations of how a child should die. These types of deaths made the participants' feelings of grief more intense and a sense of acceptance harder to achieve. Even though they wanted to save these children's lives, they often described feeling "so angry" that children should have had to die in this way. For example, Alex stated that she found her "grief very difficult" for those children who had been run over by cars, resulting in multiple broken bones and tire tracks that you could still see on their bodies. Dale, Jamie, and Sean vividly described pictures that had remained imprinted on their minds of children who had bled to death. As Jamie said, she remembered blood everywhere and thinking that "it was just horrific." Dale stated that the child's death was incredibly graphic and the child had just bled and bled and bled.

Sean: "... the kid was in shock and she coded. So like we were pushing blood and doing heart compressions. Anyway she ... died after an hour of resuscitation. I looked at the room and there was blood everywhere. It was a mess. A mess in her room. ... And the parents were just put out of the room when it happened. This I found a very difficult moment." (5 plus years intensive care experience)

Sean commented further that she had reflected on the course of events for several days following this child's death. The child had been diagnosed with a terminal form of cancer, but there had been an anticipated death trajectory of several months and the staff had expected a more peaceful death with palliative care providing support and comfort to the child and family. Therefore, Sean's feelings of grief had been influenced by the dissonance of her ideal expectations for this child and the reality of her death. She found this child's death difficult to accept despite having come to terms with the rightness of having attempted to save her life at this point in the child's illness. However, Sean had a sense of remorseful that it could not have been a better death. Sean said it was more difficult to cope with these types of deaths because

there were no answers to help her understand why this should happen.

"... knowing that this kid would die, that helped. ... But oh, looking at the room and seeing how [pause]. I asked myself what did you do to her? How did we do that? But finally when we think about, when I think about it after, like we couldn't do anything else about trying to save her. You know? I always think about would there have been a better way to do it? When I ask myself this big question after, I find it hard because we have no real answer for it."

As part of their expectations of the right way to die, the participants also implied, through their stories, that this should include the presence of the right nurse. For example, Dale, Alex, and Pat stated that they believed, that whenever possible, it was in the family's best interest if a nurse was present at the time of the child's death to whom there had already been an established sense of closeness. The family could best be supported and comforted by someone who already knew and understood their needs. It was "not fair" to expect the family and nurse, unfamiliar to the child and family, to develop a close relationship at this most horrible moment in the family's life. They described experiencing feelings of guilt or remorse when they had not been able to be with the family when the child died. In addition to helping the family, their presence at the time of death facilitated their own sense of acceptance and gave them the opportunity to say good-bye to the child and family. Therefore, when they were not present for the death of a child with whom they had become emotionally involved, they stated they found it harder to come to terms with it.

The participants stated that sometimes there had been no options. There had been no right nurse for the situation. The more experienced nurses stated they had learned "to cope" with these situations and they managed their feelings of grief by using a strategy they believed would help them at that time. For example, if they had not been working the day the child died, they sometimes had attended the child's funeral. Sean recounted one story in which she had been called upon to provide comfort and support to parents she had not met prior to the death of their child. She had expected to care for this family's child in the immediate post operative period but the child had died unexpectedly during the operation. Sean had never experienced

this type of death before. During the interview, she had difficulty describing how she had felt. She expressed feeling a sense of sadness for the family but also felt "peculiar." (In the following excerpt the term "kid" has not been used to depersonalize the child. Sean has used this word respectfully throughout the interview.)

"Also I had another case where I was expecting a kid from the OR and she died in the OR. So I had to, it was me who had to bring the baby to the parents. I was more sad to see the sadness, to deal with the sadness of the family. But the kid herself, I didn't know her at all. So it was peculiar. It was very peculiar [pause] to bring a body of a kid that you didn't know. [pause] 'Twas like, it was not the same. Like I really didn't feel sad at losing somebody I didn't know. But I felt uh [pause]. I don't know how [long pause] I don't know what is the word really. [pause] It felt bizarre [whispers the word]." (5 plus years intensive care experience)

She described managing her feelings by focusing on those aspects of her nursing care she believed would help the family deal with this crisis. She had been able to feel a sense of satisfaction because she had a belief in the value of this supportive role. Feeling a sense of satisfaction had helped her to manage her sadness and the "bizarre" feelings she had been experiencing.

On a few occasions, the participants perceived that differences in opinion existed between colleagues about the allocation of a nurse at the bedside because s/he was competent to care for the child versus assigning a nurse familiar with the child and family. In the following account, the participant felt that the right nurse had not been present at the time of the child's death when another option had been possible.

Pat: "I was thrown in right at the end. I didn't know this family at all. ... I thought this is very cruel, to everybody, you know. They don't know me from a hole in the wall and here they are; they're going to lose their baby with somebody they don't even know." (5 plus years intensive care experience)

Therefore, the nurses' feelings of sadness were compounded by feelings of remorsefulness and anger which prolonged their grief and were "harder" to manage.

Sometimes, the participants had conflicting internal expectations of themselves regarding their presence at the child's death and this compounded their grief. For example, several of the

participants described that sometimes they had not been ready to accept the child's death and therefore they had had conflicting feelings. On the one hand, they felt they should have been present to meet the family's needs. They had had a strong sense of professional responsibility to the family. However, they had also wanted to meet their own emotional needs and felt they would not have been able to cope with their feelings of grief if they had been present at the time of the child's death. Jamie described this struggle with her feelings at the time of the death of a child to whom she had been strongly attached. In this situation, the condition of the child had rapidly deteriorated and it had not been expected he would live past the next few days. Jamie had not been scheduled to work and had planned a trip out of town. She had been torn between canceling her vacation to be with the child and family and not wanting to be present at his death. She had not been ready to come to terms with the probability that this child would die.

"And I thought you know he's going to get better. ...[so she leaves on vacation]. And I called every day to find out how he was doing. And on Thursday I called my answering machine to get my messages. And it's almost like I knew. And there was a message from a nurse: 'Please call me. I'm at the hospital.' And then I get another message from his father: 'Please call me. I'm at the hospital.' I almost didn't want to call. I didn't want to know that he had died. And I didn't call that day. I called only the next day because I was, I just knew that he had died. And the next morning I called and they said yes, he passed away. They took him off the ventilator. And I felt so out of control. And I felt that I should have been there. But yet I don't think I could handle being there. And I remember telling him: 'Don't do it while I'm here.' So I thought the little bugger, he made sure I wasn't there. ... So then I cut my trip short and I went back and everything. ..." (less than 5 years intensive care experience)

In the months that followed this child's death, Jamie struggled with her inner conflicts. Just as Benner and Wrubel (1989) noted in their work on coping with caregiving, Jamie was trying to find the right level and kind of involvement with the children and their families that would prevent this dissonance in the future, through a process of self reflection.

Interpersonal Dissonance

The participants also expressed that they had experienced interpersonal and organizational conflicts related to differences in values, beliefs and/or expectations and these

conflicts had affected the type, intensity, and duration of their grief responses. Sometimes, the dissonance occurred when their set of expectations regarding ideal family behavior at the time of the child's death was different from that demonstrated by the family. For example, the presence of the family at the death of the child was part of the perceptions that the participants had developed for how a child should die. Therefore, when the parents had been present in a loving way with their child, the death had been more acceptable. For example, Sean stated that when the parents gave their love to the child at the last moment, when they held them, kissed them, and put their favorite music on, then she had been able to begin to come to terms with the child's death and to start her own grieving.

This was in direct contrast to those children's deaths where the parents were not present. The participants had a strong belief that children should not die alone. Although they tried to be non judgmental and rationalized why parents might not have been present, they could not emotionally understand it. The nurses had provided loving care to the child on behalf of the parents at the time of the death, but they found that they had felt more sadness, and sometimes they had been angry with the parents, and the deaths had been harder to accept because they had not wanted the child to die alone.

Sean: "I also saw parents that were not even here. That they were almost calling to see if the kid was dead or not. I found that really hard also. Because I was feeling that the kid wasn't receiving what he deserved in his last moments. Of course we try at that point. ... like to hold the kid, to talk to him, being the same thing as the mom would have done. But I didn't live the dying of these kids, the death of this kid, as easily. Okay? Because I found that the kids in their last moments they deserved better, deserved better things than what we can give them. And then I try to understand the parents, ... I try to not judge them... But not being there at the last moment, this I have a lot of trouble with that." (5 plus years intensive care experience)

Similar thoughts were expressed by all the participants. Dale added that even though it had been more difficult to see and share the sadness of the parents, she ultimately found it had been easier to grieve the death of the child when the parents had been present at the time of death. It was this lack of understanding of why a parent would purposely let their child die alone that had made it more difficult to cope with her feelings of grief. The presence of a grieving

family acknowledged that the child was loved and valued. The child's life was important.

* But I always question why a mother or even the father does not cry or express more feeling. That some of them just come in and walk out.... And these parents basically just left and that was it. I felt sorry for the child because I felt like he was abandoned. Even though he wasn't but it was a feeling I had. ... You don't understand someone that loses a child and basically has no emotion, turns around and leaves. I think I prefer someone to really just cry it all out there. Then I know." (5 plus years intensive care experience)

It is also possible that the absence of family might have represented the participants' own fears that no one would grieve their loss if they should die. Pat stated that one of the reasons she had had fears of death and dying when she had worked in the adult setting was that, in her experiences, adults frequently had been left in the hospital to die alone. Because family had not been present to visibly express their grief, she questioned if any one had really cared about them. Jamie stated that she only wanted for the children and families what she would want for herself or her loved ones in the same situation. Perhaps the presence of the loved ones at the children's deaths represented the participants' universal hope that compassion, love, and caring will be present in each of their own personal experiences with death and dying, either for those of their loved ones, or more particularly, for their own.

The participants stated that coming to terms with the child's death had been facilitated when the families' emotions had been expressed in a manner that fit the expectations of how the bereaved grieve in this society. That is, the participants had found the death of the child easier to cope with when there had been a quiet dignity to the family's expressions of grief.

Pat: "The other ones are, kind of, go along and don't do anything out of what you consider I guess norm. They don't rant and wail and fall apart and need to go into psychiatric care or you know what I mean. Like those that just kind of accept it and things just kind of flow. And they were not questioning and they're not, you know. Or they may question but it's not to that extent where you really begin to wonder about everything and. I guess those that are just not as verbal in a sense and those that are resigned to the fact that their baby is not going to survive. I think those eventually they just kind of fade in. You know they, they, you go through it and it hurts at the time and you know you grieve for them, you say a few prayers, and you move on. It's the other ones that are at the extremes of things you know. They're the ones that make it more difficult. The family that totally were not accepting and were very, very angry at everybody, everybody. ..." (5 plus years intensive care experience)

In contrast, the nurses had experienced more feelings of helplessness when there had been violent expressions of sadness, loss, or non acceptance and a sense of death process accountability when the parents had expressed extreme anger.

Whenever possible, the participants stated that they tried to create an environment they believed would help the families cope with their feelings of grief at the time of the child's death. They believed that the parents (and child if appropriate to the situation) needed to be part of the decision making process as to the timing of the child's death and how that child should die. This meant that the family had to have full information of their child's progress and prognosis throughout the entire length of stay in the hospital. There also had to have been congruency between all health care professionals. Therefore, their grief had been compounded by feelings of anger when they perceived that there had been limited communication with the family and/or when physicians had offered only partial truths. They had felt angry when parents had been given a false sense of hope because the physicians had only reported on the system for which they had been responsible rather than looking at the child holistically. The families had not been enabled to anticipate the death and to make informed choices about how their child should die.

Dale: " But all the other people that come for consults basically don't look at the child as being a whole child. If the cardiologist comes: 'The heart is fine. It's beating strongly. It's pumping blood.' So the parents think, oh well the heart is good. And then this poor child succumbs to kidney failure soon afterwards. Oh well then we have to go on dialysis. So you got the nephrologist, the real people to come in to start dialysis. 'The dialysis is working well, so don't worry.' Dialysis is working well! They're just looking at the kidney. Dialysis is working well so to the parents it's going well. The cardiologist goes: 'The heart's going well, the kidney's going, well the kidney's not working, but the dialysis is well.' Suddenly you have some liver problems that appear. So you call the GI specialist in. They come in, try a few things and they're able to, to help the liver heal a bit more. So they tell the parents: 'Well it's fine, the liver seems to be getting better.' But if you look at the child as a whole, nothing is working properly. And you as a nurse, you're stuck into this. You hear these guys say well, to the parents: 'It's good. Keep on. Hold on'. But in the end you say, if you do continue on, to fight, the child is not going to go anywhere and probably will suffer more than anything else." (5 plus years intensive care experience)

The participants had also experienced feelings of guilt or a sense of powerlessness when they thought they might have been able to better prepare the family for the child's death. They believed that the quality of the child's death process had been compromised when the team

had not been truthful with the parents.

Sometimes, poor communication meant that the family had not been prepared to make a decision about the implementation of extraordinary life saving measures for their child. The team had then been forced to attempt to save the child's life in a futile situation, resulting in the child having had a violent death, rather than a peaceful and dignified one. The participants felt that "enough was enough" and the quality of the child's death process needed to be respected. In addition, the participants expressed concerns that it had been these final moments that became the memories with which the parents had to live. As Pat described, both the staff and family were left with the "awful" mental picture of a child with his chest open, a once beautiful baby whose ears had become so distorted from the fluid that had been retained, that the baby was no longer recognizable.

" Because I really feel like, at some point, where are we going with this? And why are we still doing this if we know the outcome one way or the other? And that I find very hard. I find that hard to to keep going and put families and babies and everybody through all these things we know are futile. You know, at some point we can't play God any more." (5 plus years intensive care experience)

At the time of the child's death, the participants appeared to have struggled to create an atmosphere they believed would help the families cope. The literature has supported this aspect of caring for bereaved parents in intensive care settings (Hazinski, 1992; Miles, 1985; Miles & Demi, 1986; Rando, 1984) and it was also supported by their experiential knowledge. They believed that the family deserved to be with their child in a private and quiet atmosphere, to stay with their child as long as was necessary to say good-bye, and to perform any rituals at the time of the child's death that would facilitate their grief process. When the circumstances within the unit prevented the nurses from ministering to the needs of the family in this manner, anger, guilt, and/or feelings of powerlessness became a part of their grief response. For example, Pat described a negative death where she experienced incongruity between what she had theoretically known would facilitate the family's grieving and what measures had been available to the family.

"... And I didn't feel like I did what I could have. I really would have wanted them in a private room. There was no private room. This was like a horrendous time in the summer. Every bed space was, you know, there was the noise level and everything else. So here you've got a whole pile of people behind this one itty-bitty little curtain and you have to get out from the bed because the mum was holding him. And I just, I didn't feel like they really got good care in that sense, you know. And it left me feeling very, I was angry at the system." (5 plus years intensive care experience)

The policies and procedures of the organization related to the care of the deceased were also incongruent with the participants' values. For example, many of the policies related to a coroner's case interfered with how they wanted to care for the child after the death. They were not able to remove tubes so that the family could hold the child or touch the child in the same manner as they would have without all the equipment. Sometimes, the mandated autopsy had not been the preferred choice of the parents and funeral arrangements occasionally had to be delayed. Another example related to the shrouding and preparing of the body for transportation to the morgue. These procedures often intensified their feelings of grief. They felt sadder if they had been sad; angrier, if angry; guiltier, if they had felt guilt. The wrapping of the bodies in plastic, the tying of their limbs together, and the placing of infants in a suitcase-like structure for transportation, were all considered disrespectful, inhumane, and dehumanizing activities. This latter procedure is implemented in order to be respectful to the visitors and staff, but once again, demonstrate our society's refusal to confront death, even in a hospital setting. The system required the nurses to perform actions that were in conflict with their values. These death related activities also forced the nurses to face their own mortality. This finding was also identified by the data in the pilot study. The participants stated that the nurses had to transport the child's body to the morgue as part of their hospital policy. All the participants stated how difficult it was for them to leave the child in a cold, barren environment. The following account most poignantly illustrates this dissonance.

"But the worst, the worst feeling in [pause] I had was when I brought him to the morgue. [shudders] I hope I never have to go to the morgue again. [deep sigh] We went there and I did what I had to do. I wrapped him up in a warm cover and and you know what nurses do when a patient dies. And uh we went into the morgue where they put the bodies and there was nobody in there, and it was cold. It was [pause] horrific. Like I, I put [child's

name] down and I gave him a great big hug and a big kiss [crying] and he was going to be alone in there [pause] all night. [sniffles] It wouldn't have been so bad I guess if it wasn't cold. [crying, long pause]. I just hope I never have to walk into a basement and put anybody down there, in there again. I'll have to do it, I know, but. [pause]. Uh it's just [voice very soft, almost inaudible; tempo slow]. I was just, there wasn't no more, it was just like if you were bringing a body and there was no more respect, there was no more love, there was no more feeling. Here you are. You're dead. They put you on the table. You're cold. We'll see you tomorrow morning when we do an autopsy on you, you know. When we cut you open. [voice raised and swift]. Just. [sigh] It was ruthless. I don't know if that's a good word to use, but [sigh]. It was bad."

On many occasions, this dissonance appeared to have been further compounded by conflicts associated with the timeliness of "saying good-bye." The organization's procedures for caring for the deceased body required them to face the finality of the child's death before they were emotionally ready to do so. Once again, the reality of the situation necessitated they perform tasks that were incongruent with their own needs. Dale's account demonstrated that emotional readiness to say good-bye did not always occur at the same time as the cognitive acceptance of the death.

