

The Lived Experiences of Nurses Caring For Dying Pediatric Patients

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Throughout the course of their careers, nurses care for patients who are sick, suffering, and in the process of dying (Maeve, 1998). Caring for dying children is a unique type of nursing practice and perceived as contrary to the natural process of life (Papadatou, Martinson, & Chung, 2001). Nurses who care for terminally ill patients of all ages fear burnout and the creation of psychological barriers between the patient and themselves, including the inability to become aware of death (Davies et al., 1996).

Therefore, caring for children who are dying becomes an important topic in helping the nurse transition through the child's dying process. Nurses may have difficulty making meaning and ultimately adjusting to when a child's life ends, thus creating the potential to interfere with patient care (Papadatou et al., 2001). Barriers created by nurses who care for dying pediatric patients may be due to severe grief, and may even result in withdrawal from patients and families (Davies et al., 1996).

Unfortunately, the topic of the meaning and essence of nurses' lived experiences in the caring for dying pediatric patients has barely been explored (Davis et al., 1996; Tubbs-Cooley et al., 2011). The lack of investigation and exploration in this subject matter may be due to the emotional sensitivity of both the nurses and bereaved families. Death and dying at the end of a long life are understood as part of a natural process, and observed as an occurrence when the patient is at the end of a long and fulfilled life (Mukherjee, Beresford, Glaser, & Sloper, 2009). Conversely, the death of a child is

Nurses and healthcare professionals may have difficulty adjusting to and comprehending their experiences when a patient's life ends. This has the potential to interfere with patient care. Reflection on past events and actions enables critical discovery of strategies to benefit both nurses and patients. This qualitative phenomenological study explores the lived experiences of nurses caring for dying pediatric patients. The philosophical underpinning of Merleau-Ponty (2008), in combination with the research method of van Manen (1990), was used for this study. The Roy Adaptation Model (RAM) (Roy, 2009; Roy & Andrews, 1991) was the nursing model that guided the study to help understand that nurses are an adaptive system, using censoring as a compensatory adaptive process to help function for a purposeful cause. Nine female nurse participants with one to four years of experience were interviewed. The context of the experiences told by nurses caring for dying pediatric patients uncovered seven essential themes of *empathy, feelings of ambivalence, inevitability, inspiration, relationship, self-preservation, and sorrow*, and these themes demonstrated a connection formed between the nurse and the patient.

Key Words: End-of-life care, death, dying, pediatric, censoring, adaptive process, burnout, psychological barriers, grief.

considered to be unnatural and brings on a much different perspective when it happens (Dawson, 1995).

It is essential that nurses understand the care needed during this time, especially when care includes facilitating the process of dying and giving support during the last moments of life. These last moments of life are extremely critical because the moment of death is a finite point in time in which each action becomes a permanent fixture in the caregiver's memory. In discovering nurses' lived experiences of caring for dying pediatric patients, we are able to understand the importance of knowing how to interact with the dying child. This discovery of knowing how to interact may be due, in part, to personal knowledge, which comes from the inner experience of becoming aware of one's own self and the self of others (Chinn & Kramer, 2008).

The purpose of this study was to explore, describe, and understand the lived experiences of nurses caring for dying pediatric patients, and to gather information that may help future

nurses when caring for the dying child. Specifically, this study sought to answer questions concerned with 1) nurses' interactions with pediatric patients and their families, 2) thoughts processed by nurses as their young patients approached death, 3) ways in which nurses cope with these thoughts, and 4) ways nurses integrate these issues into patient care. Additional questions that emerged and were addressed concerned the actions, feelings, and emotions of pediatric patients during the final stages of life, and how nurses were able to identify these cues. Themes and essences that emerged from the interviews provided insight into understanding the ways in which nurses "nurse," as well as information on nurses' essential tasks in caring for dying pediatric patients. This article will focus on how nurses interacted with the dying pediatric patients.

Methods

The phenomenon of this study was the lived experiences of nurses

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caring for dying pediatric patients. In conducting this study, the methodology of van Manen (1990) was used to explore the phenomenon of nurses' experiences in caring for dying pediatric patients. According to van Manen (1990), the purpose of phenomenological research is to establish a reconnection of recollection with the original experience, and give individuals an opportunity to look at the world and re-examine the meaning of the event.

