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Original Article

Nurses' coping with the unexpected death of children and adolescents

Processos de confronto dos enfermeiros face à morte inesperada de crianças e adolescentes

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Objective: to understand the coping strategies nurses use to cope with unexpected death in pediatrics. **Methods:** qualitative research involving six nursing professionals working in pediatric emergency and intensive care services. Content analysis was performed. **Results:** two groups of categories emerged from the data describing coping processes: strategies focused on assessing the situation in which the professionals try, through rational processes, to understand and accept the unexpected death; strategies focused on emotional management, in which the suffering resulting from the confrontation coping with the unexpected death is acknowledged, seeking strategies to better manage the event. **Conclusion:** the professionals suffer and seek coping mechanisms to manage the process of mourning over the unexpected death of a child/adolescent.
Descriptors: Pediatric Nursing; Death; Stress Disorders, Traumatic.

Objetivo: compreender as estratégias de confronto utilizadas pelos enfermeiros para lidar com a morte inesperada em pediatria. **Métodos:** pesquisa qualitativa com seis profissionais de enfermagem que trabalham em serviços de urgência e cuidados intensivos pediátricos. Procedeu-se a analise de conteúdo. **Resultados:** dos dados emergiram dois grupos: Estratégias centradas na avaliação da situação em que os profissionais tentam, através de processos racionais, compreender e aceitar a morte inesperada; estratégias centradas na gestão emocional, em que é reconhecido o sofrimento resultante do confronto com a morte inesperada, procurando estratégias de melhor gestão desse confronto. **Conclusão:** os profissionais sofrem e procuram mecanismos de confronto para gerir o processo de luto com a morte inesperada de criança/adolescente.
Descritores: Enfermagem Pediátrica; Morte; Transtornos de Estresse Traumático.

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Introduction

Children in intensive care or emergency services are highly vulnerable, who require continuous, complex care, in a fragile balance between life and death. In turn, childhood is undoubtedly associated with health and longevity so that, when an unexpected death occurs, this event is potentially traumatic and can emotionally affect the professionals working in these services, namely nurses[1].

The death of the child, by its magnitude, is assumed to be a tragedy; one of the greatest challenges health professionals face, and there is an acknowledged lack of preparation to face these situations[2]. The unexpected death of a child/adolescent is a critical incident that can be defined as an unexpected event that provokes an emotional impact that can compromise healthy people's confrontation ability, in this case, health professionals, causing profound stress[3].

The high technology present in intensive care and emergency services is aimed at recovering the health condition of critically ill patients. Care is not always successful though, so death in this highly technological world is assumed to be a failure. Although professionals sometimes tend to find a rational meaning for death and the great suffering it unleashes, accepting the death of a child/adolescent is very difficult. It is a non-normative event that deeply affects not only the family members but also the professionals[4-5]. There are feelings of frustration and impotence[5] that are exacerbated when a child/adolescent dies[6]. The evidence shows that the death of a child/adolescent has a high probability of triggering symptoms of intrusion, hyperarousal.and avoidance in the health professionals, considered as dimensions of Secondary Traumatic Stress[1]. This suffering, which results from caring for others, is also called compassion fatigue and is often accompanied by symptoms such as headaches, sleeping difficulties, fatigue, and depression[4,7-8].

Considering the recognition of this event as a potential stressor, several attempts have been made to describe and classify the coping mechanisms that health professionals use when dealing with these situations. These processes are described in terms of coping strategies[9], characterized as a set of cognitive behaviors, emotions or processes the individual uses to deal with internal or external situations, which are evaluated as exceeding their personal resources. The coping strategies are divided into two functional categories: problem-focused coping and emotion-focused coping[9]. The first, focused on the problem, is structured as a direct action on the problem, taking on behavioral changes, or intervening to change the environment, for example, seeking information, professional help or modifying lifestyles. On the other hand, emotion-centered coping is oriented towards the regulation of emotions, producing subjective changes in order to reduce unpleasant emotions, through strategies such as avoidance, minimization, distancing, and selective attention among others[9]. In this perspective, the effectiveness of the coping processes depends on the controllability of the situation, which presupposes its evaluation. Thus, strategies focused on the problem are more adaptive when the problem situation is considered controllable. In turn, strategies more focused on emotions can be adaptive, when the situation is not controllable or modifiable[9].

In a recent systematic review of nursing professionals' coping strategies in face of the death of adult patients, two types of resources were identified: internal and external[10]. Internal resources refer to the personal resources that nursing professionals use to deal with death and include setting limits through detachment or emotional control, reflection, expression of emotions (namely through crying), beliefs about death, personal and professional experiences, and daily routines and activities. External resources, on the other hand, refer to the search for social support from colleagues, friends, and family, spiritual practices and training and education to cope with death situations.