"And and since you're young, people tell you don't put any plastic things on your head and all. And when you wrap the child, it's as if you're going to suffocate this poor child. You know he's dead and you don't find it appropriate to put a plastic bag on his head. But the shroud is being made of plastic and you wrap him quite tight and then they ask you to put three ties around, one around the neck, around the waist, and it feels weird doing that. Every time you do it, it's like ugh [release of breath]. So this, this is really the end. The child passed away but there's still some, the body's there and you have to wrap him up and as soon as you finally cross the shroud over the face is, it's the end." (5 plus years intensive care experience)

A variety of coping strategies were developed by the nurses to help them manage their feelings of grief while performing these tasks, such as the use of black humor, peer support, and the implementation of rituals, such as prayers, that were integrated into the hospital's procedures. These personal rituals helped them cope with the inhumane aspects of the tasks they were required to perform and helped them manage their feelings of grief. Unfortunately, sometimes the unit was so busy that when the child died, the nurses were required to hasten their care for the deceased. In these situations, there had been no time to integrate their personal rituals with the organization's procedures. Therefore, the means by which they

normally coped with their feelings of grief had been removed. In fact, their feelings appeared to have been intensified by the addition of feelings of anger resulting from the perceived insensitivity of others. For example, Pat stated that sometimes she felt like she was working at the SPCA when a colleague would push her to hasten the removal of the body because the bed was needed for another admission. She stated that she did not feel supported by anybody in these circumstances and her anger was so intense that she wanted to hit someone or something. She stated that she found these deaths very difficult to accept and her feelings of grief hard to manage.

Occasionally, the participants were just not able to complete the post mortem care. Their emotional involvement with the child had been so strong that the dissonance between their readiness to say good-bye to the child and being forced to end the relationship through the shrouding ritual (or transporting the child to the morgue) was too great. In the following illustration, Sean described how it had been the support of her peers that had helped her to manage her feelings of grief when the child died. Their sensitivity to her needs permitted her to choose the time and the way that would be appropriate for her to say good-bye.

"Oh [laughs]. Why is it? Oh it's just uh. To do the bath and all that, that's fine. I can touch the child and talk to the child. Sometimes we joke when we do that [laughs]. But just to, not to close, like uh, the sheet, the plastic, on their face, and to not see them and just to know you are going to send them to the morgue, it is so morbid. Aahh [shudders]. I cannot seem to put words [long pause]. I know that it's only the body. I know all of that. But in my head, like she, the little soul was in the body a few hours ago and now we are just taking the body to the morgue. But I find it really morbid. Like with [in reference to the child who she had known for nearly 4 years and had previously stated: Like every, everybody knew him so much that he felt like our son to everybody] who was the 4 year old, three nurses were there and like we couldn't do it. [laughs] It was like a nurse from the float team who didn't have him as much. So she came and she said; 'You just go and I will do it.' And we were all feeling the same way. Like we needed someone who knew him less to be able to cover his face. For us, we don't see them after, so, well, for him I saw him after, but for the others, I don't see them after their face is covered. So it's the last good-bye." (5 plus years intensive care experience)

It has been established that children's deaths are frequent in the pediatric intensive care environment and that the participants commonly experience grief when the children for whom they care die. It has been identified that their feelings of grief are intensified and of longer

duration when certain contextual factors are present at the time of the child's death. For example, the participants said their grief was more difficult, harder, or more painful when multiple deaths were encountered in a short period of time, when they had shared the family's feelings of grief, had become emotionally attached to the child, or when a conflict about the death had occurred. The participants stated that with experience, they had learned to cope or manage their feelings of grief in order that they could continue to survive in the intensive care unit. The next section examines in more detail the coping strategies that the participants used to manage their feelings of grief.

Section 4: Coping With Grief

4.1 An Overview

All of the participants in this study had sustained multiple patient losses, some of which were more significant to them than others. It has been documented in the literature that repeated exposure to the deaths of patients places the nurse at increased risk of burnout, with subsequent withdrawal from the care setting (Caldwell & Weiner, 1981; Hay & Oken, 1972; Munley, 1985). The fact that the experienced participants in this study had sustained recurrent losses of children for whom they had cared, yet described strong feelings of satisfaction in their jobs and continued emotional commitment to the children and their families, appears to be contradictory to these reports. The experienced participants repeatedly stated that it had not been their feelings of grief that had changed over the years, but rather, how they had learned to manage them more effectively. Parkes (1972) emphasizes that experience with loss tends to make subsequent losses easier to resolve due to the fact that coping strategies have been established and the fear of the unknown has been reduced. One might suggest, therefore, that the participants' ongoing experiences with children's deaths may have assisted them in the development of effective coping strategies. Some of the coping mechanisms, such as self

nurturance and termination of relationship activities, helped them to survive the immediate feelings of grief when a child died. Other strategies, such as self reflection, helped them to thrive in this environment, not 'in spite of' their exposures to death, but 'because of' their personal growth that resulted from their coping with children's deaths. The literature on coping with stress is certainly congruent with this premise. It has been suggested in the stress literature that, whether work-related stress leads to burnout, a career change, or to feelings of job satisfaction, depends upon the nurse's ability to develop and utilize constructive coping strategies (Benoliel, 1985; Saunders & Valente, 1994; Vachon, 1987).

Just as the participants had learned, through diverse experiences with death, about the wide scope of their grief responses and the broad range of contextual factors that could influence their grief reactions, they also learned how to effectively cope with their grief. Learning to cope appeared to have been a work in progress and a trial and error process. Because each death was different, there could be no predictability to their grief responses. Therefore, they could not predict which coping strategies would help them manage their grief. In addition, it appeared from their accounts, that it was necessary for them to have developed a variety of coping resources because there was no one strategy that was effective for all nurses or for all deaths. Therefore, the participants had to implement a variety of coping strategies for each death until they had successfully found one that would help them manage their grief. One might be reminded of the sea-god Proteus of Greek mythology who had the power to change his shape at will. When captured, Proteus would assume any number of terrible shapes such as a lion, a dragon, many other animals, and even a tree until he found a shape that caused his captors to release him. His ability was one of adaptation that was necessary for his survival (Hamilton, 1942). Like Proteus, each time the participants experienced another death, they had to change their coping strategies until they found one that successfully released them from their feelings of grief. The ability to change their coping strategies gave them the power to adapt to the ever changing factors in each child's death and to manage their resulting grief.

It appeared that the experienced nurses could manage their feelings of grief more quickly than the inexperienced nurses. It seemed this was related to the number of strategies they had developed through a process of trial and error and due to the simple fact that they had had more opportunities to discover which strategies were successful for them. Similar to Benner's (1984) work on the nurse's development from beginner to expert nurse, a parallel process appeared to have occurred in the participants' development of strategies for coping with their grief. For example, Saunders & Valente (1994) suggest that the first time a child's death is encountered, nurses, inexperienced with death, may rely on primitive defense mechanisms such as avoidance and denial. The nurses' feelings of grief prompt them to revert to the only coping mechanisms with which they are familiar. For example, Casey, inexperienced to both intensive care and children's deaths, stated that she was overwhelmed with the painful emotions she was experiencing. Because she did not know what to do about it, she said she had been avoiding dealing with her feelings. However, she realized that avoidance was not helping her to effectively cope with the deaths she had experienced. Casey described how she had tried to manage her grief by attending the children's funerals and writing follow-up letters to the families because she thought these strategies were supposed to help. She had found they had not been effective in managing her feelings of grief. It appeared that Casey had not yet developed a cache of resources that would be effective for her and the different types of deaths she would experience, nor had she discovered those coping strategies that are developed from within.

This section describes how these participants managed their grief. Five themes related to coping have been identified. They are (1) self expression, (2) self nurturance, (3) termination of relationship activities, (4) engaging in control taking behaviors, and (5) self-reflection.

4.2 Theme - Self Expression

All of the participants interviewed cited expression or ventilation of their feelings as

helpful to them in working through the deaths of children for whom they had cared. Self expression appeared to have had both a public and private domain. For example, several participants cited that they had written articles, presented at conferences, or had worked on different projects associated with death, dying, and grief as a means of acquiring and understanding more about these topics. They had examined their role as a nurse in these issues and as Alex stated, this process had helped her cope with her own grief. In addition, sharing that knowledge with other nurses had been important to her. This was one example of grief expressed in the public domain.

Alex: "So within a professional milieu, I guess I've done things that have helped me understand personally and then taken it one step further and um, helped other people understand things. It, you know, comes back to acquiring more knowledge and using your knowledge to cope." (5 plus years intensive care experience)

In contrast, several of the participants expressed their feelings in a more private domain through the keeping of a journal or a diary. For example, Pat stated that she kept a journal of the events of the death and her feelings because it helped her to release some of the painful emotions she was experiencing, especially her anger.

Several of the participants spoke of using humor, especially black or gallows humor, when they felt particularly challenged in dealing with their grief in the work place. For example, they mentioned laughing with their peers when they had to prepare the child's body for transfer to the morgue. For a brief period, humor served to keep the participants from acknowledging the painful emotions that they were experiencing. It permitted them to release some of their emotions in a manner that was more personally acceptable to them in this environment. They found it easier to laugh and remain in control than to cry. They were quick to note that they were careful how and where the humor was exhibited. It was only with their colleagues in a private setting.

"I have to joke a lot. Even in a bad situation if I can step away. I won't do it in front of the patient, but if I can step away for five minutes, I'll joke with somebody, you know. I'll laugh. I'll joke. I have to do that."

Other authors, such as Hay & Oken (1972) and Vachon (1987), have reported similar findings in their work on coping with stress in critical care environments. Vachon stated that it has been hypothesized that the intensive care unit or emergency room that does not have black humor going back and forth may in fact be one that is experiencing considerable stress (p. 206).

All the participants stated that they dealt with their grief by talking to colleagues and friends from work on an informal basis, and/or with friends and family in their personal world. How much each participant talked, what they chose to share, when they wished to share it, and with whom they spoke about different aspects of the death experience was very individual and varied from one death to another. As Alex said:

"It is good to talk about it to a certain extent, but sometimes it is not helpful. Sometimes it just makes it hurt more. I think you really have to talk about it when you're ready. When it feels good to talk about it, not just to talk about it." (5 plus years intensive care experience)

From the participants' stories, it was discovered that they had often had great difficulty discussing or talking about their feelings of grief at a time when such discussion would have been most appreciated and needed, such as at the time of the death itself. In some cases, this difficulty appeared to have stemmed from the participants' reluctance to upset others, particularly their friends and family or their colleagues. Most of the participants stated they had limited their discussions with their loved ones because they wanted to spare them exposure to the "shit job" with which they were sometimes confronted.

Sean: "I often don't want to come home and unload the whole day on my, you know, on my boyfriend's shoulders. Um. Not that I can't, just that I don't think sometimes that's really fair to him. But I certainly can and get a lot of support if I do." (5 plus years intensive care experience)

In other cases, they were not ready to share their feelings. However, it was quite evident from their stories that, although they may not have been able to talk about their feelings and/or the events of the death, there was the paradoxical need not to have been alone and/or to have had

their feelings ignored. The support of peers who would share their grief by the mere power of their presence helped them to manage their feelings and facilitated the release of the grief and decreased the acuity of emotions. As noted by Knapp (1986), the simple physical presence of another individual who can feel the depth of what a grieving person may be experiencing tends to remove the sense of isolation that often crushes these individuals. In the following account, Dale described how her feelings of grief had been made easier by having her lived experience of grief shared by her nurse manager. Dale had been cared for in the same way that she had cared for the grieving families.

Dale: "Often if uh times are really hard [the head nurse] will be one of them, will come to us and just basically take our pulse, see how we feel. If we need some help, [head nurse] is a very good counselor and basically I think carries a lot of um, I don't know, I feel like [head nurse] carries a lot of power just by, coming along and touching my shoulder and saying: 'Are things okay?' Just that touch is kind of, I feel better [voice tempo and tone have changed - lighter]. I don't know, just [head nurse] presence there is enough to help a lot of us. And if you do have more problems, if you go, [head nurse] will ask us to come into the office. [Head nurse] will take part of our grief." (5 plus years intensive care experience)

In contrast, Casey stated that she had transferred from one nursing unit because her nurse manager had told her that, if she could not work without that support when a child died, then she was not a good nurse. She was told she needed to get her support from within her self or outside of the work setting. As Casey so insightfully stated:

"We work as a team in every other aspect, you know. I don't see why we can't sort of support each other as a team too." (less than 5 years intensive care experience)

The participants recognized that significant people in their lives, such as close friends or family, were not interested in discussing deaths of children in the unit. This was particularly evident when the participants had been new to intensive care. They had not yet developed a support network of colleagues with whom they could discuss the issues of the death and their feelings of grief so they did not have to bring them home. Instead they dealt with their grief by attempting to discuss their problems with people outside the work environment whom they knew before they started working in the unit. This is congruent with the findings by Gribbins &

Marshall (1982) in their research on stress and coping in the neonatal intensive care staff nurse. However, the participants had quickly learned that no one understood their world and therefore could not effectively support them. This is illustrated in the following account by Casey, inexperienced to intensive care and with children's deaths.

"I really don't talk about it with, with anybody. You know. I. It's funny. Like my mum was very supportive when, when [name of child] died and it was the first time that I sort of, you know, discussed with her and, you know, she's the only one, you know, um just how how kind of. It felt so unfair and like I just, I didn't wanna, I didn't wanna see this. ... And I guess that's what's, that's what's so frustrating is that you kind of walk out and, you know, you meet a friend for dinner and they don't want to hear about this stuff. Like they don't want to, and so you kind of, just sort of put it, put it behind you, but it, you know, I don't, that's not, that's not the answer [crying]."

The inexperienced nurses then had no one to whom they could ventilate their feelings and from whom they could receive support. This inability or decision not to communicate seemed to have amplified the emotional feelings and extended them over a much longer period of time. More important, the longer the silence continued, the harder it seemed to be to deal with their feelings. In fact, for several participants, it appeared that the interview situation itself was the first time they had had the kind of in-depth opportunity to discuss openly the details, as well as the hurt, surrounding the death of some of these children.

In contrast, the more experienced participants described how they had learned over the years that they could not manage their feelings of grief by bringing them home. They had needed to develop a variety of networks to fulfill various needs. Sometimes they spoke with their peers who had also been exposed to the same death. Sometimes they shared their feelings with others who they knew had similar values about death and dying. On other occasions, they talked with the bereavement coordinator or the nurse manager for the unit. As Sean stated, she had discovered that her feelings of grief were prolonged if she could not talk about the death with someone from work. Sean's words best reflect what the others had similarly articulated. Her words demonstrate the experiential nature of learning this coping strategy.

" So just like to get support and to feel that somebody else was feeling the same way as me has helped me. Because I understood over the years that it is not in bringing all my sadness and my anger at home that will resolve this. I really understood this because I was bringing at first, maybe not only with, when I had a kid that died, but uh, like I was bringing a lot of my things at home and uh nobody can understand what we can live here, like mostly in the ICU. Others just can't understand it. So I kind of changed my way of getting support. Like I'm trying to find my support here instead of at home. And when I am at home, it doesn't mean that I won't talk about it, but I won't be as emotional because I would have lived my emotions here. But I find that it's important to do it. Because if I don't do it, I kind of bring it with me too long." (5 plus years intensive care experience)

It appeared that all the participants had eventually developed a fundamental need to talk about their feelings and what they remembered about the death of the child. They needed to reveal their sadness, to release their anger, to allay their guilt, and to have someone else understand their reactions. This was one of the ways they were able to confront the reality of what had happened. It was a means of normalizing their reactions. Talking was: a reaffirmation of the death, their suffering, their beliefs; a venue for giving words to their sorrow; comforting, comprehending, healing, remembering. Sean expressed these thoughts when she described how her grief had been facilitated when it had been shared by one of her fellow nurses.

Sean: "There's some cases like him [in reference to a story that haunts her], some stories, that a few people are gonna live the same thing at the same time, so we can really understand each other. So when I feel that somebody understands me, I feel like a relief, a release, a release. ... You need them to sit and talk with you. ... There's always a nice person we can share with." (5 plus years intensive care experience)

Sean further described that from her learning of how shared grief had provided some release from the intensity of the emotions, she had helped others with their grieving by sharing their grief with them. Sean went on to describe a situation of a novice nursing colleague who had just experienced her first death of a child who had died suddenly and unexpectedly. She pulled the curtains around the child's bedside to provide her with privacy and came to talk with her. As she described, it was not because she wanted her to stop crying, but because she felt a lot of her sadness and felt, if the nurse could talk about it and share some of her feelings, this might help her manage her feelings of grief.

Most of the participants had attended the bereavement workshops that were offered annually for the staff in the unit. Alex stated that she had participated because gaining knowledge helped her to understand her own feelings of grief. Others had attended as one means in which they could share their experiences with others or to hear from others how they felt and how they had learned to manage their grief. However, not all the participants had availed themselves of the organized opportunities for support, although they acknowledged they were of some help to some people. They stated they were not comfortable discussing their feelings of grief and their experiences with death in this type of open forum. For example, Casey said that because she had not been in the unit long enough, she would not feel comfortable having a general group of nurses see her upset. From another perspective, Dale stated she had not attended the workshop because "it's nothing tangible;" "it's too psychological." She said that it helped her more to talk about a child's death with one or two of her peers at coffee.

Because each death had been different, the participants stated their need to talk had varied. Sometimes they needed to talk about the death right away, to get feedback from colleagues, especially if the death had been unexpected or particularly graphic. Other times, it had been better for them to be alone. But what was the most important thing to all these participants was the knowledge that they could talk with someone if they wanted to; that they had a choice.

Being able to express one's feelings of grief, in the presence of those who understand, not just at the time of death, but over time, is well supported by the grief literature. Vachon (1987) reported that nurses, who expressed burnout, or who had made career changes, frequently felt isolated and unable to discuss with colleagues their feelings about a patient's death. When a patient died, nurses felt a real sense of loss but hesitated to share their sadness and vulnerability. They felt as if they were the only person with feelings of anger, helplessness, guilt, and hopelessness. Seemingly, other colleagues acted as if nothing unusual had

happened. Such nursing authors as Adams et al. (1991) and Eakes (1990) reported that hospice nurses who had resolved their grief had developed a strong informal support network, often within their place of work.