Experiences, feelings, and actions create behaviors that guide individuals to interact with situations within a specific environment (Dobratz, 2002). Once identified, these experiences, feelings, and actions provide the basis for important nursing education and nursing theory to enhance patient care interactions. Reflection on these interactions help to discover critical concepts that affect the way nurses perform when a pediatric patient is dying for the benefit of both the nurse and patient. This discovery also provides insight into the nurses' thought processes, including emotional responses, nursing actions, nursing interpretation of the dying pediatric patient's actions, and family concerns. Through these interactions, nurses make a difference, for the better, in patients' lives (Dobratz, 2002).

Sample

After the City University of New York (CUNY) Institutional Review Board (IRB) approval was obtained, registered nurses who worked on pediatric units and cared for dying pediatric patients were selected through networking and purposeful sampling, and were chosen on the basis of availability and likelihood of voluntary participation in this study. Purposeful sampling allowed the selection of individuals who had similar experiences within the phenomenon and then permitted the researcher to understand the phenomenon in question (Polit & Beck, 2004). The researcher had no prior relationships with the nurse participants; however, participants were selected by word-of-mouth snowballing recruitment. All participants needed to have a minimum of one to four years of pediatric nursing experience, allowing for a timely recall of pediatric death. Exclusion criteria included nurses who had their own child die or had experienced a child within their immediate family die from terminal illness.

Formal consent was obtained from each participant prior to interviews and data collection. The study sample consisted of nine participants who were all female, registered nurses, actively employed on pediatric units, and had between one and four years of experience. Participants' ages ranged from 24 to 37 years. Three participants were married, six were single, four were mothers, and five did not have children of their own. Of the nine participants, eight lived in a suburban area, and one lived in a metropolitan area in a large city in the northeast states. All nine were actively employed at large metropolitan hospitals. Nurses' names were withheld, and pseudonym names were assigned to protect their identities. The nurses were referred to as follows: Abby, Betty, Conny, Dotty, Eddy, Fanny, Gabby, Heidi, and Ivy.

Data Collection

The researcher conducted semi-structured interviews, asking nurse participants open-ended, non-judgmental, and non-leading questions, while encouraging them to share their stories. Interviews were conducted face to face and were digitally voice recorded for transcription purposes. Interviews lasted approximately 35 to 45 minutes, and questions were asked, such as: "Tell me what it is like to care for dying pediatric patients." Subsequent clarifying interview questions were also asked, such as: "What does that mean?" or "Can you give me an example?" Exploration of the experience was unique to each participant and absent of uniformity. However, properties and dimensions of the interviews developed into categories of data, and when no new categories or relevant themes in the data emerged, saturation and determination of sample size was then said to have been achieved (Corbin & Strauss, 2008).

Data Analysis

From a qualitative perspective, exploration was used to study the phenomenon of the lived experiences of nurses caring for dying pediatric patients. Qualitative research proposes to discover the perceptions of individuals within a particular phenomenon, and give an opportunity to look at the world and re-examine the meaning of a particular event. The qualitative research process used for this study was inspired by the philoso-

phy of Merleau-Ponty (2008). The philosophical underpinnings of Merleau-Ponty (2008), focus on the human in the "lived experience, embodiment, and the meshing of the individual and the world," allowing for pediatric nurses to tell their own stories by providing representation through examples of their experiences and describing their experiences as they lived them. To clarify, "lived experience" is the personal daily practice and reactions each nurse encounters through caring for a dying child. This philosophical approach, in combination with the research method of van Manen (1990), provided the six activities or steps the qualitative researcher needed to follow (see Table 1). These six activities guided the collection and analysis of data that explored and described meanings that comprised the lived experiences of the nurse caring for the dying pediatric patient.

Results

Interviews clarified nurses' passion in caring for dying children, providing a greater understanding of why these nurses continue to practice within the realm of pediatric nursing. They all felt their presence with the dying child was needed to help ease suffering. Several nurses expressed self-doubt regarding the care they gave, but the overall feeling was that they were there to help support, comfort, and guide the child and family. Seven themes emerged to describe the phenomenon of nurses caring for dying pediatric patients: a) empathy, b) feelings of ambivalence, c) inevitability, d) inspiration, e) relationship, f) self-preservation, and g) sorrow. These themes were discussed and identified throughout the nine interviews in relation to the dying pediatric patient and were brought to light by the qualitative research process of van Manen (1990). This phenomenon would not exist without these themes and their examples.