Thus, the objective of this study was to describe the coping strategies that nurses used to cope with the unexpected death in pediatrics. It is intended to con-

tribute to the development of interventions that help to minimize the negative impact of this type of event on the health of nursing professionals, also improving the quality of the care they provide.

Methods

A qualitative study was developed at two central hospitals of Portugal, one in the North and the other in an island region. As an inclusion criterion, nurses should have previous professional experiences of unexpected death in children and adolescents. As this is a qualitative research, a convenience sample was constituted, with nurses working in the emergency and pediatric intensive care services and who agreed to participate in the study. The sample consisted of six nurses, five of whom were female, being the number of subjects determined by the theoretical saturation criterion[11]. The ages ranged from 32 to 53 years old and five were married and had children. The data were collected in 2013, between February and March, as part of a mixed research study. Subsequently, in 2015, the qualitative data were reanalyzed, due to their richness.

The data collection instrument used was a semi-structured interview, and a script was developed with open questions that addressed both the impact of the unexpected death event and the coping processes used of face the event. Regarding the exploration of coping processes, and following the discussion of the emotional impact of the situations of unexpected death in pediatrics, the interviewees were asked if they felt the need to mobilize strategies to overcome these situations. They were also asked to list and describe the strategies used. Thus, the research was guided by the following question: what coping processes do nurses use in the face of the unexpected death of a child/adolescent?

The participants were asked for their informed consent and anonymity was guaranteed in the data treatment .. In this assumption, the code NP was used when transcribing the interviews, placing a number between the two letters, which refers to the interview number, such as N4P. The interviews were recorded using an audio recorder, fully transcribed and the records were subsequently erased after their analysis. The texts were analyzed using a content analysis method[12]. The stages of coding and formulation of categories and subcategories were performed. In order to ensure the consistency of the data analysis, after developing the categorization system, two researchers analyzed the data independently and, later, the level of agreement between the two analyses was evaluated. The study received the approval of the institutional review boards at both hospitals under opinions 306/2013 and 1/2013.

Results

Based on the content analysis process, two groups of coping processes emerged describing strategies that nurses used to cope with the unexpected death of children and adolescents. A first group is based on assessing the situation, taht is, through reflection and analysis of the event, nurses seek to make the unexpected pediatric death more reasonable or tolerable. Through rational processes, nurses seek to withdraw the emotional burden of the event, which potentially traumatic for the nurse. The second group of strategies focuses more directly on the emotional management of the event, including processes that, starting from the recognition of the emotional suffering the unexpected death causes, somehow seek to minimize it or make it more manageable from a personal perspective.

Strategies focused on assessing the situation

The nurses mentioned that they tried to face the event of unexpected death in pediatrics through cognitive analysis processes. By dividing the problem into a set of facets or dimensions, they focused only on a few more specific ones, such as, clinical aspects (the circumstances of death, resuscitation attitudes and

the type of death) or professional performance, a process that was denominated as focusing on clinical or professional aspects. According to the interviewees, this strategy made it possible to distance themselves from the situation, especially in relation to its more threatening/disturbing nature, and thus to facilitate the coping. *I focus more on the clinical point of view go there ... what happened, what was done, whether we did right or wrong, we did that or this ... it went well if it went wrong ... More of this, it's more objective ...* (N4P). In assessing the situation from a more rational and therefore less disturbing perspective, one can maintain a greater perception of control or competence, insofar as this strategy allows the professionals to evaluate their performance as the most appropriate to the situation.

These efforts to separate the most objective dimensions of professional practice from their impact on personal life are not always experienced as being very successful though. *Work stays here outside the door. However much we want to separate things, our feelings at home change. ... because that is the time that we as a mother, to think that we attach too much importance to things that have no importance at all. ... But at these moments we block, ... because they paint the walls and at this moment someone will not have anyone to paint the walls. So we stop there a little* (N5P).

In the discourse analysis, other type of evaluation strategies also emerged, such as the search for a meaning for the event, in which the nurse tries to become aware of the inevitability of death. *I know that maybe there is destiny ... or some fate that would be written* (N4P), and keep in mind that death is a common situation in the profession and especially in critical care services. *What I thought was: I have to learn how to cope with this otherwise I'm working in the wrong place!* (N1F). There were also references to the fact that it is easier to accept the death of the child/adolescent when one thinks about the frail condition in which the child would stay if remained alive, that is, an attempt to reassess the event seeking to highlight a more favorable or less negative perspective. *I think that, if he was alive it would get much worse* (N3P). *The valuation of the nurse's role in the support given to the parents in situations of unexpected death. We ourselves feel more professionally valued. Emotionally we feel more relieved ... When they leave here, the son died here, but they'll also have the notion that we did everything that could be done ... we must always give that hope that everything was done that had to be done, which was the last possibility ... ... to transmit to parents that everything was done, that there was nothing left to do that should be done* (N6P).