4.3 Theme - Self Nurturance

The participants discussed their use of a variety of self nurturing activities that helped them to restore a sense of equilibrium in their feelings, even if only temporarily. Doing something special for themselves helped them to reduce their feelings of sadness and the selected activity sometimes helped them release their emotions, such as anger, in a way that was acceptable to them. For example, several participants discussed buying something for themselves, exercising, gardening, or soaking in a hot bubble bath was helpful. They described these activities as mindless, requiring little concentration and energy. However, the physical activity allowed them to do something they enjoyed. One participant talked about making arrangements with friends to see a movie or to go out to dinner, when she had just experienced the death of a child. Others described surrounding themselves with things that were alive. Those who had children said they would go home after a death in the unit just to be with their own families. This was described by one of the parents in the study who not only got a sense of pleasure from her young child's presence, but was also able to release some of her feelings of grief by talking with someone who would enjoy the pleasure of her company without being affected by the words.

"That's how I compensate and I go home now and I grab my little fella and I talk to him. I talk to him like an adult; talk to him you know about what I go through sometimes and just to see him smile you know but he doesn't know what I'm talking about."

One participant discussed being involved with community service activities working with healthy, normal children. These self nurturing activities have been discussed in the literature by Vachon (1987) in her work on how health care professionals cope with work related stress. Eakes (1990) also reported that hospice nurses often practiced similar lifestyle management

activities, such as exercise and hobbies, to help them cope with their grief.

4.4 Theme - Termination of Relationship Activities

Even though contact with the family after the death of a child was not a requirement of their jobs, all the participants cited some form of follow-up with the families for some of the children for whom they had cared. Family follow-up was described by the participants as yet another strategy they found helpful in assisting them to come to terms with the child's death. These follow-up contacts often involved attending the child's wake, going to the funeral, writing a letter, making follow-up phone calls, making a home visit, or seeking word of the families' progress through others. This specific need to establish a sense of closure regarding the nurse-family unit relationship following the child's death was also noted by Gray-Toft & Anderson (1986-87) and Eakes (1990) when they explored how hospice nurses coped with stress. Further, Sheard (1984) identified follow-up with the deceased patient's family as a strategy for fostering nurses' resolution of grief and viewed this as a viable method for terminating the extended relationship nurses often develop with families.

However, they all cited that they did not routinely do this. It was only used as a coping strategy for certain deaths. Sometimes, family follow-up had been necessary because the nurse had not been ready to say good-bye to the child. This appeared to have occurred primarily when there had been a strong feeling of personal loss when the child died. This was illustrated by Jamie (and discussed previously under the theme of the nurse-family unit relationship) who described, how in an attempt to manage her feelings of grief, she had kept in contact with the family. She had attended the funeral, visited the home, and had made phone calls as necessary. She had not been ready to "let go" of either the child or her relationship with the parents and felt the parents also needed her support. It appeared that ongoing contacts provided the nurses with an opportunity to recount the child's death with the family and to both give and receive support and reinforcement for the care provided. Such a process not only

served to hasten acceptance of the reality of the death but also allowed for mutual sharing of feelings associated with the loss. Numerous sources agree that individuals must disengage from the deceased before they are able to reinvest in new relationships (Bowlby, 1961; Kavanaugh, 1972; Parkes, 1972; Worden, 1991). As stated by Marocchio (1985), processing through the loss situation and openly sharing the associated emotions are considered vital to the resolution of grief. The fact that these nurses had felt comfortable contacting the families again is viewed as another effective strategy in managing their feelings of grief.

Sometimes, the family follow-up provided the nurses with the opportunity to terminate their relationship with the family members. The participants wished to show the family how much the child and family had meant to them; to demonstrate that the caring portion of the relationship had not been just part of their job.

Dale: "If we were very close to the parents well we'll attend the funeral. ... What I like though is uh, often the department will send sympathy cards to the parents and then we're able to write one last word for them."

It was frequently during these contacts that the nurses received positive feedback from the family members.

Other merits were also associated with this contact with the family. Sometimes, family follow-up was needed to release them from feelings of death process accountability. They were able to terminate the relationship with the family and come to terms with the child's death when they had been able to resolve their painful feelings of guilt. For example, Dale described how she had felt very guilty for having gone home at the end of her shift instead of staying with the family when their child had died. She said she felt as if she had abandoned them at a time when they really needed her support. She had not been able to manage her feelings of grief through the use of her other coping strategies and had continued to feel "really, really bad for the next few days." Therefore, she made the decision to attend the child's funeral service. The family's expressions of appreciation for the care she had given, to both the child and the family, helped Dale to resolve her feelings and to come to terms with the child's death. She had finally been

able to emotionally terminate her relationship with the family.

"I went to the um funeral. Then, when I walked in, the father looked at me and kind of opened his arms and he gave me a big hug. And I felt so reassured. Being that, okay, the parents don't, are not mad at me for leaving them at the last minute. And that kind of said, oh, okay, this is it. I kind of accomplished what I was missing. And from, from that point on, well I of course, I, I felt much better." (5 plus years intensive care experience)

The need for family follow-up to help the nurse manage her feelings of death process accountability is also illustrated by Sean's story. Sean had developed a strong emotional connectedness to the mother of a child who died suddenly and unexpectedly. Sean had experienced feelings of guilt about the child's death, even though she acknowledged those feelings were illogical and illegitimate. It had been her emotional connectedness to the mother that had caused her to feel that she had let the mother down. Similar to Dale, Sean's normal strategies for coping had not been effective in helping her to manage her feelings of grief. Therefore, she had not been able to detach or terminate her relationship with the mother. Talking with the mother and sharing the mother's sense of acceptance helped Sean cope with her own feelings of grief and facilitated her coming to terms with the child's death.

"But the way I coped with it afterwards, like I didn't know, um, if I should like call the mom and talk with her. But I did call her. That helped me a lot to hear her like talk about it. And also, after that it was her calling me back and giving me an update about how she was feeling at that point. So that was like the end of the story. It was, it has been like my way to grieve finally, like to talk to the mom after." (5 plus years intensive care experience)

However, Sean stated that this means of managing her grief had not been a helpful coping strategy for all children or families to whom she had had an emotional connectedness. It had been through experience, a trial and error process, that she had discovered that this coping strategy was only effective for her in certain circumstances. She noted this in the following account.

"Like I think last June, the person that follows the family after, she was going on vacation, she asked me to follow one family. So I did say yes because I had remembered that story of the little girl and remembered that had helped me to close my grieving. ... It was a kid that I followed a lot, that I was bound to this family.... And when I was coming to call every week, like at first we call every week and after every month, each time I was so nervous. Like I was so nervous about what they would feel, what uh, I wouldn't know what to

answer them. But uh, I was thinking: 'I hope I say the right things.' So, I guess uh after that I realized maybe it was not a good way for me, for everybody [every death], to grieve. I thought it would be a good way for me to finish my grieving but maybe it has been a good way with this particular story at first. But maybe not for everybody. And like I was doing that from home. So it was my day off. I don't need to feel that stress in my house, you know.... So I know that I will not do it again. Just because I don't need to feel how I felt." (5 plus years intensive care experience)

Traditionally, involvement in the funeral ritual or other follow-up activities has been encouraged as a mechanism for reinforcing the reality of the loss and stimulating emotional withdrawal from the deceased for the bereaved (Gray-Toft & Anderson, 1986-87; Rando, 1984; Sheard, 1984). However, just as has been noted with Sean's account, none of the other participants interviewed in this study cited attendance at funerals or other forms of contact as a routine coping strategy they employed. The majority of the grief literature is related to the bereaved who had experienced the loss of a significant other with whom there had usually been an intimate relationship of long duration. Therefore, the time required to detach from the relationship was also a lengthy one. In the case of these participants, the relationships were frequently of short duration and, although there was a degree of emotional connectedness to facilitate the meeting of the family's needs, a deeper sense of emotional involvement had not always been established. Therefore, the rituals performed at the child's death appeared to have helped them to say their good-byes to both the child and the family. Other strategies were then implemented to help them cope with their feelings of grief.

All the participants stated they enjoyed receiving intermittent accounts of the families' progress after the death of their child. Receiving information that the parents were successfully surviving the loss of their child appeared to have facilitated the nurses' dealing with their own feelings of grief. For example, they stated it made them feel happy that the parents were expecting another child or that they had resumed former activities in their lives, such as returning to work. On the other hand, it appeared that when the participants received word that families were divorcing or had suddenly moved away, then their own feelings of grief were intensified. It had made the child's death more difficult to accept if they had not already done so.

It appeared to accentuate their concerns that perhaps they had not done all they could have in the death process which they believed could have facilitated a more positive grief recovery.

Pat: " And that family today is like not doing well.. they're not doing well. So I don't know if they'll end up staying together but it's like really conflict between the husband and wife and. I think like from what I hear, statistics are very high with people who separate after this, you know. And I feel that this is something that maybe ,would not have been avoided or whatever, ... but if maybe things had been different, maybe it would have been a different experience for them. ... Like feeling that, you know, maybe they would have, it's a difficult time, and I don't think much would have made it better, but these few little things, had we been able to put them in a side room, all these little factors that maybe it would have been different. I'll never know. I mean, I'll never know." (5 plus years intensive care experience)

4.5 Theme - Engaging In Control Taking Behaviors

One strategy that the participants appeared to have utilized for managing their feelings of grief was to develop control over certain aspects of their practice. This seemed to have developed from a knowledge of one's role and expected role performance, which evolved over time because of the accumulation of more and more experiences. As noted by Vachon (1987), engaging in control taking activities is a more active coping mechanism that implies actively seeking to change a part of one's work environment and/or one's nursing practice. Operationally, this coping strategy appeared to have involved setting limits on one or more aspects of their clinical practice and organizing their work to manage their feelings of grief and sometimes, to even give them a sense of personal satisfaction at the time of the child's death. These behaviors included (1) establishing boundaries, (2) withdrawing or distancing oneself, and (3) fulfilling personal death rituals.

Establishing boundaries

Establishing boundaries or setting limits on aspect's of their practice was a coping strategy that the more experienced participants had learned how to do. Establishing boundaries helped to protect them from the bombardment of painful emotions they could potentially experience given the multiple deaths to which they were exposed. For example, as has been previously

identified, the participants had established boundaries on the implementation of the coping strategy, self expression. The participants described how they had learned through experience, who they would share their feelings of grief with, where they would talk about the deaths, under what conditions, when they would talk, and even how much and what they were willing to share with others. Similarly, it has been previously discussed under the expressions of grief, that boundaries had been established around the release of tears. They had established their own personal limits on how much they would cry and under what conditions they would permit themselves to do so. They had learned how to suppress their pain and to control their emotions until such time they felt it was safe.

The more experienced participants described how they had needed to set limits on what they felt they could competently handle at a certain point in time. For example, some nurses had learned to set limits on the type of children or families with whom they would work for a shift or two while they were feeling emotionally drained. They appeared to have known their own personal limits of what they could psychologically give of themselves during their grieving. They just could not spend time with certain types of patients or families who they knew would be emotionally difficult. Sometimes, it was because they needed time to reflect on the child's death and so they requested a patient assignment that would facilitate this. In the following account, Pat described how she had requested a specific type of patient assignment after she had experienced three successive deaths so that she could manage her feelings of grief without having to miss work.

Pat: " I had a patient in a side room. Isolation room. And it was so nice because I had my radio. I was able to shut out the world and not hear it. And I really needed that. You know. I needed to kind of come back to work and just be able to just shut the door and be alone with my thoughts you know."

When exposed to multiple deaths, the participants also stated that they needed to feel the joys and happiness and the sense of personal satisfaction they experienced when a child successfully recovered from an acute illness. There was a limit to the number of deaths they

could experience without feeling these rewards of the job. As Dale said, you only need to see one child pull through to help bring back the meaning of working in the unit.

"I mean when I take over a child and the child goes well and leaves the ICU, it's great. It's a good feeling. It beats probably the ten last deaths I had. At least one left and I'm happy, we're all happy, the family's happy and it's a joyful moment." (5 plus years intensive care experience)

In other words, the participants had had to learn when they had reached their personal threshold of being able to effectively manage their feelings of grief and when they needed to restore a sense of equilibrium in their feelings. Therefore, they had learned to request assignments that would allow them to regain a sense of balance in their practice. All the more experienced participants expressed these boundaries, but it was best articulated by Pat.

"So I'm trying to be careful with myself in if I think too much is too much then I'm gonna go around and say it, you know. I mean I let people know I was, it was too much. ... But uh I'm, I think part of coping is also being able to say woah. You know. I've had enough. And I know at one point uh, with that one family, after I just lost the one that was very difficult and I ended up with this one ... people asked me if I wanted it, my um assignment switched and I said no, I can't do that. I can't do that to the family. As difficult as it will be for me, I cannot just get up and leave them at this worst hour kind of thing. I, I can't do it you know. But I said after this, after this, I want a break. After this I want something happy, someone who's going to get extubated and down to the floor on the next day." (5 plus years intensive care experience)

The experienced participants spoke of the need to set limits on their level of involvement in the relationship. Establishing limits on the nurse-family unit relationship was described as making the feelings of grief less intense and easier to manage. However, there was a delicate balance between emotional involvement and detachment. As described earlier in the section on emotionally involved relationships, the nurses had described their struggles with learning to find just the right level of emotional connectedness that brought them feelings of satisfaction while at the same time reduced the intensity and duration of feelings of grief. It appeared that the less experienced nurses had not yet found a range of involvement that was comfortable for them. Jamie had been struggling with the establishment of this balance through a process of trial and error, while Casey seemed to be still overidentifying with some of the bereaved families.

All of the nurses recognized and accepted the fact that they could easily become more attached to some children and families than to others for all those reasons identified in the theme nurse-family unit relationship. However, at no point during the interviews did any of the nurses give evidence of having withdrawn to the point of being cold or emotionally unattached. They did not seem to be saying the nurse should have no involvement; rather, they were implying that there was a problem in becoming consumed with the situation. Sean's summary of her thoughts about the need to set limits on the nurse-family unit relationship reflects the inner struggle she has experienced in the process of achieving an appropriate balance. Sean is a seasoned nurse but she acknowledged that the balance has sometimes been difficult to maintain, although it has been a necessary one in order to be able to manage the grief she has experienced when the children die. In the following account, Sean refers to the strong emotional involvement she had had with the mother of a child for whom she had cared. She stated she had had difficulty coming to terms with the child's death because of this attachment. Sean had learned to establish boundaries regarding the level of involvement with the children and their families, but also described how those boundaries in no way precluded the development of attachments in the working environment. Rather she had made attempts to establish boundaries between her personal and professional commitments.

"But I have tried [pause]. Like I think I wouldn't like to live the situation with the first mom all the time. Because I try to stop. I have seen. I can see some nurses doing that. And I don't find it very healthy. Because I have my own life and my own problems. I have death in my family too. So I try to, I'm trying to separate the bo'n. That's okay to live plenty what I'm living when I'm here. Like if I feel more bound to somebody. 'Cause I think it's normal that we feel bound with some parents and to feel less bound with other parents. So I find it's okay when I'm here to give everything that they need to them when I feel really bound. But I don't want to become friends with all these parents. I think it's a way to protect myself." (5 plus years intensive care experience)

Like Sean, most of the participants had learned, or were learning, to regulate the intensity of the attachment and the extent to which their attachments carried over into their non professional lives. This is similar to the research findings of accumulated loss phenomenon among hospice caregivers (Adams, et al., 1991). In this population, grief was found to have been intensified

and prolonged when there had been a blurring of personal and caregiving commitments. For these participants of this study, the capacity to stay in the intensive care unit appeared to have rested on the nurses coming to terms with regulating their attachments and monitoring their own grief levels. As Alex illustrated in the following account, she had quickly learned to separate her two worlds and to not take her work home with her. She said if she had allowed herself to dwell on every death that she had experienced she would have been chronically depressed.

"I think I've always been able to not allow my professional life to interfere or to overflow too much on my days off. I wouldn't say that you know when I'd leave at the end of the shift that that's it and I don't have any recollection of what happened in the previous 12 hours. But I don't, I don't dwell on it. And I think that's helped me [pause] survive and work in this area so long. ... You know, I think that I maintain a certain level of professionalism in the sense that I have never been the type of nurse to develop friendships with any of my patients. Whether adults or working with kids. And that has helped me." (5 plus years intensive care experience)

Alex continued to reflect that part of the way that she had been able to establish limits on the level of her involvement with the child and family, without feeling that she had compromised their care, was through her belief that the care of the family unit was a team effort. Alex had found that sharing the child's care, also meant that the feelings of grief were shared. She did not feel so isolated when the child died and this helped her cope with the painful emotions she was experiencing.

"Although over the years I've had certain patients that I looked after a lot and have become attached to, I've never been the type of nurse that um, got overly possessive about my patients. They weren't 'my' patients. They were patients that were in the unit and I just happen to be a nurse who happens to work in that particular unit. Um whereas I know of some other nurses tend not to feel that way. But I guess that's the way I have of helping me cope with things. It's a shared responsibility. And therefore, at some level, it's a shared grief experience when they die. And that for me doesn't make it as isolating for me and it's not as lonely. And so I think that helps."

Distancing

Closely aligned to establishing limits was the use of withdrawal and distancing to cope with feelings of grief. For the purposes of this study, distancing differed from the previous description of controlling one's level of attachment. Establishing boundaries on the level of

emotional attachment was used to help reduce the intensity and duration of painful emotions because of the threat that children could die. In contrast, distancing was needed to manage their feelings of grief when they anticipated the patient was going to die or immediately after the death of a child and seemed to be of short duration. It appeared that both inexperienced and experienced nurses used distancing to manage their grief.

The participants described distancing themselves by either depersonalizing the child or detaching themselves emotionally from the child and family through task oriented behavior. The participants indicated that they distanced themselves in order to remain in control of their painful emotions until they felt it was a safe time and place to express them. They also used distancing in order to retain the emotional energy required to grieve the child's death and heal themselves. They had learned through experience that giving of themselves too quickly drained them of their last reserves of energy and then it took longer to grieve the child's death. Distancing or withdrawal appeared to have occurred both in their personal and professional lives. For example, one of the participants from the pilot study who had children described how she needed to withdraw from her personal commitments immediately after the death of a child for whom she had cared. She said it often took several days until she felt that she could give of herself fully to her friends and family. She stated this was even more necessary if she had to return to work the next day.