Empathy

The nurses spoke about several experiences that captured the meaning of the theme of "empathy," and was illustrated with descriptions of the innocence in children and the notion that death is not supposed to happen in childhood. Abby described the feelings she experienced concerning pediatric patients when she

Table 1.
Research Method of van Manen (1990)

Steps	Description of the Steps
First Step	Identify a phenomenon of interest, turning to the nature of the lived experience, expressing reflection by the participants to make sense of the meaningful experience.
Second Step	Conduct an investigation of the phenomenon as the lived experience, not as it is conceptualized, and provide the opportunity for participants to describe their experiences from their own perceptions.
Third Step	Reflect on illuminated essential themes that characterize the phenomenon through listening to, transcribing, and reflecting on the interviews to allow the phenomena to arise.
Fourth Step	Write and rewrite in order to describe the phenomenon through the use of coding, memos, and diagramming.
Fifth Step	Maintain a strong relation to the phenomenon in terms of pedagogy to provide the rigor of the research process.
Sixth Step	Balance the context by considering the parts as well as the whole by stepping back and evaluating the wholeness in context to its parts to see how the parts contribute to the whole.

said: "It's someone's baby. It's a child. You know, they're not supposed to die. They're supposed to be healthy, you know. It's sad." This was further enhanced by Betty, who said: "You have those kids, and you have those times with them where you think that they're not going to make it." Conny conferred with empathy felt toward children when she stated: "Because it's a child. Because it's an innocent human that hasn't had a chance to live." This was also described by Heidi, who stated: "I'm not saying that a child losing a father isn't just as sad, because I do. But I think what differentiates is just that this person (is a child), who knows what their life could have been."

Fanny also expressed empathy when she described her feelings toward the dying child: "He was a person, and he just was suffering the entire time. And it was very, very hard for me to deal with." Gabby expressed empathy when she talked about dignity in dying, and how creating a dignified setting for pediatric death is important for peace and comfort during the process: "It's just too hard to wrap your head around a child dying. It's not the natural order of things."

Empathy can be thought of as an individual's identification with and response to an event (Wilson & Kirshbaum, 2011). Empathetic reactions may be a result of understanding and compassion felt toward the patient and family. As with other research studies (Dawson, 1995; Morgan, 2009), nurses felt it was not a natural process to see a child in the throes of dying and death, and not congruent with the way the life

process should unfold. Nurses perceived children as individuals who should be living productive, healthy, happy lives. When children die, the potential for the future of the child's life is lost, leaving parents and nurses to grieve (Morgan, 2009).

Empathy can further be viewed as an emotion felt by nurses when they place themselves in the patient's situation, personifying the experience and treating the patient as they would want to be treated. When empathy involves alleviation of pain, avoidance of suffering, and promotion of a new level of health (Mattsson, Forsner, Castren, & Arman, 2013), nurses will try to deliver patient care so these concepts can be achieved. This was evident when the nurse participants discussed their feelings of empathy, describing their reactions to the pain inflicted on the children, making the children more presentable to the family, making the children feel better, bringing on a peaceful death, and even placing themselves in the parents' shoes. As one nurse stated: "I don't want to remember seeing my child like that," reflecting as if the patient was her own child. Stayt (2009) found that empathy toward patients and families contributes to the emotions of caring provided by nurses.

Feelings of Ambivalence

Nurses discussed struggling with their feelings during their experiences of caring for dying pediatric patients. Betty described her feelings of ambivalence by questioning why the children were subjected to the treatments and drawn-out life-prolonging procedures when she

stated: "I'm sure a nurse said like, 'What are we doing here?' Like you can't even feel good that you literally saved someone's life because [pauses, voice waivers] it was for no reason."

Dotty spoke about her experience when caring for a dying child of Chinese culture, explaining that in this culture, they do not speak about death and dying with the patient because it is taboo. Her feelings of ambivalence were illuminated when she said: "I find, in the Chinese culture, they don't want to let the patient know they're dying or they have a risk of dying. So there's also that aspect of the nurse, of separating your beliefs. So that's a struggle."