Strategies focused on emotional management

The emotional management strategies describe processes that, starting from the acknowledgment of the emotional suffering the unexpected death caused, somehow seek to diminish it. They include the containment of emotions, through the suppression of impulses, but also their open expression. More active management processes of emerging feelings were also mentioned, through the search for emotional support, the performance of mourning rituals or activities that promote relaxation and well-being.

The interviewed nurses described efforts to control the expression of emotions in the face of the unexpected pediatric death. *There are different situations ... some more striking than others and that upset more ... but I think I already have a good shell!* (laughs) *... at least I manage not to feel emotionally moved ... I can keep calm, serene, without showing myself* (N4P). Their ability not to be emotionally moved, in a professional context, is considered as a facilitator of adaptation to the event and thus a form of emotional control. *I do not cry. It's funny I ... analyzing I was basically a weeping teenager type and when I started working here I was 22 and I notice now that I do not cry ... I very rarely cry* (N5P). This emotio- nal control towards the suffering of the patient´s family was even referred to as a sign of respect for their pain. *I try not to show myself as indifferent, but I also try not to get emotionally moved and be calm and ... they being, I am not part of their group. I am with them, but I am not part of their group* (N4P).

A reference was also made to the open expression of emotions, more specifically to crying, as an emotional management strategy. *It reaches a point that I try to discharge somehow... so as not to hold back the emotions* (N6P). In this category, the interviewed nurses also described some leisure activities and hobbies as strategies to

relax and manage the most disturbing emotions. References were made to gardening, reading and other activities aimed to change routines. *I have my free space, which is where I have my garden, my backyard, which is where I stay ... and then yes ... I think a lot* (N4P). *Going for a ride, like, unplanned, is a great thing for me. The fact that I know, for example, that tomorrow I'm off duty and go anywhere, or I'm going to cook, do something that I like ... I like painting* (N6P).

Seeking emotional support from team members, other professionals or the family were also included in this group of emotional management strategies. The nurses mentioned that they seek support from their teammates, particularly to talk about the event or simply to feel empathy with what they were experiencing, in order to better overcome the situation. *Yes, we usually talk after it happens, after something happens, at least the first days, also because these situations are sometimes more marking and we end up communicating somehow, informally* (N6P). In the reports, these moments of sharing occur mainly informally and unplanned, although reference has also been made to the organization of dinners, also intended to provide opportunities for sharing and discussion. The demand for support also occurs with family and friends though. *I have an aunt who worked for many years here, she was an assistant, and sometimes I say "the shift today was very bad" and I do not have to say anything else* (N1F). *Sometimes I need to talk ... I need to get home and comment on something to get myself free* (N4P).

Sometimes, the nurses' support happens beyond the professional context, such as participating in the children/adolescents' funerals. Being present in this type of ritual still expresses an attempt to process the loss, thus reducing its emotional impact. *I often go to the kids' funerals. ... It helps to mourn and it helps to put an end to the story ... ... I thought that at some point it was important for me to go ... that it was necessary for me to go to put an end to the story. To mine and theirs ... Usually, there is one or another that I went alone ... there are two or three people, co-workers, who end up being my friends ... because we have a very similar way of dealing with death ... we go and she also goes, we do not talk about the reason, but she also needs to put an end to the situation ... and we move forward* (N5P).

Discussion

Assuming the limitations of the study, which derive from a small size of the sample, and from a specific reality, there are reflections that emerge from its results. The clinical situations in intensive care units are complex and highly vulnerable. The training of health professionals in general and particularly of nurses emphasizes the cure or control of situations though, resulting from scientific and technological developments in the health area. AS such, the confrontation with the death of a child is a disturbing, unexpected and tragic event, because it occurs at the onset of human development[5]. All this entails the need to mobilize a set of strategies to manage these situations, which is evidenced in this study and somehow corroborated in earlier research.

In the analysis of the interviews, the nurses described several coping strategies used to deal with the unexpectead death of a pediatric patient. This suggests that the unexpected death experience in pediatrics is effectively a stressor potentially traumatic, so nurses develop various startegies to deal with the event.

In the first group of strategies, which were referred to as focused on the assessment of the situation, three subtypes of strategies were included. In the initial group of identified strategies - which were named as focused on clinical aspects – the central feature is the attempt to frame the event of unexpected death in pediatrics within more acceptable circumstances, either because it is concluded that, what the professional performance is concerned, all possible efforts were made, or because this event was considered as something inevitable.