P3: "If somebody at home were to say to me 'I got a booboo,' I would go 'I don't care. You have a booboo, that's nothing to what I've seen today. Take care of your booboo yourself.' ... Whereas on the normal day I'd say 'Oh come here,' you know, I'll look at it or I'll fix it. But I just don't want to hear it.... Fix your own booboo. I gotta fix mine. Mine is too [pause]. ... I just don't want to take care of anybody right now. I want to take care of myself." (less than 5 years intensive care experience)

While at work, Dale described how "you can build a wall around you" if you are assigned to care for a child that you know is going to die." She stated that she would still give a hundred per cent care, but that she would try not to think about what was going to happen. She would use strategies that would prevent her from getting to know the child.

The fact that caregivers tend to avoid dying patients and their families has been documented from the work of Munley (1985) and Quint (1966). In Vachon's (1987) study, nurses reported avoiding and distancing from patients more than did the other professional groups. In fact, those working in specialty areas such as adult and pediatric intensive care units, reported using this coping mechanism more than other nursing groups. However, in this study, the participant also stated that, although they could try and depersonalize the child, it was impossible to "shut themselves off" from the family when they were present. Even during these difficult circumstances, the nurses appeared to have been committed to meeting the emotional needs of the family. The participants still became emotionally connected to the family through sharing the family's grief and as a result, identified more readily with the family members. Therefore, their grief was intensified despite having attempted to distance themselves from the child. These latter findings have also been described by Borozny (1990) in her study of caring for the brain dead patient in an adult critical care unit and by others who have studied nurses working with the terminally ill in a palliative care home environment (Adams, et al., 1991; Eakes, 1990).

The participants also described how they used task oriented behavior to manage their feelings of grief. As Dale said, "she will just work; she just has to work" as soon as the parents leave after the child dies. The participants described focusing on one's technological role, relating more to the physical needs of the child or assisting others in the care of other children in the unit. Being task oriented appeared to be one way of remaining in control of their feelings of grief. For example, Casey stated that she had been able to remain in control of her crying by "doing more" with the child as opposed to "talking with" the family about their loss. Being task oriented also allowed them to psychologically distance themselves from the families to protect themselves from identifying with the family and experiencing the feelings that such identification might precipitate. As both Jamie and Casey said, in order to get through the rest of the shift, after the child had died, they had to go to the intermediate care unit and play or read

books to one of the children and that made them "happy." By being "wrapped up" in the child who was alive, they had been able to avoid the painful emotions of their grief. Once again, Borozny (1990) and Vachon (1987) noted that being task oriented was a strategy used to cope with the stress of dealing with death and dying.

Fulfilling personal bereavement rituals

Being involved in the care of the child after the death appeared to have helped many of the participants manage their feelings of grief. As noted by Rando (1988), "personal bereavement rituals give form, structure, and meaning to our feelings. They are unique opportunities for communication, ventilation, and appropriate acting out" (p. 261). Rituals have many specific therapeutic properties that can help the individual certain feelings and thoughts.

It appeared that engaging in personal bereavement rituals enabled the participants to do something constructive to overcome their feelings of emptiness and powerlessness that sometimes accompanied their feelings of sadness. It gave them a sense of control and provided an immediate focus for their grief. Rituals allowed them to channel their feelings into an activity that had a distinct beginning and ended with a clear purpose. In this way it made the feelings more manageable. For example, Dale said that when she had completed the child's bath and the shrouding and the child had been taken from the unit, it was as if all her emotions had been carried away with the child. With the completion of all these rituals, she had then been able to continue on with her work for the rest of the shift. For some nurses, the organization's rituals sometimes helped them to manage their feelings of grief, particularly their sense of loss of control over the situation, by prescribing specific actions to help them get through the emotional chaos at the time of the child's death.

Performing the personal bereavement rituals also allowed them to express and display their feelings if they so desired. As Pat said, it was often during the bathing of the child, behind closed doors, that she would finally permit herself to cry.

Some of the nurses used symbols to express their feelings of grief. For example, Pat, in the main study, and two of the participants in the pilot study wore angels on their lapels and gently touched them throughout the interviews when they were speaking of the deceased children. They stated that when a child passed away they would say that God had made another little angel today and their eyes lifted upward when they talked of them. They stated this had helped them to cope. As Rando said: "Rituals give you permission to outwardly express your feelings. They provide acceptable outlets for your feelings and give you symbols to focus upon."

Participation in rituals also appeared to have given the participants the opportunity to acknowledge that a loss had occurred and to say their good-byes. As Dale said, being present at the child's death and doing what needed to be done, was sometimes necessary for her own closure. She needed to see and not just hear that it had happened. Performing the personal bereavement rituals helped the nurses in the necessary process of withdrawing their emotional attachment to the child and family and coming to terms with the child's death. This ultimately helped them to cope with their feelings of grief. Dale described how she needed to perform the care after the child's death as her way of terminating her relationship with the child. Although she understood that some of her colleagues wanted to reduce her emotional pain by performing the rituals on her behalf, she preferred to complete the tasks herself.

Dale: "... Of course when death comes they basically all come to you. All they want is to lend a hand and I see many situations ... when a colleague would come along and : 'well if you want to leave, go into the nurse's lounge, sit down and just rest and we'll take care of the rest.' To my mind, it's NO [stated forcefully]. Don't take care of the rest. I have to finish. I need a sense of completion here. If I go and sit down over there I'll just be thinking I'm missing something. ... Like I find they're trying to be nice in sending me away. But I don't want to go away. I might need just five minutes. But I don't want you to do a thing here. It's my patient. I want to be with him 'til the end. I want to do things. I might need help. ... But I don't want you to do a thing until I get back. And even though they want to do good, like all they want is to be nice to me. Still [small laugh] don't be too nice. I want to be there." (5 plus years intensive care experience)

Dale also expressed what all the participants stated and that was they wanted the choice to complete the care alone, or with help, or to have someone else complete it for them. As Sean

had described in her care of a child, to whom many of the nurses had become emotionally attached, they could not perform all the rituals of care at the time of the death because they had not been ready to say good-bye. Others, less attached to the child completed the care. On the other hand, Pat stated that she had needed to be alone to say her good-byes by herself. She had never had the courage to tell her colleagues to leave her alone because she had not wanted to appear rude. In summary, the participants stated they just wanted and needed to have the choice. Dale also noted that this was particularly important for new nurses because often the more senior staff, in their desire to help, would push them out of the way. The new staff then tended to pull themselves out of the situation because they did not feel comfortable enough to acknowledge that it was not what they wanted. This was also noted by a nurse in the pilot study who stated that when she was a novice in intensive care, she was told to go for a break after her first experience with the death of a child. The nurse in charge stated that others would care for the deceased child's body. Because she felt overwhelmed by the death, she did as she was told. However, she stated she had feelings of guilt for having left her patient and felt like she had never had the chance to say good-bye. She said that she had eventually learned to say to her peers that she was not going to leave because she needed to stay for a sense of closure with her patient.

For some of the participants, the bereavement rituals also promoted the social interaction that they found was necessary for them to cope with their feelings of grief. As noted by Dale earlier, all the nurses wanted to lend a hand. The team wished to support one another in their grieving and were willing to be present to help with the care and/or just to talk. Sean stated that she could not be alone for the shrouding of the child and there had always been someone there with her to complete that task. Sometimes they laughed together; sometimes they cried together.

Finally, the integration of personal bereavement rituals into the organization's prescribed policies and procedures helped some of the participants cope with the dissonance of their

expectations for the ideal death and the reality of the situation. This integration gave them a sense of satisfaction and helped them to have realized some of their nursing goals for the child and the family. Some described the need to talk to the child even though they realized the child had died. Others stated they needed to say special prayers for the child. Pat described the rituals she performed at the time of a child's death that helped her come to terms with it. The rituals also gave her a sense of satisfaction and peace because of the knowledge that she had done everything she could for the child.

"I felt like I was able to give. Like it's really bizarre. But after a baby dies I like to, I take time. I take the tape off with the alcohol remover and I want to put powder on or the cream or whatever. And other people I find, it's okay just like: 'Okay, it's done. Let's get the things out. Get everything cleaned up. Out the door.' To me I guess it doesn't give me time to say good-bye and time to end. And I need that. And I need to take my time. ... And I find too that I'm like, I'm very careful, you know. To me it's still a baby. It's still and I guess I think about the family members or if it was me if somebody was you know ripping off the tape and I wouldn't want me taken care of like that. I take the best care I can ... And I guess that's why I prefer to just to do it on my own. Because I find that people do it not the way I would do it." (5 plus years intensive care experience)

4.6 Theme - Self Reflection

"Some form of separation is taking place. Some part of me is falling away. I am slipping guiltily, even furtively, into another life. And in another life I could cry out, 'Haunt me. Haunt me,' as teenagers we once called out, 'Haunt me, Cathy,' to add intensity to it all. But I am not Heathcliff ... nor was meant to be. Am an attendant ... widower. One who waits, pathetically, for some rhythm, to bring him back to some form of life."

Hart, 1995, p. 197

From the outset of the interviews, all but one of the participants identified that there had been certain deaths in the unit that had continued to "haunt them." They described "these stories" as ones that had "affected them the most," either in a negative or a positive way. From an analysis of their transcripts, this appeared to have meant that, for a negative experience, their feelings of grief were the most intense, of long duration, and had been the most difficult to manage. In contrast, a positive experience left them with a strong sense of satisfaction and their grief had been more easily managed, despite having experienced painful emotions. Pat, Dale, Jamie, and Sean identified three deaths that had continued to "haunt" them, and they told

these stories in great depth and detail. They constantly referred to them when making comparisons to other deaths that were less difficult. Casey said she had experienced five deaths and she still thought about them all and continued to relive her feelings of grief for them. Four of these had occurred in the pediatric intensive care unit. Casey shared all her stories. Only Alex was not able to recount specific cases. For this particular participant, who had been exposed to many deaths over a long career in pediatric intensive care, her grief response and the contextual factors were identified through an aggregation of the experiences, and fragments of individual stories were offered as examples to clarify her thoughts. Alex had also identified that the coping strategy she used to deal with her grief was one of intellectualization and therefore, describing her experiences of grief was done through a more depersonalized process. For all participants, the identification and telling of the stories that haunted them did not preclude them from relating other stories throughout the interview, but it was these deaths that they had wished to share in order that their grief be understood. As stated by Dale:

"I really wanted to talk about those three people that really haunted me." (5 plus years intensive care experience)

Why did these deaths continue "to haunt them even years later? Why had the participants continued to "hang on" to these stories? From one perspective, the stories that "haunt" them seemed to have been a means of reaffirming that they have continued to be caring human beings in this highly technical environment. As one of the participants in the pilot study said, because these children were still part of her memories, she was not a cold hearted machine who was only able to attend to the child in physical crisis. She still remembered what the children had meant to her.

P2: "... I'm still a warm person. I'm still a feeling person. I haven't forgotten those children, those situations or people. And that I think we can get um hung up on what we identify are the skills that are important, or who, what do I define as a good critical care nurse. Yeah, I'm a certified [critical care nurse], you know, you get these lovely letters there. I think I almost want to put 'and human' afterwards, you know." (5 plus years intensive care experience)

In addition, it seemed that the stories had been a critical component of their experiential learning. The participants appeared to have frequently reflected upon these "best" and "worst" deaths, particularly when they were exposed to another death. In one respect, it was as if these stories were the gold standard against which all other deaths had been compared. The nurses had survived the worst deaths they had experienced and had learned ways to cope with their feelings of grief. When they had had to grieve the death of another child, they simply remembered how bad their grief had been in the past by recalling those deaths that had represented the worst they had had to face. They used the memories from these stories as a healing tool for all subsequent deaths.

Dale: "Those are the ones that haunt me the most because they're always in my mind. If it's a nice day outside I don't think of them at all. Things go well. As soon as I encounter a very bad situation, they come back. I don't know. Maybe they are my kind of pop-up valve in my mind. That just by thinking of them, uh, sort of they're there helping me to just overcome what just happened. So they're people that kind of do now I guess occupy a very important place in my mind and in my life now. Because I use them all the time just to get over a certain bad situation.... They haunt me or at least they stay there for probably a good reason. 'Cause they're there and uh just by thinking of them okay they give me the strength okay. It's like my grieving process for the people at the hospital." (5 plus years intensive care experience)

The ability to engage in self reflection, a necessary element of experiential learning, appeared to have been necessary to survive and thrive in this environment. Self reflection helped them to (a) come to terms with a child's death; (b) create meaning; and (c) accept their own feelings of emotional pain when a child died, all necessary to cope with their exposure to multiple deaths. Coming to terms with death, creating meaning, and accepting their grief, what Worden (1985) has termed tasks of bereavement, did not appear to be a linear process. In fact, it appeared from these interviews, that self reflection affected all these "tasks" simultaneously. Reflecting upon one area impacted on another. For example, it seemed that as the participants began to find meaning in their experiences, this helped them to come to terms with children's deaths. In addition, if the participants found that creating new understanding through a self reflective process had facilitated their coping with a child's death, then this appeared to have

enabled them to accept their feelings of grief. This finding can be related to certain observations about grieving reported in some of the literature. For example, both Bowlby (1961) and Parkes (1972) have noted a sense of the continued presence of the deceased among bereaved persons. Parkes found that there is painful repetitious recollection of the loss experience, which is the equivalent of worry work and which must occur if the loss is to be fully accepted. He stated that these recurrent patterns of thought seem to enable people to ward off anxiety while at the same time attempting to grapple with the problem (p. 95).

Experiencing multiple deaths appeared to have altered the lives of these nurses, but the changes that grief had brought about were variable and highly individual. A common feature of the participants' accounts were statements indicating that their grief had been associated with a learning process that had brought about changes over time. These changes included new perspectives about life, death, and dying, grief and grieving, and sometimes, even their personal philosophy regarding their professional role. This ongoing learning process appeared to have required that they be exposed to many children's deaths. Through a process of reflection they had learned to: (a) understand how they reacted to the death of a child; (b) identify what factors of the death affected their grief response; and finally (c) understand which coping strategies helped them manage their grief. It appeared that it had been the constant bringing forward of past experiences with death and reliving them in light of new feelings and new knowledge that had led to new understandings and changed perspectives. In the following account, Jamie described how her grief experiences were different now after working in intensive care for several years simply due to the acquisition of a greater amount of knowledge.

" So they're different in that [long pause] that initially your knowledge base just scratched the surface so you really couldn't figure out the whys of the thing, the whys of it. And now you can figure out the whys of it much easier ... so cognitively it makes it easier, but emotionally it doesn't." (less than 5 years intensive care experience)

A similar experiential process of change was identified by Harper (1977). She found that health care professionals who continued to genuinely care for their patients despite multiple and

repeated exposures to death had learned to accept their own feelings of pain and grieving. They had learned how to recover from their grief by developing a new set of personal values that brought them a strong sense of satisfaction when working with the dying. This too was reported by Eakes (1990) in her study of grief resolution in hospice nurses.

When asked what they felt affected their grief, the participants answered that the number of deaths they had been exposed to had been an influencing factor. It was the learning that resulted from each past experience that had helped them cope with their feelings of grief with future losses. Each new exposure to death with its resulting feelings of grief took on different dimensions depending upon the nurse's past exposures. Each new experience added to the depth and breadth of each of the elements of grief. Thus the nurses learned from each new experience. For example, Jamie was able to recall that with her first experience of death she had not known how to behave or what to do. She had not known if there was a correct way or an expected way to behave towards the family, colleagues, or self. She stated that she had withdrawn from the bedside and watched the nurses and the child. However, once they had lived through that experience and had reflected upon it, they were able to bring to the next death the lessons they had learned from the past, such as what factors in the death had caused them to react the way they did and what had helped them to manage their feelings of grief. As Alex said, if some of the unknown becomes known then it's easier to cope with.

As another example, some participants described how they had made changes in their approaches to the care of the child or they had incorporated new coping strategies in light of what they had discovered during their self reflections. In the following example, Pat described how she had spent her vacation time reflecting on a death that had been "difficult" for her and had caused her own grieving to be "very hard". She had discovered that having a sense of accomplishment with her care of the child and family was what she needed to be able to accept the death. It had been this acceptance that had enabled her to let go of her feelings of anger and guilt. Once she had identified this, she had empowered herself by implementing actions

that she perceived would give her control over those factors that influenced her feelings of grief in a negative way. She felt better able to face future exposures to death.

"I realize that I am going to have to be stronger in dealing with certain people. That when it's going to be 'Forget it. Stop pushing. Back off.' ... I will not let people have their way kind of thing. If I had a child dying I think I would be a heck of lot more aggressive to get this kid in the side room and do the comfort measures and things like that that I know are right, within me. I mean not everybody deals with it like that, that's fine. But I have to be able to live with myself after this. And I have to know within myself that I've done what I think is the best for the family and the baby or child. So I think that's how in a sense I came back stronger." (5 plus years intensive care experience)

Reflecting upon new experiences in both their professional and personal lives appeared to have resulted in new perspectives that enabled the participants to reinterpret a past experience with a child's death. From the new vantage point, different aspects of past situations stood out and assumed a new importance. For example, Casey recounted the story of her first and only experience with the death of a child from a sudden and unexpected illness. She had cared for this child during the diagnostic determining of brain death and the subsequent preparation of the body for organ donation. She had experienced feelings of guilt associated with the dissonance of the situation. She described how the withdrawal of large amounts of blood for diagnostic purposes had made her feel that she had contributed to this child's death. She also expressed that she had been overwhelmed by her feelings of helplessness and with how "incredibly unfair" she had found the death. This was a story that in the telling was still acutely painful for her. She was still in the process of coming to terms with this child's death. However, it was while caring for an organ recipient several months later that she had found herself undergoing an extensive review and possible reinterpretation of that death in light of her new experience. She had felt excited and happy that a child's life had been saved because he had received a heart transplant.