Ambivalence is defined as the state of having mixed feelings, mixed beliefs, or contradictions of thoughts and feelings (Petty & Krosnick, 2014). When discussing ambivalence in patient care, nurses described a sense of doubt as to whether or not the care rendered was appropriate for the situation. Each nurse participant discussed similar issues related to ambivalence, whether the issues were concerned with the healthcare prescribed for the dying children or the struggles nurses faced with their own emotions. The nurses spoke about the care they gave, and questioned whether their care caused pain and suffering. In relation to this, Morgan (2009) found that ambivalence may be emotionally distressing when nurses are asked to behave in a manner contradictory to their beliefs. It may be feelings of "disquiet" or listening to the "conscience" concerning nursing actions that create ambivalent feelings about what is

experienced (Lee & Dupree, 2008), concurring with reports of nurse participants in the current study of ambivalence in the type of care rendered, specifically comfort measures and curative treatment.

Inevitability

Nurses spoke of how they had “seen so much” and that they could “predict how things were going to go,” describing their experiences of inevitability. Abby discussed the inevitability of death as expressed by the child. She described how the children know they are dying and how they understand their inevitable future. She stated:

One child, he had three friends die in about a two-month period, and he's like, 'Well if they're dying, I'm next, and there's no way that I'm not next. I can feel it.' And within, I would say about three months, that he passed away.

Betty described inevitability when monitoring the dying pediatric patient's status: “The oxygen desaturations are lasting longer. And longer. And longer. You just see things start taking longer. Like he's not coming back up as quickly as he usually does.”

Conny clarified inevitability when she described the experience through the eyes of the dying child: “I know it sounds a little bad to say, but sometimes, you just need to let them go. In a way, it's like you're just prolonging their suffering.” This statement described prolonging the suffering of the dying pediatric patient and knowing what would happen despite all efforts. Heidy described her experience by this description of what a patient said to her: “This is what I want. I just want it to be over.” Ivy reinforced this when describing one dying child: “She had fought her fight, and knew what was happening to her, and was okay with what was going to happen.”

Inevitability is defined as a situation that is unavoidable and an event that is certain, but is yet to come (Peach, 2000). Death is sometimes an inevitable outcome for patients despite technology, increasing survival rates, and cures for illnesses (Lehto & Stein, 2009). Pediatric nurses may, from time to time, face the burdensome task of helping patients manage the inevitability of death. Most nurses spoke

of “knowing” through experience when death was near. It was evident during the interviews that each nurse struggled with the concept of children dying; however, nurses spoke about humanity and compassion concerning their perceptions of what the dying child was going through at the time of death, and knowing what the outcomes were going to be because they had seen it play out so many times before.

Inspiration

“Inspiration” was identified when nurses observed the strength and resilience they detected in their pediatric patients. For Betty, one child was a source of inspiration:

Sometimes, you do look at them, and you're like, this kid's never going to make it. And then you see them three weeks later, and they're bouncing up and down, and you're like, 'What's happening?' Kids are resilient, and I guess that resilience kind of passes onto you.

Inspirational lessons can be learned from the experiences of caring for dying pediatric patients, as Dotty described: “Every patient I've taken care of that's passed away has taught me something. At the very least, I can think, ‘Okay, I'm a better nurse because of this child for this reason.’” She further elaborated on this when she stated: “So in her passing, I've learned, ‘This is for her.’ Like every day, I will have a smile on my face for her because I know she would.”

Inspiration can also be felt by nurses when the experience of caring for dying pediatric patients defies the odds. Eddy described caring for her dying pediatric patients as “miraculous.”

You really do see those miracles when you would bet anything that this child was not walking out of here. And they do... When you know that everything scientific is telling you that it's impossible. But sometimes it can happen. And we've seen it.

Inspiration is a process of being mentally stimulated to do or feel something, creating a motivating reaction typically experienced when facing challenges in the process of goal attainment (Straume & Vitterso, 2012). Inspiration includes spiritual feelings and coping that compel an

individual to make meaning of incomprehensible events. Pendleton, Cavalli, Pargament, and Nasr (2002) found that inspiration and spiritual coping, influenced by external and/or internal demands, goes beyond the resources within the person themselves, and creates a search for significance and meaning in a stressful time.

Inspiration and inspiring reflections were mentioned by nurse participants during their interviews, providing descriptions of the religious and spiritual coping they seemed to have interpreted from their care of dying pediatric patients. Inspirational reflections by nurses were described as the actions of and thoughts spoken by dying pediatric patients. Even something as symbolic as smiling created an inspirational representation of a dying pediatric patient. Being inspired by individuals at their most vulnerable moments helps define what is important in life, and arouses redefinition of priorities and life significance. Inspiration takes on meaning making, in which positivity is perceived from the caregiving experience (International Work Group on Death, Dying, and Bereavement [IWGDDDB], 2006).