Thus, through rational processes, the nurses sought to identify several facets or dimensions of the phenomenon, in order to focus on those that protected them from the most disturbing nature of the event, and more often those of a technical or clinical nature. In a systematic review[10], reference is also made to

this strategy, calling it setting limits and including it in the group of intrinsic or personal resources. This strategy, which allows us to distance ourselves from the most unbalancing aspects, has also been described previously in other studies and is frequently called compartmentalization[6,13]. The use of this strategy also allows "giving time" to the professionals to deal with the emotional impact of the event later, thus ensuring a more "facilitated" professional performance at the moment of the patient's loss[6]. In this study, which is corroborated by the literature, reference is also made to the fact that, despite nurses seeking to use this type of strategy, they say that it is not always effective and that, although they try not to take work home, sometimes this is difficult[14].

Another strategy identified was the search for a meaning for the event, considering death as a predictable/inevitable outcome given the clinical situation of the child/adolescent, or as an expected event in critical services. In accordance with a recent study, however, each person interprets this meaning according to their background experiences, their belief system, and their own relationship with the child[15]. It has also been described that death is perceived as a relief from suffering, where the outcome is considered the best, given the circumstances, which somehow helps to give meaning to the situation, and consequently a better acceptance. In turn, in a study developed with critical care nurses, these processes were described as acceptance, arguing that they involve two complementary processes, which are resignation and normalization of the phenomenon, as happens in this study[16].

Finally, cognitive reavaluation, also described within this category of coping strategies, involves efforts to mentally reshape the event in order to highlight its most positive aspects. Supporting the child/adolescent's family can be a positive aspect as it may facilitate the parents' grief but also benefit the nurses' coping processes[14], as long as they feel useful and competent in the face of such a devastating event. The evidence points out that the care that the health professionals provide to the parents, at a time when they are emotionally affected, is fundamental in coping with the situation[3,7]. Moreover, professional accomplishment and satisfaction with their role as a professional seem to function as a protective factor for the nurses in relation to the exposure to traumatic events[17]. Professional satisfaction is also reported as a moderating variable of suffering and burnout[4].

The second group of strategies the interviewed nurses described is focused more directly on the emotional regulation processes. These include strategies that, departing from the identification of the emotional suffering the unexpected death causes, focus on an attempt to mitigate it in different ways, such as the control of emotions or their expression, among others. The control of emotional expression involves setting limits and taking emotional distance from death[10].

Emotional control is difficult in the face of the death of children and adolescents though, which often leads to emotional exhaustion, expressed by headaches, fatigue, and depression[4]. In this sense, crying can be a way for nursing professionals to express their emotions and deal with the death of a patient[10]. A position of compromise can be pointed out though, inasmuch as the nurses can express themselves through crying, but within reasonable limits, so that they do not create embarrassing or role-exchange situations.

One of the coping strategies the emergency nurses use most in the face of death, as reported in the literature, is the practice of hobbies, such as physical exercise and meditation, which translates into significantly lower burnout rates[18].

The search for support is frequently cited in the literature as a strategy for confronting patient death situations[10,19]. In one study, this appears as the strategy the participants reported most frequently who, in addition to nurses, also included doctors and social service technicians[6]. As a strategy to promote coping, peer support translates into the possibility of receiving a validation of the experience, which contributes to obtaining a sense of self-confidence and sharing/

universality about the difficulties experienced[20]. Sharing and discussion among peers is also a strategy that facilitates coping, as it is also a learning opportunity, helping to validate the experience and also to understand the negative impact on others[6].

Peer support may also be negative and may exacerbate stress though. The sharing of emotions sometimes proves to be of little benefit in managing the physical and emotional exhaustion resulting from the confrontation with the death of a child or adolescent[4]. By sharing the more negative aspects of the experience, there is a risk of prolonging their emotional impact and of exacerbating a more negative reading of the event, due to the involved professionals' mutual reinforcement of this perception[6]. Another strategy referred to is participation in grief rituals, and this practice influences the ability to confront the death of the child/adolescent[5]. This participation can fit in the dimension of spirituality and can be significant in these situations, leading to a reconsideration and reassessment of the assumptions of life[6].

Conclusion

This research allowed us to discover the coping processes the nurses used, and it was verified that they have a diversified repertoire of coping strategies. Despite the attempt toward emotional control and cognitive redefinition, these results reveal the personal difficulties in managing these situations appropriately, in accordance with the consulted literature. This difficulty is well expressed in the need to vent emotions, and even in the participation in funeral acts, or even projecting the reality experienced in their personal life.

Collaborations

Lima LMM contributed to the research design, data analysis and interpretation and writing of the article. Pinto CAS contributed to the data analysis and interpretation, writing of the article, relevant critical review of the intellectual content and final approval of the version for publication. Gonçalves SMB contributed to the research design, data collection and review of the article.

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