"... And I almost felt, I almost felt like I was, I was sort of um, a contributing factor in this. That, that, I was sort of playing a role in taking their daughter away. You know we had to do um, we had to do the, the preparation for [crying] for organ transplant and you know, taking a hundred cc's out of this girl and it just, it, it, it didn't, it didn't feel, it didn't feel right. But then at the same time, you know, two months later we were, I was taking care of a baby who was getting a heart transplant and I mean I was so excited [voice momentum

faster, lit to voice]. We were so happy we were saving this little, this little boy's life. And at that point, I started to look back on, on the experience with [child who donated organs] a little bit differently, but still at the time it was, it was a, it was a, it was lousy." (less than 5 years intensive care experience)

As described by Kolb (1985), when an individual, such as Casey, experiences a conflict between their feelings or thoughts, they are forced to resolve the dialectically opposed views. One way of managing this is through self reflection of the differing experiences and transforming one of the events by giving it new meaning in light of new understanding. This is experiential learning.

Coming to terms with children's deaths

It appeared that those participants who had worked in intensive care for many years and still found it highly satisfying, despite the frequent deaths of children, had also learned how to cope with death. They were no longer afraid of death because they had come to terms with it.

Alex: "I don't necessarily see all deaths as a negative thing. I mean there's lots of kids that I acknowledge for whatever reason, there just isn't anything that we can offer to them, other than making their death more comfortable for them, for the child and for the family." (5 plus years of intensive care experience)

When and how the participants had been able to come to terms with children's deaths had been individually determined. This was reflected in two participants' accounts of the same disease process, septic shock. In the following examples, lack of control over the disease process and the suddenness and unexpectedness of the death were the contextual factors that had intensified their feelings of grief. But the same aspects of the death had been viewed from two entirely different perspectives and therefore how they had managed their feelings had been different. In the first account, the suddenness with which this disease works, the devastation it creates, and not having an immediate diagnosis were the foci of this participant's thoughts. Alex stated that it had been more difficult for her to cope with this type of death because she had not been able to intellectualize it.

"Like the kids who come in in septic shock ... I've seen several kids come in awake and alert, talking and within several hours deteriorate to the point that they're intubated, totally unresponsive, on all kinds of drugs to maintain their hemodynamic status, blood pressure and things like that. And then they die. And it just amazes me that they can die from bugs so quickly. And to be able to see the physical change in the child. ... And at the time where we really don't know what's wrong with the child I find it difficult and I guess that reflects my need to intellectualize things. I'm better able to deal with the death of the child if I know what's wrong and if there's a diagnosis. It just helps me understand it. And I cope by understanding things. ... " (5 plus years intensive care experience)

In this second account, Sean stated that she had been able to accept the deaths caused by this disease as long as she had perceived that the best possible care had been given to the child. She believed that the disease process was ultimately out of the teams' control. Sean had coped with her feelings of grief through her focus on this understanding of the situation.

"A child that dies of meningococemia, that doesn't haunt me, if the death, if the process came away with something that I've defined as positive about it. Because there's very little you can do for that thing, with that disease anyway if I've managed it, if I as an ICU nurse and the group have managed it well, then that doesn't bother me." (5 plus years intensive care experience)

But for all the participants, there had been a strong need to understand why the child died. As noted by Parkes and Weiss (1983), understanding gives one a sense of control over the situation and therefore, making sense of the death is an initial and enduring task of grieving, regardless of the circumstances of the death. For these participants, understanding had been a way of coping with the death. Sometimes, understanding had relieved them from feelings of culpability. Other times, it had helped them to manage their feelings of powerlessness or feelings of vulnerability. For example, this was inferred by Alex who described that she had had more difficulty coping with her feelings of grief in those situations when there had been no explanations for the child's death.

It appeared that coming to terms with death as a part of life was associated with feeling a sense of "relief" or "release." In some of the participants' stories, it seemed that once they had come to terms with children's deaths, then they began to view some deaths as a release for the child from physical suffering and a release for the family from the emotional pain of watching their child die. In other stories, it appeared that once the participants had acknowledged a

feeling of release, they may have been able to come to terms with some children's deaths. In either case, they described that it had been easier to cope with the children's deaths when this occurred.

Dale: "Because in my mind it was probably better for the child to pass away. Because he was like suffering a lot more than anything else. That's probably also another thing that helps us overcome the grief. That when we see that there's no outcome for the child. And the child passes away, well for us, it's more deliverance than anything else." (5 plus years intensive care experience)

Coming to terms with death in their professional world also appeared to have helped some participants manage their feelings of grief when they had suffered a loss of a significant other in their personal lives. As a point of illustration, Pat described how her feelings of grief had changed over the years by stating that she was no longer afraid of death and that death was not always an undesired choice in life. She had recently experienced the death of a loved one in her personal life and she stated that having had to live through the deaths of many children had even helped her accept the death of this significant other in her life. Her experiences with death and her reflections on the meaning of life had lead her to view life not just in terms of longevity but also in terms of the quality of an individual's living. She had wanted her loved one released from the emotionally suffering of having had to have all his needs taken care of by everyone else. She believed that her loved one was in a much better place.

Pat: "I think when I used to work with the adults I used to fear death. I didn't want to be involved with it. I didn't want to be around it. I didn't want to know it existed. Period. I tried to basically shut it out as much as I could because I couldn't cope with that I guess at the time. From coming here [to the PICU], I didn't have much choice but to cope and deal with it. ... And I look at death differently now. I guess it's just more of a part of the cycle [of life] you know. ... So it's gotten me to where I didn't want to look at death. But now maybe that it's the best alternative. That I don't want to see people suffer more than need be ..." (5 plus years intensive care experience)

When questioned about what had helped them to grieve and accept those deaths which they had not been able to logically understand, the participants identified that it had been time that facilitated their coming to terms with their feelings of grief associated with the loss of the children. Dale identified that the passing of time had been an ally in diminishing the emotional

pain associated with the loss of the children for whom she had cared. She described the process as the "fading of pain." Sean described how she had lived her feelings of grief intensively when the child died and then it appeared as if her grieving had been finished. But in fact, if she had not been able to understand the death, her grieving had not been finished because she had been unable to come to terms with the death. She said time had allowed her to accept the death. Time provided them with the opportunity to reflect on their past experiences particularly in light of the ongoing experiences that would add to their understanding and offer new appreciations. Time gave them the opportunity to create new meanings.

Finding meaning - children's deaths are not in vain

Reliving the deaths that "haunt" them reminded the nurses what they had learned from the deaths of these children. These stories represented the need to make the loss intelligible, to facilitate understanding, to make the senseless, sensible. The nurses needed a way of coping with all these children's deaths. Through the process of time and using other experiences to compare, they had searched, or continued to search, for reasons for the death, reasons they could accept, reasons with which they could feel comfortable. In essence they had searched for assurances that the child's death had not been in vain. Saunders and Valente (1994) stated that "finding meaning is an emotional and cognitive processing task that involves symbolizing and understanding the emotional experience of the death" (p. 321). Similar to the findings of this study, Saunders and Valente found that finding meaning becomes complex when circumstances (such as untimely, preventable deaths or inadequate treatment) contradict the nurse's values or evoke questions about the nurse's role or moral obligations in the situation.

Creating meaning of both an individual death and many children's deaths occurred at a much deeper level than searching for cause and effect reasoning. Sean stated so simply what

all the participants expressed many times throughout the interviews: "Why this kid?" When the participants asked why did this happen, it appeared that they had not been looking for the physical reasons for the child's death. The real questions being asked were: Why should a child die? Why did this particular child have to die? As has been previously noted under the theme of dissonance, children's deaths did not fit the participant's assumptions of the world. Therefore, as has been identified by Parkes (1972), there must be an attempt to make sense of the loss, and if that death does not fit into one's set of assumptions about the world, then the individual will have to modify those assumptions (p. 95). Rando (1986) has suggested that resolving the meaninglessness of a child's death may be an impossible task. In our society today, youthful deaths, particularly of infants and young children, are regarded as "ultimate tragedies." Children are not supposed to die. Knapp (1986) has written that in fact, a child's death is philosophically unintelligible in today's world. Rando has suggested then that it is perhaps more useful to focus on the meaning of the child's life instead (p. 188). This is the strategy that the participants in this study have used to cope. They have created meaning from their time spent caring for the child and family.

Over time and with experience, the more seasoned participants realized that they had to find a new meaning, a new understanding about why these children died and why they have continued to care for children who die. In fact the participants appeared to have been constructing this new meaning all through the work of reliving their stories. Reliving the stories allowed them to review, reassess and reconstruct the events in light of new understanding that came with new experiences. It was through this process of reflecting upon all these children's deaths that each of the participants, in their own way, in their own time, had examined these questions of why children die. As Pat stated:

"... I've learned a lot. As difficult as some of them were. Things that I think in a sense we're only there to learn, I've learned through some of these things." (5 plus years intensive care experience)

Therefore, one way that the participants had found meaning was through the lessons they had learned from their experiences with death, particularly those deaths that have continued to haunt them. Sometimes, the meaning of the child's death had been related to how the participant had learned to better meet the needs of the next child and family. Thus they have learned to develop a sense of control over the event and this helped them cope with the deaths of other children.

Sean: "And each experience that I have, also helps me work through the next experience better. Like, uh, what the parents are feeling, how to prepare them, and um [long pause]. I kind of learned to find the words better sometimes. So I have learned from my experiences." (5 plus years intensive care experience)

In the following excerpt, Dale described how acceptance of the death of a baby for whom she had cared had partly been achieved because of the lesson she had learned from the child's death. In this situation, the baby had been taken to the operating room for emergency surgery at the change of shift. Because she had not known how long the surgery would take, she made the decision to go home. The baby died shortly after she left the unit. Dale had felt very guilty for not having been there to support the parents at the time of their child's death. She had found it more difficult to manage her grief because of these feelings. Dale learned from this death that being available to support parents to whom she had established a connectedness would facilitate her future grief experiences. It would better meet her own expectations of holistic care and would facilitate the termination of her relationships with the family.

"But I just could still, in my mind, it comes back every now and then. I have to be probably more careful not to leave the patients or the parents so fast, when they probably do need a familiar face. So many people pass and take care of their child and maybe if one of us could be a familiar one, well that would be nice." (5 plus years intensive care experience)

Pat described the change in her experiences of grief as having moved from one stage to another. In her early experiences with death, she had been unsure of what to do to help the family. She had been uncomfortable being with the grieving family due to her feelings of vulnerability and fear of death. However she had felt guilty for not having better met the families'

needs. She described how she was no longer afraid to be with the families because she had learned through her experiences with death and from their feedback that her presence was valued. Her experiences had validated her professional role at the time of a child's death.

Jamie described how she had been learning how to cope with the difficult deaths that she had experienced by "finding something positive in the deaths." For one experience, she believed it to be what she had brought to the child's life and that of his family that she found meaningful. It had taken months of reflection and feeling the painful emotions of her loss before she had been able to find this meaning. Her response involved a personal philosophy that gave value to what she was doing as a nurse in intensive care, that validated her professional role.

"Like I said I just think that I've made a difference in this child's life and I have to look at, I try to look at the positive things. If I just keep thinking well he died and it's awful, well then I won't move on. But I think, hey, you know, I brought him some good stuff and I brought good stuff to his family. And I'm glad I was there and that's how I deal with it.... And there's always a good thing, no matter how awful it is." (less than 5 years intensive care experience)

For some of the more experienced nurses, the meanings they had created ultimately had had a significant change in their values within their nursing practice. This had helped them cope with subsequent children's deaths. The following participant's account describes how her whole philosophy of nursing practice in the intensive care unit had changed over the years due to the lessons she had learned from the deaths of some of the children and caring for their families and the feelings of grief she had experienced.

Alex: "It's more the family concept. And that's a big difference in me. Um, from where I was as a new nurse in a pediatric intensive care unit, um, to where I am now as an ICU nurse and what I value and what I believe as a nurse. Um, nursing's role is in a death of a child um as a supportive, as a [pause]. I'm secondary to what mum and dad are. Where as back then, mum and dad were secondary to me." (5 plus years intensive care experience)

For some of the more seasoned participants, their multiple exposures to death had also changed their attitudes on a more existential level such as those toward life and death. As Pat noted, many factors had brought about the changes in how she experienced grief. In part it had been due to the influence of age and other life events. However, she also stated that it had

been "living all these grief experiences" over more than five years of intensive care nursing that had strongly influenced her current philosophy of life, which subsequently helped her manage her feelings of grief.

"... And I guess over time I think I've become more of a spiritual person. ...And I've learned to enjoy a lot more of what I've got because who knows when I won't have it. ... And I find that I'm getting closer to my parents. My sister keeps saying it's because you're getting older. But I'm coming to I guess really value life. I'm getting to really see that we're not here very long so better appreciate each other... I don't think I would have come to appreciate as much as I do now if I hadn't have been here and dealing with all these families and seeing the different processes, the grief processes. And I think it's done a lot for me. It's done a lot for me in life. Appreciating life. And even as tough as, I mean if I come back tomorrow and I have another child who's dying, it's not that it's not going to be tough. It's gonna be. I know it's going to be. But I also know certain things that I'm going to try and do to make it better. And I know where I stand on that and I think that helps." (5 plus years intensive care experience)

None of the participants made reference to strong religious convictions related to coping with grief. The participants who had arrived at a personal philosophy of life and death referred more to the development of a spiritual philosophy as result of their exposures to children's deaths.

Sean also said her life had changed by having experienced many children's deaths. She stated she had changed her perspective on her own personal problems. She no longer felt stressed over events in her life that she did not consider to be life threatening. It had been her exposures to children's deaths and seeing the pain of the parents that had lead her to believe that this life event was "the most horrible" problem that one could face. She also felt better able to cope with her own daily life problems because she had learned a number of strategies to deal with her feelings of grief with each of the losses she had experienced in her professional life.

Finding meaning is consistent with the grief literature on the loss of a significant other. Schneider (1984), in his work with bereaved adults, has maintained that "the process of abstracting what is fundamentally important about the loss involves reformulating and reframing the context meaning of the loss" (p. 61). Rowe (1984), in her work on grief, wrote "the individual world of meaning is a complicated, interconnected network of meanings that encompasses not only present relationships with people and things but past and future and the projects on which one is engaged" (p. 14). Carter (1989) reported that the search for meaning overlapped the

search for comfort for some of the bereaved adults in her study. The bereaved sought ways of creating some kind of positive meaning which were revealed in such statements as: "I'm on a real quest of the meaning of life," and "I want to use the experience to help others - make it meaningful" (p. 356).

Vachon (1987) also reported a similar coping strategy in her study of 600 experienced caregivers who care for the critically ill, the dying and the bereaved. She found that in addition to having a strong sense of professional competence and pleasure in their work, the caregivers needed some type of philosophy to underpin the work that they did and to explain the suffering to which they were exposed (p. 194). Vachon reported that some caregivers developed a personal philosophy that put life and death into an alternate perspective. This may or may not have had a religious or spiritual underpinning. For many caregivers their philosophies regarding their professional roles helped to sustain them. These caregivers wanted to feel that, because they were there, the suffering was less than it might have been had they not been present. These findings are consistent with how the participants in this study have learned to cope by finding a way to believe that the children's deaths were not in vain.

These descriptions are all consistent with the finding of creating meaning in this study. Grieving the loss of the children involved creating new meanings through discovering what they value about working in intensive care and in caring for children who die. As well they learned to envision new possibilities of how to cope with their grief in light of this.

Accepting grief

Another significant feature of the more seasoned participants' learning was their stated willingness to accept their own feelings of pain and grieving. From the comments of the participants, this seemed to have been associated with two factors. First, the nurses had found meaning in their experiences with death. Second, the nurses had learned that they had made a difference in the lives of the children and their families even when the child died. They had

affirmed their value as a nurse in this environment even when a child's life had not been saved. Some of the participants, such as Pat, Alex, and Sean, stated they had even experienced a high degree of satisfaction from the role they played in these circumstances, in addition to the joy they continued to feel from those children who survived. As Pat said, as "tough" as she knew it would be to have another child who was dying, she also knew she was willing to face it because she had learned she had something to offer the child and the family and because she knew what to do to make it better. In fact, it appeared that in order to have continued to feel the joys and happiness from those who lived, it had been necessary to accept the pain of those who had not. It was through their involvement with the children and their families and the integration of support and comfort measures into their practice, such as connecting and sharing, that had enabled them to meet the holistic needs of the child and family. This was their ethos of intensive care nursing. This was their reward.

Having learned to face and accept the reality of their grief was not evident in the stories and accounts of those participants who had had few grief experiences. In fact, as has been previously noted, Casey, who was a novice to intensive care, was still trying to emotionally survive the deaths she had experienced and had not yet learned how to effectively manage her feelings of grief. In fact, she had stated that her coping strategy had been to try and avoid dealing with her feelings. It hurt too much.

"... And I just think a loss is so, is so huge and I think one of the reasons I don't talk about it is because there's not [long pause] there's almost nothing good about it. I mean there's nothing. I don't really know if it can be resolved. I just, I know that whenever um, I see something or do something that reminds me of one of these kids, you know, it makes me very, it makes me really sad. But I don't really delve any deeper than that. I just. It almost, it almost hurts too much you know. ... I think I have some work to do on understanding how it affects me. Because to be honest I really, I really try to avoid dealing with it. And I think one of the reasons I told [nurse manager] that I would do this was to try to, you know, understand a little bit more how it does affect me." (less than 5 years intensive care experience)

Because of these painful feelings Casey was struggling with the decision to stay in a intensive care environment. She had not found meaning to the children's deaths. She had not been able

to work through the pain of her grief. In fact, she had strong concerns about her abilities to handle her grief.

Harper (1977) found in her work with social workers working with the dying patients and their families, that it had taken many experiences with deaths for the health care professionals in her study to begin to accept their own feelings of pain and grieving. Intellectualization, emotional survival, and depression were the steps necessary to achieving this acceptance. If they were not able to do so, it was after these three steps that the individual would leave the work environment. Parkes (1972) affirms the need to acknowledge and work through the hurt associated with grief. He says, "it is necessary for the bereaved person to go through the pain of grief in order to get the work done. Anything that continually allows the person to avoid or suppress this pain can be expected to prolong the course of mourning" (p. 173).

In summary, the participants' grief experiences were varied and unique and were part of an experiential learning process. Ongoing exposure to death had changed how they had thought about past experiences and how they had learned to cope with future losses. Self reflection was an antecedent for effective coping. Those participants who had accepted death and grief as part of the experience of nursing in the pediatric intensive care unit had continued to feel a strong sense of purpose and satisfaction.

CHAPTER 5

Conclusions

This chapter begins with a summary of the findings. It is followed by study limitations, recommendations and implications for nursing practice and concludes with directions for further research.

5.1 Summary

Grief for pediatric intensive care nurses, that occurs when a child for whom they care dies, has been defined in this study as a highly individualized phenomenon which pervades every aspect (physical, emotional, social, spiritual) of their being. It is a complex phenomenon that requires a holistic view of the multiple contextual factors that interact with the deaths of the children and the development of relevant coping skills over time, both of which influence the grief response. Because they are exposed to many deaths on an ongoing basis, the nature of their lived experiences of grief is an ongoing experiential learning process. Therefore, the situation after the deaths of many children is characterized by cognitive, affective, and behavioral changes in the nurses.

The experienced nurses in this study did not describe actually gaining freedom from grief, yet they did not appear to be in a permanent state of grieving despite always being exposed to death. Instead, they described an increased ability to effectively cope with their feelings. Through a process of experiential learning, it appeared that they had moved from novice to expert grievers. This could only have occurred by having been exposed to a variety of deaths; by having allowed themselves to feel the pain of their loss; and then by having reflected upon their experiences. The participants described how they had discovered to effectively manage their grief by learning from different people and different deaths. They had learned from observing and talking with their peers. Through a process of trial and error, they had learned

what contextual factors influenced their grief responses. With each new exposure to death, they had also learned that there was a breadth and depth to their emotions that they could not have known through their readings or from the stories of others.

The more experienced participants had learned to know what they could change and what was beyond their control. Then, they had found a way to accept that which they could not change and developed coping strategies that helped them deal with their grief. Reflection on their experiences told them what strategies made them feel good and under what circumstances. A variety of approaches, such as helping parents create positive memories and engaging in meaningful interactions with the bereaved families, facilitated coping with the immediate pain of grief. Then, it appeared that they discovered that some of these same strategies influenced how they had come to terms with the reality of children's deaths. Therefore, a short term purpose resulted in a long term effect. It appeared that the more experienced they became, both with the living and the dying, the more they learned. They identified what was personally acceptable to them in their nursing practice and then they learned how to integrate and delicately balance the support and comfort measures of caring with the cure goals of the intensive care setting. Each experience with death seemed to have been a process of self discovery, professional validation, and change. They had learned what brought them a sense of accomplishment and personal satisfaction in their job. Then they had discovered that, if they wanted to continue to experience the joys of saving children's lives, they had needed to learn to: (a) come to terms with the reality of children's deaths as a part of the world of intensive care nursing; (b) acknowledge and work through the painful emotions of grief, and even to permit themselves to experience the positive feelings that sometimes occurred; (c) find ways to cope while experiencing their hurt; and finally (d) establish a new reality of pediatric intensive care nursing and their role in an environment where some children die, despite all efforts to save them. Some of the experienced nurses had even come to terms with the harsh but simple reality that certain deaths cannot be overcome. There have been

deaths that they will never let go of; instead they have learned to manage their feelings.

The experienced nurses in this study had survived and thrived in this environment despite these multiple exposures to death because of their personal growth and their strong belief in what they identified as caring behaviors, such as emotional commitment and sharing the lived experience of grief. Despite having learned to set limits on the type of nurse-family unit relationships, they had not permitted these limits to diminish their level of professional commitment and degree of caring with the children and family. In fact, they had learned that it was this commitment, even to the dying child and grieving family, that ultimately had helped them cope with their own feelings of grief. The experienced nurses in this study had been able to obtain personal satisfaction from caring for dying children and bereaved families and reported that, although rewards were primarily from saving children's lives, rewards also came from meaningful interactions and from families' gratitude for emotional support provided. In summary, the experienced participants in this study had learned to cope with their grief through what Watson (1985) has called "transpersonal caring", a situation in which "both the nurse and the patient are changed by the actual caring event" (p. 58). Watson (1989) says,

"When both the care provider and the care receiver are co-participants in caring, the release can potentiate self-healing and harmony in both. The release can allow the one who is cared for to be the one who cares, through the reflection of the human condition that in turn nourishes the humanness of the care provider" (p. 132).

5.2 Study Limitations

One of the limitations of the study arises from the sample. Because the sample was selected from only one institution and with only informants who could speak English, these nurses will not necessarily be representative of the population of pediatric intensive care nurses. This is of particular importance given that it was found in this study that the context influenced the nature of the nurses' grief. However, it is also noteworthy that the findings from the pilot study, conducted at another institution, indicated there were similarities in the nature of their grief and there have been similarities reported in other nursing research. It is also

important to remember that the purpose of qualitative research is to discover meaning, not to measure the distribution of attributes within a population (Field & Morse, 1985, p. 59). Therefore, the question of generalizability is not necessarily pertinent to exploratory research.

Another limitation of this study is this beginning researcher's knowledge of the philosophical underpinnings of the various phenomenological approaches to qualitative research. A researcher expert in Heideggerian phenomenology might have been able to uncover aspects of the analysis in greater depth.

Finally, this researcher's interview technique may have presented a limitation to the study. Those participants who had had few exposures to death and were struggling to cope with their feelings were more limited in the depth of their discussions as compared to the more experienced nurses. It is unclear whether this was as a result of their inexperience or due to this researcher's beginning skill level with phenomenological inquiry. Again, a more advanced qualitative researcher might have been able to facilitate a fuller disclosure of the participants' lived experience of grief.

5.3 Recommendations and Implications for Nursing Practice

This section examines the implications and recommendations for nursing practice based on the findings of this study. This is accomplished by presenting an integrated perspective of the four major roles of the Clinical Nurse Specialist (CNS) - educator, clinical practitioner, consultant, and researcher (Hamric & Spross, 1989).

The proposed recommendations focus on recognizing and honoring the grief of nurses, and assisting nurses to learn how to effectively manage these feelings rather than 'doing something for' the nurses to take their grief away. A wide variety of formal and informal resources are recommended. It is proposed that the CNS working with pediatric intensive care nurses should have experienced the death of children and can effectively cope with his or her own feelings of grief. It is also recommended that the CNS be comfortable discussing death and

dying and grief and grieving so that issues around nursing grief and bereavement can be brought to the forefront. It is recommended that the CNS create a supportive environment in which discussions around these issues become part of the unit culture.

Implications for educator role

It has been found that to cope effectively with their feelings of grief, nurses must come to terms with issues and feelings of vulnerability; issues related to the mortality of their loved ones and maybe even to their own dying. Coming to terms with these issues requires self reflection, a critical element to the experiential learning process. The CNS has a role in providing the nurses with educational opportunities that enhance reflection. This should ideally begin even before nurses, inexperienced with intensive care nursing and/or with death, are faced with a child's death in this setting. The CNS can help the nurses recognize their own mortality and explore with them their coping strategies. For example, it is recommended that the orientation program be developed to include the opportunity to explore one's attitudes and feelings towards death, utilizing exercises such as those offered by Benoliel (1982), Rando (1984), and Worden (1991). Even the questionnaire by Shneidman that appeared in *Psychology Today* (1970) offers an excellent opportunity for each individual to reflect upon their perceptions of death in a less threatening way and establishes a milieu in which death and dying and grief and grieving are discussed openly.

It is also recommended that ongoing opportunities for similar explorations be offered through such exercises as suggested by Saunders & Valente (1994). These exercises can help nurses examine their responses to death. They can be done privately or shared in a group discussion. In addition, the development of a nursing caregiver bereavement resource package, similar to the one developed by Mings (1995), is an example of a cost effective and low resource-intensive educational intervention that nurses can engage in privately. Any of these exercises would provide a beginning step for a nurse's awareness of feelings of sadness

or of vulnerability about death. As noted by Benoliel (1985), nurses who accept these feelings, acknowledge them, and then allow them to pass will have a greater potential for developing an "emotional muscle" which builds expertise in caring for dying children, their bereaved families, and for one's own self.

Ongoing educational workshops on death and dying, and grief and grieving, such as those conducted by Saunders & Valente (1994), are also recommended from the findings of this study. Bereavement workshops serve three functions. They allow the attendees to (1) intellectualize the experience; (2) recognize their emotions as part of grief; and (3) listen and/or share their thoughts and feelings with those who truly understand in a supportive environment. However, it is strongly recommended that the structure and content of these workshops be developed and conducted using the research findings from caregivers' grief rather than primarily focusing on theories developed from patient and family loss. It is proposed that these former findings may be more beneficial for normalizing the nurse's bereavement and for recognizing individual and cultural differences.

The CNS can also develop a bereavement resource center that could contain such items as books, pamphlets, articles, and video and audio cassettes on death and dying, grief and grieving, and stress and coping. All resources should be current and related to care of the caregiver, in addition to care of the child and family. This type of activity would facilitate those times when the individuals need to work through their grief privately.

It is also recommended that the CNS involve interested intensive care staff nurses in the development of any or all of these educational endeavors. Involvement in projects such as these, becomes a catalyst for each individual's own self-exploration. "Involved individuals cannot read, discuss, dissect, review and ponder issues around nursing grief and bereavement without considering his or her own thoughts, feelings, attitudes, and past events" (Mings, 1995, p. 122).

Implications for practitioner role

Theories of dying, grief, and loss have been developed to help describe sequences and stages and to predict how sorrow will manifest itself (Kubler-Ross, 1969; Parkes, 1972). Although these theories are helpful in understanding what one is observing, they can become constricting if professionals begin to use them as a "must do" if one is to grieve appropriately. Nursing has perhaps done itself a disservice by using such models in their educational programs because they have suggested an orderliness and segmentation to a life experience which was not found in these participants' experiences. In fact, it was found in this study that there was no one right way to grieve; there was no one set of feelings for certain situations of death; no two nurses grieved in the same way. In addition, each participant found that they did not grieve the same way from one death to another. Grief theorists, such as Parkes (1972) have not addressed the grief experience confronting those individuals who face multiple and accumulated losses. Therefore, it is recommended that the CNS help intensive care nurses recognize the uniqueness of each person's experience with the death of a child and their resulting grief responses. Although grief is a universal human experience (Bowlby, 1961; Freud, 1917; Parkes, 1972), each person ascribes her or his own meaning to the death and it has been found that the meaning can change with more death experiences. Therefore, it is recommended that the CNS assist the intensive care nurses to understand the uniqueness of each of his or her own experiences, to recognize that there is a broad spectrum of feelings as part of normal grief, and to explain the experiential nature of grieving. The CNS has a role in sensitizing nurses to the need for choices at the time of the child's death as each person will have his or her own way of coping with their grief responses. Offering one's presence at the time of death to assist with the care of the deceased child acknowledges to one's colleagues that grief hurts. However, respecting an individual's choice to deny that offer and to allow one's peers the privacy and time to say good-bye, will facilitate coping with grief. Sensitizing others to these issues can reduce a nurse's sense of isolation at work and can facilitate collaboration with

colleagues.

It has also been found that each participant uniquely lived her or his loss by getting fully in touch with the lived experience of sorrow and by having the presence of another who would witness and be supportive in bereavement. Support from others is required both at the time of the child's death and over time. Therefore, it is recommended that the CNS be available to provide both emotional and situational support to the nurses. This can be done by increasing one's visibility during the time of a child's death, particularly for those situations that may intensify the grief, and being present to support the nurse in the delivery of care to the child and family. For example, the CNS could be available to the inexperienced nurse, when a nurse has formed a strong attachment to the child and family, when feelings of anger and/or guilt have been demonstrated, or when there have been numerous deaths in a short period of time. Being available to help the staff care for a child at the time of death will also help the CNS identify situational issues that may potentiate or hinder nurses' grief. S/he can then work towards making policy change on behalf of the staff.

It is recommended that the CNS have the flexibility in his or her daily schedule to spend time with a grieving staff nurse on an informal basis both at the time of the child's death and over time if the nurse should want and need to talk. It has been found that one's presence to listen and to "carry the burden of grief," even for a short period of time, is therapeutic and acknowledges that experiencing the death of a child and caring for the bereaved family is difficult for the nurse. The nurses, particularly the novice intensive care nurse, may not seek out the support of the CNS or other peers. Therefore, it is recommended that the CNS offer frequent opportunities for talking and for the sharing of their stories. Talking about the stories enhances self reflection and is part of the experiential learning process. It has been found in this study that their stories are highly significant. They can offer clues about who the deceased child and family were to the nurse, the contextual factors within the death that have influenced the nurse's grief response, how that grief may be expressed, and how effectively the nurse is

copied with the death. It has been found that the nurses tend to use such occasions as coffee and lunch breaks to share bits and pieces of these stories. It is recommended that the CNS share in some of these times. Capturing the nurse's readiness to talk and to be reflective about the meaning of the child's death will require flexibility and creativity on the part of the CNS.

It is recommended that the CNS recognize that there may be a need for different interventions for the novice intensive care nurse and for the more experienced nurses. Ideally, it is recommended that the novice not be placed in situations in which errors, from lack of knowledge or skill related to inexperience, could be perceived as contributing to the child's death, for example assigning the novice to a child immediately following complex open heart surgery. In this respect, the feelings of culpability can be reduced. It is also recommended that the CNS be prepared to care for a dying patient along side the novice nurse and/or preceptor the novice with a senior nurse, who has been identified as an individual who effectively copes with her grief. In this way, the CNS or preceptor would be able to role model care of the dying child and the provision of emotional support to grieving families. S/he would be able to emotionally support the inexperienced nurse in the care of the deceased child and demonstrate and/or discuss the strategies that s/he has developed to effectively cope with her/his feelings of grief. It also provides opportunities for the novice to receive positive reinforcement throughout this new experience. Sharing in the care of the dying child may be one way to diminish feelings of death process accountability as the care of the child will have been a shared responsibility. It may also provide spontaneous opportunities to talk about specific aspects of the situation that causes certain feelings to occur. This helps to normalize feelings, facilitates self reflection, and creates a supportive environment that acknowledges death as a difficult event for nurses and that discussions around issues of death and grief are part of the unit norm. Additionally, it is suggested that the CNS capitalize on the bereavement experience of the more seasoned nurses.

It is recommended that the CNS identify those patient care situations that may potentiate

the nurses' grief reactions at the time of a child's death, such as disagreements between the physician, nurse and/or family concerning ethical issues around continuation of a child's treatment, or patients who are having pain control issues. In these situations, it would be beneficial for the CNS to provide a forum for dialogue so that these issues can be discussed openly and honestly. Decisions about what is in the best interest of the child as it relates to the dying process can be reached in a collaborative manner in this milieu. The CNS has a role to play in sensitizing others to the dilemmas faced by both the families and the staff in these situations. Talking about the child's death may begin the reflective process and will potentially help the nurses to rally their coping resources, to don their emotional armor.

It is also recommended that the CNS facilitate the organization of critical incident debriefings in situations that create the potential for a more intense grief reaction. These could include, but are not limited to, such deaths as those that are sudden and unexpected, graphic and/or violent deaths, situations in which errors may have contributed to the child's death, multiple deaths in a short period of time, death after a lengthy resuscitation, and death of a health team member. It is strongly recommended that any staff member be enabled to call for a debriefing session.

Implications for consultant role

Education alone regarding grief and grieving is not sufficient and the CNS cannot be the sole provider of support. Both the organizational and intensive care environments must be conducive to the provision of supporting its staff. However, sometimes there are impedances to this support. "People can't even imagine what our job entails, they don't even have a clue" how I feel when "it's a shit thing I sometimes have to do." This fact makes it imperative that nurses working in this setting not only receive support from their peers in their work environment, but that nursing management recognize and acknowledge the intensity of their grief reactions because of the depth of their commitment to humanistic care in this highly

technical setting. It is recommended that the CNS communicate the ethos of intensive care nursing and its impact on the nurses' grief to non-intensive care personnel. In the consulting role, the CNS can interpret the role of nursing in this specialized setting, and in these specific clinical patient care situations, to other nurses and professional staff. The CNS can share with others that pediatric intensive care nurses are not only masters of high technology but that they are masters of high humanistic care. There has been the assumption that palliative care is dichotomized from intensive care nursing. While those nurses who work in palliative care become masters of comfort and support, it has been assumed that those working in intensive care have solely focused on the therapeutic, high intervention and highly technical aspects of nursing. On the contrary, these participants have demonstrated that they have had to master both aspects of care. On many occasions, they have had to quickly, and sometimes suddenly, move from their cure goals to a palliative care nursing role. One hour they have been involved in advanced life support measures and in the next they have been trying to create positive memories for the family during the child's dying process. It may be challenged that no one can change this fast. But it was described by the nurses in this study that they valued a holistic approach to the care of both the child and family, including those situations in which the child was dying. Being able to shift modes of care appeared to facilitate their grieving. Therefore, it is recommended that the CNS act as a consultant to the nurse manager of the intensive care area to augment the educational programming to include meeting the bereavement needs of the staff as well as the clinical components of continuing education. In addition, the CNS can act as a consultant to health care educators in the academic environment to enhance their death education programs for students. Nursing education has traditionally focused on client-centered death and dying issues. It is recommended that the curriculum also address nurses' grief. Seminars are an ideal format to discuss these more personal issues.

It is also recommended from these findings that the CNS act as consultant to administrators to facilitate policy and procedure changes related to the care of the deceased

child. Many of the areas of care that create dissonance for the nurse can be eliminated through consideration to the current institutional practices. Nurses frequently have been required to carry out tasks that have been considered by other health professionals as disgusting and demeaning, with a disregard for the emotions that these activities render. For example, it is suggested that the shrouding or transport of the deceased child to the morgue by a nurse who has established a strong bond to the child and/or family is both inappropriate and insensitive to the caregivers.

In the consultant role, the CNS can also provide nursing advocacy by sensitizing staff to the dilemmas faced by nurses exposed to frequent deaths. Suggesting that nurses need opportunities "to save lives" after a child's death or that management facilitate shift changes so that a nurse can attend a child's funeral if desired are illustrations of nursing advocacy.

Implications for researcher role

One step in the process of assisting nurses with coping with their grief is for the CNS to disseminate research findings regarding caregivers' grief, especially pediatric intensive care nurses' grief. Nursing and multidisciplinary grand rounds provide opportunities for the CNS to sensitize caregivers to the importance of acknowledging caregiver grief both from a psychological perspective but also as it relates to the research literature on stress and burnout. Unit-based nursing and/or multidisciplinary research committees are another venue for reviewing and critiquing current findings on nursing bereavement. This would serve four purposes: (1) to mentor bedside nurses in critiquing qualitative and quantitative research on nurses' grief; (2) to augment the utilization of nurses who are able to influence staff in the implementation of research findings related to nurses' bereavement into practice; (3) to encourage staff nurses to identify nursing bereavement issues in their own practice that warrant investigation; and (4) to provide a forum for interested staff nurses to document their own experiences for publication purposes. The CNS could provide support by assisting interested

nurses in writing their thoughts and feelings in an anecdotal format and/or viewing their experiences from the perspective of a phenomenological dialogue.

It is recommended that the CNS be involved in unit-based research to determine the efficacy of some of the interventions identified in the literature as enhancing support for the bereaved nurse. It needs to be determined if strategies, such as critical incident debriefing after a child's death, are effective in helping the nurses' cope more effectively with their feelings of grief. Collaborating with other disciplines and being involved in multi-centered research studies exploring nursing bereavement issues, such as the effectiveness of critical incident debriefing, will increase access to resources and enhance the generalizability of the findings.

Finally, it is recommended that the CNS conduct unit-based research to explore, in greater depth, the differences between the novice and experienced nurses as it relates to their coping with grief. For example, the CNS could compare the responses of novice nurses to those of experienced nurses on their perceptions of the adequacy of bereavement educational interventions and their feelings of being supported with managing their grief. This type of information would help to identify if levels of educational bereavement programming are required. Publishing an analysis of personal inventories from nurses attending the bereavement workshops and its relationship to existing literature and personal clinical experience is another recommended research related activity.

5.4 Directions for Further Research

The findings, that there is an ongoing presence of the deceased and a timelessness to the nurse's feelings of grief, challenge current medical science conceptualizations of bereavement that postulate grief is time bound and that healthy recovery depends on severance of emotional bonds with the deceased (Engel, 1961; Parkes, 1972). Furthermore, qualitative and quantitative studies are needed to develop a substantive theory of nursing grief that is contextually appropriate, accounts for variability by cause and circumstances surrounding

the death, and is culturally relevant. For example, although findings of this study supported components of Bugen's (1977) model of human grief, such as the interaction of closeness of relationship and perception of preventability with the intensity and duration of nurses' grief, this study highlighted that perception of preventability also encompassed the process of dying. As well, two new dimensions, predictability and experiential learning, appeared to be critical influencing factors. Therefore, research is needed before Bugen's model of prediction and intervention can be considered applicable for health care providers dealing with multiple, accumulated loss. Qualitative studies are needed to identify further the contextual factors before they can be considered as variables in a quantitative study.

It has already been identified that professional caregiver bereavement has not been addressed in the same depth as family member grief. The findings of this study further support the most current nursing literature (Carter, 1989; Demi & Miles 1987; Jacobs, 1993) that grief is highly individualized and that there is no one recipe to effectively manage grief responses. For example, this study has found that there is an experiential learning process to coping with multiple, accumulated losses for pediatric intensive care nurses. Therefore, qualitative studies are required to document in further depth the experiential learning process. A longitudinal design would be advantageous in determining if there is a sequence of experiential learning to coping with grief and if there are specific strategies that would be more helpful than others to help the nurses manage their grief responses at each of these stages.

Findings of this study reflect that certain contextual factors in this setting strongly influenced the participants' intensity and duration of grief and their abilities to effectively manage their grief. These critical factors, such as presence of family, work support systems, and the nursing ethos of the unit, need to be further examined. Given current efforts to strengthen family participation in the care of the critically ill child and adult, the impact of more intense involvement with families on nurses' grief needs to be examined. Studies should also examine the impact of the environmental milieu on nurses' grief. The experience of grieving should be

further explored using a qualitative approach with a different selection of participants, such as nurses working in adult intensive care units, or pediatric nurses working in non-critical care specialties. By exploring other nursing environments, researchers can better understand the role of the environment on nurses' grief versus the role of the contextual factors of the death itself. They may also be able to identify if there are other contextual factors that influence nurses' grief. It is important to determine if there are commonalities to nurses' grief across nursing environments in order that nurses be enabled to work collaboratively in their development of interventions that can have more generalizability.

Hockley (1989) found that it was very hard to decide how to provide the bereavement teaching that nurses need, and indeed, if it was possible to teach someone how to effectively look after dying patients or their bereaved relatives or even to deal with their own grief. (in Spencer, 1994, p.1143). Studies need to be conducted that examine the effectiveness of educational and work support interventions on helping nurses' grieve effectively.

5.5 Ending

While the topic of grief has received considerable attention and has been researched at length, there is a paucity of literature that has focused on health care professionals' experience of grief. The purpose of this study was to investigate the grief experience of pediatric intensive care nurses when their patients die.

A phenomenological method was used in this study in order to obtain rich descriptions of nurses' experience of grief within their workplace. The purposive sample consisted of six registered nurses employed in an intensive care unit in a university-teaching pediatric hospital. All volunteers had experienced at least three children's deaths. In-depth, semi-structured interviews were conducted with the study participants in order to generate the data base. The audio-taped interviews were transcribed and analyzed for recurring themes emerging from the data according to the procedure outlined by Colaizzi (1978). These nurses acknowledged they

suffered multiple exposures to children's deaths and commonly experienced grief. The interviews revealed eight themes that included one theme about their grief responses - hurting; two themes that described the influencing contextual factors - nurse-family unit relationship and dissonance; and five themes that related to coping strategies employed to manage their feelings of grief - self expression, self nurturance, termination of relationship activities, engaging in control taking activities and self reflection. Further analysis revealed that managing their grief effectively was an experiential learning process. The themes were compared with the broader literature on grieving the loss of a significant other, grief and the health care professional, and the literature that addressed issues of occupational stress in the care of the critically ill, the dying, and the bereaved. The findings of this study could encourage further research that examines interventions designed to enhance the type of education and support needed in relation to the experience of nurses.

The following poem provides an summary of the veiled meaning contained in the participants' stories. It was written by Beth Perry (1996) from her exploration of the nature of exceptionally competent oncology nursing practice but ideally this poem communicates the emotions of this study.

Shared Journey

Together,
nurse and patient
rise above the pain,
suffering,
and despair
of cancer,
to climb to the top of the mountain that
has no summit.
They take turns
carrying one another.
For they know that neither
can get there alone.
In their time together,
they share through touch,
silence,
and light-heartedness.

in their time together,
they learn about themselves,
their needs,
their strengths,
their limitations.
But most of all
they learn about their similarities.
They both share a common fate
of mortality,
an understanding which makes
the pleasures of life more intense.
They both possess the potential
for knowing joy,
awe,
and wonder.
They both understand
that though the physical body
may be diseased,
disfigured,
distasteful,
the spiritual body can be healthy,
beautiful,
and whole.
Through the intimacy of their
relationship they discover
they are valued,
they are worthwhile,
that they can
and do,
make a difference.
Each, in their own way,
creates meaning out of their experience.
As they reach higher and higher planes
the patient may leave to take up challenges elsewhere,
while the nurse,
having gathered strength
from the journey
is able to carry on.

Perry, 1996, p. 6.

REFERENCES

- Adams, J. P., Hershatter, M. J., & Moritz, D. A. (1991). Accumulated loss phenomenon among hospice caregivers. The American Journal of Hospice & Palliative Care, 8 (3), 29-37.
- Allan, J. D. & Hall, B. A. (1988). Challenging the focus on technology: A critique of the medical model. Advances in Nursing Science, 10 (3), 22-33.
- Atkins, S. & Murphy, K. (1993). Reflection: A review of the literature. Journal of Advanced Nursing, 18, 1188-1192.
- Averill, J. R. (1968). Grief: Its nature and significance. Psychological Bulletin, 70, 721-748.
- Bailey, J., Steffen, S. M., & Grout, J. W. (1980). The stress audit: Identifying the stressors of ICU nursing. Journal of Nursing Education, 19 (6), 15-25.
- Barnard, D. (1985). Survivorship and medical ethics. Death Studies, 9, 115-131.
- Barton, D. (1977). The caregiver. In D. Barton, Dying and Death (pp. 72-86). Baltimore: Waverly.
- Beaton, J. I. & Degner, L. F. (1990). Life and death decisions: The impact on nurses. The Canadian Nurse, 86 (3), 18-19, 21-22.
- Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. Western Journal of Nursing Research, 15, 263-266.
- Benica, S., Longo, C., & Barnsteiner, J. (1992). Perceptions and significance of patient deaths for pediatric critical care nurses. Critical Care Nurse, 12 (3), 72-75.
- Benner, P. (1984). From novice to expert. New York, Addison-Wesley Publishing.
- Benner, P. & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. New York, Addison-Wesley Publishing.
- Benoliel, J. Q. (1982). Death education for the health professional. New York: Hemisphere Publishing Corporation.
- Benoliel, J. (1983). Nursing research on death, dying, and terminal illness: Development, present state, and prospects. In H. H. Werley & J. J. Fitzpatrick (Eds.), Annual review of nursing research Vol. 1, (pp. 101-130). New York: Springer Publishing.
- Benoliel, J. (1984). Advancing nursing science: Qualitative approaches. Western Journal of Nursing Research, 7 (1), 1-8.
- Benoliel, J. Q. (1985). Loss and adaptation: Circumstances, contingencies, and consequences. Death Studies, 9, 217-235.

- Bergum, V. (1991). Being a phenomenological researcher. In J. M. Morse (Ed.), Qualitative nursing research, (pp. 55- 71). Newbury Park, CA: Sage.
- Bertman, S. L. (1983). Bearing the unbearable: From loss, the gain. Health Values: Achieving High Level Wellness, 7 (1), 24-28.
- Borozny, M. L. (1990). The experience of intensive care unit nurses providing care to the brain dead patient. Unpublished master's thesis, University of British Columbia, Vancouver, British Columbia, Canada.
- Bowlby, J. (1961). Processes of mourning. The International Journal of Psycho-Analysis, 42, 317-340.
- Brunckhorst, L., Economou, D., Ranauro, M., Walden, K., & Plows, E. (1985). The American Journal of Nursing, 85 (10), 1054.
- Bugen, L. (1977). Human grief: A model for prediction and intervention. American Journal of Orthopsychiatry, 47, 196-206.
- Caldwell, T. & Weiner, M. (1981). Stresses and coping in ICU nursing I. A review. General Hospital Psychiatry, 3, 119-127.
- Canadian Association of Critical Care Nurses (1992). Standards for critical care nursing practice. London, Ontario, Canada.
- Canadian Council on Health Services Accreditation. (1994). Standards for acute care organizations: A client centered approach, 1995. Ottawa, Canada.
- Carnevale, F. A. (1994). Striving to care: A qualitative study of stress in nursing. Unpublished doctoral dissertation, McGill University, Montreal, Quebec, Canada.
- Carter, S. L. (1989). Themes of grief. Nursing Research, 38, 354-358.
- Cassem, N. H. & Hackett, T. P. (1972). Sources of tension for the CCU nurse. American Journal of Nursing, 72, 1426-1430.
- Chard, P. (1987). Grief: Handling theirs and yours. Emergency Medical Services, 16 (1), 36-41.
- Charnock, A. (1985). Sharing the sadness. Nursing Times, 81 (40), 40-41.
- Cleiren, M. P. (1993). Bereavement and adaptation - A comparative study of the aftermath of death. Philadelphia: Hemisphere Publishing.
- Cody, W. K. (1991). Grieving a personal loss. Nursing Science Quarterly, 4, 61-68.
- Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford University Press.

Cooper, C. L. & Mitchell, S. (1990). Nursing the critically ill and dying. Human Relations, 43 (4), 297-311.

Cowles, K. V. & Rodgers, B. L. (1991). The concept of grief: A foundation for nursing research and practice. Research in Nursing & Health, 14 (2), 119-127.

Cowles, K. V. & Rodgers, B. L. (1993). The concept of grief: An evolutionary perspective. In B. L. Rodgers & K. A. Knall (Eds), Concept Development in Nursing - Foundations, Techniques, and Applications, (pp. 93-106). Philadelphia: W.B. Saunders.

Demi, A. S. (1984). Hospice bereavement program: Trends and issues. In S. H. Schraff (Ed.), Hospice: The nursing perspective, (pp. 131-147). New York: National League For Nursing.

Demi, A. & Miles, M. (1986). Bereavment: Review of Nursing Research. Annual Review of Nursing Research, 4, 105-123.

Downey, A. M. (1983). Living, loving and losing: Implications for health and well-being. Health Values: Achieving High Level Wellness, 7 (1), 7-14.

Eakes, G. G. (1990). Grief resolution in hospice nurses: An exploration of effective methods. Nursing & Health Care, 11 (5), 243-248.

Eisendrath, S. & Dunkel, J. (1979). Psychological issues in intensive care unit staff. Heart & Lung, 8 (4), 751-758.

Engel, G. L. (1961). Is grief a disease? Psychosomatic Medicine, XXIII (1), 18-22.

Engel, G. L. (1964). Grief and grieving. American Journal of Nursing, 64, (9), 93-98.

Eriksson, K. (1992). Different forms of caring communion. Nursing Science Quarterly, 5 (2), 93.

Evans, J. (1989). Crisis, grief, and loss. The Canadian Nurse, 89 (8), 40-43.

Feldstein, M. & Gemma, P. B. (1995). Oncology nurses and chronic compounded grief. Cancer Nursing, 18, 228-236.

Field, P. A. & Morse, J. M. (1985). Nursing Research: The Application of Qualitative Approaches. London: Croom Helm.

Foxall, M. J., Zimmerman, L., Standley, R., & Captain, B. B. (1990). A comparison of frequency and sources of nursing job stress perceived by intensive care, hospice and medical-surgical nurses. Journal of Advanced Nursing, 15, 577-584.

Freud, S. Mourning and melancholia. (1957). In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol 14, pp. 243-258), London: Hogarth. (Original work published 1917).

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fischer, & E. Murray (Eds.), Duquesne studies in phenomenological psychology (Vol II), (pp. 82-103). Atlantic Highlands, NJ: Humanities Press.

Glick, I. O., Weiss, R. S., & Parkes, C. M. (1974). The first year of bereavement. New York: John Wiley & Sons.

Gray-Toft, P. & Anderson, J. G. (1986-87). Sources of stress in nursing terminal patients in a hospice. Omega, 17 (1), 29-39.

Gribbins, R. E. & Marshall, R. E. (1982). Stress and coping in the NICU staff nurse: Practical implications for change. Critical Care Medicine, 10 (12), 865-867.

Hamilton, E. (1942). Mythology. New York: The New American Library, Inc.

Hamric, A. B. & Spross, J. A. (1989). The clinical nurse specialist in theory and practice. 2nd ed. Philadelphia: W. B. Saunders.

Harper, BC. (1977). Death: The coping mechanism of the health professional. Greenville, NC.: Southeastern University Press.

Hart, J. (1995). Oblivion. New York: Penguin Books.

Hase, S. (1989). The stress of grief. New Zealand Nursing Journal, June, 21-22.

Hay, D. & Oken, D. (1972). The psychological stresses of intensive care unit nursing. Psychosomatic Medicine, 34, 109-118.

Haylor, M. J. (1987). Human response to loss. Nurse Practitioner, 12 (5), 63-66.

Hazinski, M. F. (1992). Nursing care of the critically ill child (2nd Ed.). St. Louis: Mosby Year Book.

Herrie, S. M. & Robinson, B. (1987). Helping staff cope with grief. Nursing Management, 18 (9), 33-34.

Hoagland, A. C. (1984). Bereavement and personal constructs: Old theories and new constructs. In F. R. Epting & R. A. Neimeyer (Eds.), Personal meanings of death: Application of personal construct theory to clinical practice (pp. 89-107). New York: Hemisphere Publishing.

Huberman, A. M. & Miles, M. B. (1994). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 428-444). Thousand Oaks, CA: Sage.

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participating in research interviews. Image: Journal of Nursing Scholarship, 26 (2), 161-164.

Iveson-Iveson, J. (1985). Part of the spiral of life. Nursing Mirror, 160 (6), 38.

- Jacob, S. (1993). An analysis of the concept of grief. Journal of Advanced Nursing, 18 (11), 1787-1794.
- Jacobson, S. P. (1978). Stressful situations for neonatal intensive care nurses. American Journal of Maternal Child Nursing, 3, 144-150.
- Kastenbaum, R. J. Death and bereavement in later life. (1969). In A. H. Kutscher (Ed.), Death and bereavement. Springfield, IL: Charles C. Thomas.
- Katz, S. & Florian, V. (1986-87). A comprehensive theoretical model of psychological reaction to loss. International Journal of Psychiatry in Medicine, 16 (4), 326-345.
- Kavanaugh, R. E. (1972). Facing Death. New York: Penguin Books.
- Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6, 107-114.
- Knapp, R. J. (1986). Beyond endurance: When a child dies. New York: Schocken Books.
- Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. Journal of Advanced Nursing, 21, 827-836.
- Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development. Englewood Cliffs: NJ: Prentice-Hall, Inc.
- Kubler-Ross, E. (1969). Death: The final stage of growth. Englewood Cliffs, NJ: Prentice-Hall.
- Kuntz, B. B. (1984). "I didn't think his death would hit me so hard." RN, 47 (2), 30.
- Liehr, P. R. (1989). The core of true presence: A loving center. Nursing Science Quarterly, 2, 7.
- Liehr, P. R. & Marcus, M. T. (1994). Qualitative approaches to research. In G. LoBiondo-Wood & J. Haber (Eds.), Nursing research: Methods, critical appraisal, and utilization (3rd ed.) (pp. 253-285). St. Louis: Mosby.
- Lincoln, Y. S. & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.
- Lindemann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry, 101, 141-148.
- Lofland, J. (1974). Styles of reporting qualitative field research. The American Sociologist, 9, 101-111.
- Lynch-Sauer, J. (1985). Using a phenomenological research method to study nursing phenomena. In M. Leininger (Ed.), Qualitative research methods in nursing (pp. 93-107). Orlando, FL: Grune & Stratton.

- Maddison, D. & Viola, A. (1968). The health of widows in the year following bereavement. Journal of Psychosomatic Research, 12, 297-306.
- Mallett, K., Price, J., Jurs, S., & Stenker, S. (1991). Relationships among burnout, death anxiety, and social support in hospice and critical care nurses. Psychological Reports, 68, 1347-1359.
- Marquis, S. (1993). Death of the nursed: burnout of the provider. Omega, 27 (1), 17-33.
- Maris, P. (1974). Loss and change. London: Routledge & Kegan Paul.
- Martinson, I. M., McClowry, S. G., Davies, R. & Kuhlerkamp, E. J. (1994). Changes over time: A study of family bereavement following childhood cancer. Journal of Palliative Care, 10, 19-25.
- Martocchio, B. (1985). Grief and bereavement: Healing through hurt. Nursing Clinics of North America, 20 (2), 327-341.
- Martocchio, B. (1987). Authenticity, belonging, emotional closeness, and self representation. Oncology Nursing Forum, 14 (4), 23-27.
- May, K. A. (1991). Interview techniques in qualitative research. Concerns and challenges. In J. M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (Rev ed.) (pp. 188-201). Newbury Park, CA: Sage.
- McKerron, L. (1991). Dealing with stress of caring for the dying in intensive care units: an overview. Intensive Care Nursing, 7 (4), 219-222.
- Miles, M. S. (1985). Helping adults mourn the death of a child. Issues in Comprehensive Pediatric Nursing, 8, 219-241.
- Miles, M. S. & Crandall, E. K. B. (1983). The search for meaning and its potential for affecting growth in bereaved parents. Health Values: Achieving High Level Wellness, 7 (1), 19-23.
- Miles, M. S. & Demi, A. S. (1986). Guilt in bereaved parents. In T. Rando (Eds.), Parental loss of a child. Champaign, Ill: Research Press.
- Miller, W. L. & Crabtree, B. F. (1992). Primary care research: A multimethod typology and qualitative road map. In W. L. Miller & B. F. Crabtree (Eds.), Doing qualitative research (pp. 3-28). Newbury Park, CA: Sage.
- Mings, D. (1995). Developing a nursing caregiver bereavement resource package. Canadian Oncology Nursing Journal, 5, 121-129.
- Morse, J. M. (1986). Quantitative and qualitative research: Issues in sampling. In P. L. Chinn (Ed.), Nursing research methodology (pp. 181-193). Rockville: Aspen.

Morse, J. M. (1991). Strategies for sampling. In J. M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (Rev. ed.) (pp. 127-144). Newbury Park, CA: Sage.

Morse, J. M. (1992). Negotiating commitment and involvement in the nurse-patient relationship. In J. M. Morse (Ed.), Qualitative health research (pp.333-3659), Newbury Park, CA: Sage.

Morse, J. M. (1994a). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 220-235). Thousand Oaks, CA: Sage.

Morse, J. M. (1994b). "Emerging from the data": The cognitive processes of analysis in qualitative inquiry. In J. M. Morse (Ed.), Critical issues in qualitative research methods (pp. 23-43). Thousand Oaks, CA: Sage.

Morse, J. M. & Field, P. A. (1995). Qualitative research methods for health professionals. (2nd ed). Thousand Oaks, CA: Sage.

Mount, B. M. (1986). Dealing with our losses. Journal of Clinical Oncology, 7 (4), 1127-1134.

Munhall, P. L. (1989). Qualitative Designs. In P. J. Brink & M. J. Wood (Eds.), Advanced design in nursing research (pp. 161-179). Newbury Park, CA: Sage.

Munley, A. (1985). Sources of hospice stress and how to cope with it. Nursing Clinics of North America, 20 (2), 343-355.

Norbeck, J. S. (1985). Perceived job stress, job satisfaction and psychological symptoms in critical care nursing. Res Nurs Health, 8, 253-259.

Oiler, C. (1982). The phenomenological approach in nursing research. Nursing Research, 31, 178-181.

Oiler, C. (1986). Phenomenology: the method. In P. L. Munhall & C. J. Oiler (Eds.), Nursing research: A qualitative perspective pp. 69-84. Norwalk, CT: Appleton-Century-Crofts.

Omery, A. (1983). Phenomenology: a method for nursing research. Advances in Nursing Science, 5 (2), 49-63.

Osterweis, M., Solomon, F., & Green, M. (1984). Bereavement: Reactions, consequences, and care. Washington, DC.: National Academy Press.

Parkes, C. M. (1972). Bereavement. Studies of grief in adult life. New York: International Universities Press.

Parkes, C. M. (1985). Bereavement. British Journal of Psychiatry, 146, 11-17.

Parkes, C. M., Benjamin, B. & Fitzgerald, R. G. (1969). Broken heart: A statistical study of increased mortality among widowers. British Medical Journal, 1, 740-743.

Parkes, C. M. & Brown, R. J. (1972). Health after bereavement. Psychosomatic Medicine, 34, 449-461.

Parkes, C. M. & Weiss, R. S. (1983). Recovery from bereavement. New York: Basic Books.

Perry, B. (1996). I am a nurse. Canadian Oncology Nursing Journal, 6, 6-13.

Price, D. M. & Murphy, P. A. (1985). Emotional depletion in critical care staff. Journal of Neurosurgical Nursing, 17 (2), 114-118.

Price, T. R. & Bergen, B. J.. (1977). The relationship to death as a source of stress for nurses on a coronary care unit. Omega, 8, 229-238.

Quint, J. C. (1966). Awareness of death and the nurse's composure. Nursing Research, 15, 49-55.

Rando, T. (1984). Grief, dying, and death: Clinical interventions for caregivers. Champaign, IL: Research Press.

Rando, T. (Ed.). (1986). Parental loss of a child. Champaign, IL: Research Press.

Rando, T. (1988). Grieving: How to go on living when someone you love dies. Lexington, MA: Lexington Books.

Raphael, B. (1983). The anatomy of bereavement. New York: Basic Books.

Rowe, D. (1984). Constructing life and death. In F. R. Epting & R. A. Neimeyer (Eds.), Personal meanings of death: Application of personal construct theory to clinical practice (pp.11-27). New York: Hemisphere Publishing.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8 (3), 27-37.

Sandelowski, M. (1988). A case of conflicting paradigms: Nursing and reproductive technology. Advances in Nursing Science, 19 (3), 35-45.

Saunders, J. M. & Valente, S. M. (1994). Nurses' grief. Cancer Nursing, 17, 318-325.

Schneider, J. (1984). Stress, loss, and grief. Baltimore, MD: University Park Press.

Sheard, T. (1984). Dealing with the nurse's grief. Nursing Forum, XXI (1), 43-45.

Sheard, T. (1990). "In memoriam." Focus on Critical Care, 17 (3), 238-239.

Shneidman, E. S. (1970). You and death. Psychology Today, 4 (8), 67-72.

Shoemaker, W. C., Thompson, W. L., & Holbrook, P. R. (1984). Textbook of critical care. Philadelphia: W. B. Saunders.

Spencer, L. (1994). How do nurses deal with their own grief when a patient dies on an intensive care unit, and what help can be given to enable them to overcome their grief effectively? Journal of Advanced Nursing, 19, 1141-1150.

Spoth, R. & Konewko, P. (1987). Intensive care staff stressors and life event changes across multiple settings and work units. Heart & Lung, 16 (3), 278-284.

Stowers, S. (1983). Nurses cry, too. Nursing Management, 14 (4), 63-64.

Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.). (1993) Handbook of bereavement: Theory, research, and intervention. New York: Cambridge University Press.

Stylianou, S. & Vachon, M. L. (1993). The role of social support in bereavement. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), Handbook of bereavement: Theory, research, and intervention, (pp. 397-410). New York: Cambridge University Press.

Swanson, K. (1990). Providing care in the NICU: Sometimes an act of love. Advances in Nursing Science, 13, 60-73.

Vachon, M. L. (1987). Occupational stress in the care of the critically ill, the dying, and the bereaved. Washington, DC.: Hemisphere Publishing.

Vachon, M. L. (1994). Staff stress in hospice/palliative care: A review. Manuscript submitted for publication.

Vachon, M. L. & Pakes, E. (1985). Staff Stress in the care of the critically ill and dying child. Issues in Comprehensive Pediatric Nursing, 8, 151-182.

Valle, R. & King, M. (1978). An introduction to existential-phenomenological thought in psychology. In R. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 6-17). New York: Oxford University Press.

van Manen, M. (1984). "Doing" phenomenological research and writing: An introduction (Monograph No. 7). Edmonton, Canada: University of Alberta.

Vincent, P. & Coleman, WF. (1986). Psychosocial aspects of critical care: Comparison of major stressors perceived by ICU and non ICU nurses. Critical Care Nurse, 6 (1), 64-69.

von Eckartsberg, R. (1971). On experiential methodology. In A. Giorgi, W. Fischer, & R. von Eckartsberg (Eds.), Duquesne studies in phenomenological psychology (Vol. 1), (pp. 66-79). Atlantic Highlands, NJ: Humanities Press.

Volkman, V. (1970). Typical findings in pathological grief. Psychiatric Quarterly, 44, 231-250.

Walters, A. J. (1995). Technology and the lifeworld of critical care nursing. Journal of Advanced Nursing, 22, 338-346.

Watson, J. (1985). Nursing human science and human care: A theory of nursing. Norwalk, CT: Appleton-Century-Crofts.

Watson, J. (1989). Human caring and suffering: A subjective model for health services. In J. Watson & R. Taylor (Eds.). They shall not hurt: Human suffering and human caring. Boulder, CO: Colorado Associated University.

Weisman, A. D. (1973). Coping with untimely death. Psychiatry, 36, 366-378.

Williams, C. A. (1982). Role considerations in care of the dying patient. Image, 14 (1), 8-11.

Wolcott, H. F. (1990). Writing up qualitative research. Newbury Park, CA: Sage.

Wolff, W. (1994). This man cried today. American Journal of Nursing, 94 (9), 28-29.

Woolley, H., Stein, A., Forrest, G. C., & Baum, J. D. (1989). Staff stress and job satisfaction at a children's hospice. Archives of Disease in Childhood, 64, 114-118.

Worden, J. W. (1985). Bereavement. Seminars in Oncology, 12, 472-475.

Worden, J. W. (1991). Grief Counselling & Grief Therapy: A Handbook for the Mental Health Practitioner. (2nd ed). New York: Springer Publishing.

APPENDIX A.

Questions for Semi-Structured Interview

General Information

Date of Interview (day/month/year) _____

Code Number _____ Pseudonym _____

I know that as a critical care nurse you are faced with recurrent and frequent experiences with the loss of your patients. I am interested in understanding what this is like for you and I wonder if you would share with me your experiences in dealing with the death of your patients? I will be asking you to recall specific events and situations that you have experienced. I am asking you to share with me your feelings, your thoughts, and behaviors, as well as the events and people connected with your experiences. I really value your participation in this study and thank you for your commitment of time, energy, and effort. I will be asking you a few questions but mainly would like to take direction from you in this interview. Do you have any questions or concerns before we begin?

- How did you make the choice to work where you are working? (What is pediatric intensive care nursing for you? Why do you stay in this area?)
- How long have you worked here ?
- How many children's deaths might have occurred in that time?
- Will you share with me some of those experiences with me?
- Describe to me a death of a child in the unit that still lingers in your mind as .. (use the word of the participant that they have indicated as the worst or most difficult).
- Describe to me a death of a child in the unit that still lingers in your mind as .. (use the word of the participant that they have indicated as the least difficult)
- Is there anything else I should have asked you?
- Is there anything you would like to ask me?

Before the end of the interview, the following demographic data will be obtained:

Age: 20-30 _____ 31-40 _____ 41-50 _____ ≥51 _____

Sex: Female _____ Male _____

Basic Nursing Education:

Hospital _____ College _____ University _____

Post Basic Education (Highest level achieved) _____

Work Experience

Total Years in Nursing _____

Years experience in pediatric I.C.U. _____ (Other institution) _____

Other Areas

Position

_____	_____
_____	_____
_____	_____

APPENDIX B

LETTER OF INFORMATION FOR RESEARCH STUDY

Title of Project: The Grief Experience of Pediatric Intensive Care Nurses

Principal Investigator: Judy Rashotte
Tel: (613)-526-1651

Thesis Supervisor: Dr. Frances Fothergill-Bourbonnais
Tel: (613)-562-5800 (ext. 8423)

Chair, FHS HREC: Dr. Francis Reardon, Faculty of Health Sciences
451 Smyth Road, Ottawa, Ontario K1H 8M5
Tel: (613)-562-5800 (ext. 4270)

I am a registered nurse working towards a Master's of Science in Nursing degree at the University of Ottawa. For my thesis, I am conducting a study to gain an understanding of the grief experience of pediatric intensive care nurses when the children for whom they care die. I hope the findings of this study will be valuable for nursing by heightening the awareness about nurses' grief experiences so that appropriate supports can be offered and suitable educational programs for nurses can be developed.

This letter is to invite you to participate in my study. The study will involve two interviews. The first will take approximately 45 to 120 minutes (average 90 minutes) and is the time of primary data gathering for my study. I will ask you to share with me some of your experiences with the deaths of your patients and your feelings related to those experiences. You will be free to comment as you wish about your perspective of caring for the dying patient and their families and your grief experiences. The final interview is an opportunity for you to see the findings and to clarify and verify my understanding of your experience and will take approximately 30 to 60 minutes. The interviews will be scheduled at a mutually convenient time and place. The interview will be audiotaped to ensure accuracy in data collection. All responses will be kept in strictest confidence and a coding system will exist to protect your anonymity. In addition confidentiality of patient information will be protected. If the names of patients and their families are inadvertently mentioned during the taped interview, the names will not be transcribed and at no time during the research reporting will patients or families be referred to by name. All information tape recorded in this interview will be destroyed by the investigator, Judy Rashotte, once the tape is transcribed. Once the data is analyzed, no individual subject will be identifiable.

The findings of the study will be presented at nursing forums and also submitted to

professional nursing journals for publication in order to increase professional awareness of the grief experience for pediatric critical care nurses.

You are under no obligation to participate in this study, and you are free to withdraw at any time. Your decision not to participate will in no way affect your employment or work on the unit. Should you decide to participate, you are also free to refuse to answer any questions and to withdraw an comments at any time.

I will be making a follow up call to inquire as to your interest in participating in this study. At this time I will provide you with further information and answer any questions. However, you may also call me if you are interested or have any questions or concerns. If you are still interested in participating, a time and date will be arranged for the first interview. At this interview I will ask you to sign a form consenting to your participation, and giving me permission to audiotape our interviews.

It is realized that this topic is a very sensitive and emotional one. It is hoped that by talking about it, it will not only help others working in this setting but that it may also be personally helpful for the participants.

This research project has received approval from the University of Ottawa Human Research Ethics Committee chaired by Dr. Francis Reardon (613-562-5800 ext. 4270). Thank you for your interest.

Yours truly,

Judy Rashotte, RN, BN
University of Ottawa, MScN student

APPENDIX CCONSENT FORM FOR NURSING STAFF

Title of Project: The Grief Experience of Pediatric Intensive Care Nurses
 Principal Investigator: Judy Rashotte, RN, BN, MScN Student
 Tel: (613)-526-1651
 Thesis Supervisor: Dr. Frances Fothergill-Bourbonnais
 Tel: (613)-562-5800 (ext. 8423)
 Chair, FHS HREC: Dr. Francis Reardon, Faculty of Health Sciences
 451 Smyth Road, Ottawa, Ontario K1H 8M5
 Tel: (613)-562-5800 (ext. 4270)

I have been asked to participate in a nursing research study the purpose of which is to explore the grief experiences of pediatric intensive care nurses. It has been explained to me that participation in the study involves an initial in-depth interview that will last approximately 45 to 120 minutes (average 90 minutes). I understand that I will be asked to recall my experiences with the death of some of my patients in the pediatric intensive care unit and how I worked through my feelings. There will be a final meeting, which will take approximately 30 to 60 minutes, in order for you to review the findings and to clarify and verify my understanding of your experiences. These will occur at a place and time which is mutually convenient. This information will be valuable for nursing by heightening the awareness about nurses' grief experiences so that appropriate supports can be offered and suitable educational programs for nurses can be developed.

I understand that my responses will be audio recorded and that the tapes will be erased once transcribed. I know I have the right to request erasure of materials that I do not wish to be taken outside of the interview room. I am aware that my name will not be used, that my identity will be protected and a coding system will exist to protect my anonymity. I do understand, however, that the overall results of the study may be published to promote professional awareness of the grief experiences of pediatric critical care nurses. I understand that I also have the right to withdraw from the study at any time and that my withdrawal will in no way affect my employment, or work on the unit. I also have the right to refuse to answer any question.

I understand that this research project has received approval from the University of Ottawa Human Research Ethics Committee chaired by Dr. Francis Reardon (562-5800 ext. 4270).

I hereby give my consent to participate in this study.

Signed: _____ Date: _____

Witness: _____