Relationship

During each interview, nurse participants discussed their relationship with the dying pediatric patient through statements such as: “And you don't forget the names.” “It was hard for everybody that worked there because you get attached, you fall in love with them. You hold them when they're scared.” “I can still remember the name and face of every child I've seen die.”

Relationship was also described when nurses discussed the love and attachment felt: “There is always somebody who picks that kid to love and becomes attached to that child.” Fanny summed it up well when she described her interactions and relationships with dying pediatric patients: “As much as they tell you in nursing school not to get attached, you can't help it. Sometimes, you just can't help it.”

Conny described it as:

I don't know if she knew she was dying, or I don't know if she knew she was so close to dying, but she would still recognize the nurses who loved her and who are always coming to see her and to play with her.

The dying child developed such a strong relationship with her nurses that she recognized them even at the very end. Eddy reinforced this by stating: "You can't stop the connections that you make of all of them...you know, as hard as it is at times, I really do love taking care of kids."

Relationships are sometimes established because of the amount of time spent with the dying child and is defined as the state of being connected in a physical, emotional, and/or spiritual sense (Goldberg, 1998). Relationship may also be the association a nurse experiences with others who surround connecting circumstances and shared events, and can develop among nurses and patients due to extenuating issues and events such as death and dying (IWGDDB, 2006). Relationships that form between the nurse and the dying pediatric patient is a profound event because of the natural tendency to become attached to children, especially when they are in a vulnerable state, such as illness and impending death.

Miller (2007) also found that when a patient is dying and close to death, a sense of connection is cultivated through presence, caring actions, compassion, and empathy. Caring actions were described by several nurses when they reported buying clothes or other gifts for the children. Congruent to this, Epstein (2008) reported that nurses purchase toiletries or other items for their dying pediatric patients because they feel these gestures are forms of kindness, love, and connectedness, and define the relationship.

Self-Preservation

Nurses' interviews revealed thoughts of "trying to manage, just taking care of today, so that you could go back to caring for the children the next day," illustrating self-preservation. Abby discussed her feelings about being able to continue with practicing in this specialty:

So I just show up for work the next day and just try and do the best you can to make them comfortable while they're going through this hard time. You just try and do your best, and try and be strong and go home, cry about it later.

Betty also described this sentiment when she said: "I have found that it's almost easy to compart-

mentalize and forget." Heidi also described compartmentalizing of her emotions: "When you're there at the hospital, you have to kind of put all that aside (emotions) and just do what it is you're there to do." Sometimes compartmentalizing is like thinking of it as the "syndrome" or as the "disorder" versus the "person," depersonifying the dying child to a disease process, enhancing coping and self-preservation with pediatric death.

The ability to attach and detach was described as setting boundaries through self-preservation, giving the nurses the ability to continue with their work. Betty conferred:

They're heavy, so you frequently change assignments because just trying to manage becomes exhausting. You have to be able to be their biggest advocate and attach yourself to them, to fiercely fight for them, and be able to flip the coin over and be in the hallway joking around and completely distancing yourself from them. Because otherwise, you couldn't go back the next day and do it.

Eddy said: "It's important to me personally to draw a line...I feel in order to do your job, you just have to make boundaries. Otherwise, you can't function properly and do what you need to do." Yet sometimes self-preservation is composed of finding peace with oneself, knowing you did all you could, as Heidi discussed: "I think that the outcome was greater than us, if that's what it was meant to be. So you just kind of have to learn to be at peace. It's just letting go."

Gabby described how it was easier to care for accident victims admitted due to an acute event, such as a trauma. In these circumstances, she stated it became an easier job because attachment with the child was not established: "You do everything in your power to continue to work on them, but you don't 'meet' them. You receive them down. So that's a lot easier to process because you never hear them talk to you."

Self-preservation can be defined as self-protection from harm, regarded as a basic human instinct of survival (Khantzian & Mack, 1983), and is a coping strategy that allows for an understanding and processing of what takes place in our world. The construct of self-preservation helps nurses deal with the emotional demands of patients, their families,

and patient outcomes, either good or bad (Hawkins, Howard, & Oyeboode, 2007). Self-preservation in the interaction nurses have with their dying pediatric patients helps maintain a therapeutic relationship in addition to a mental well-being. Sahler, Frager, Levetown, Cohn, and Lipson (2000) found it is common for healthcare providers to become emotionally distant from the dying child and family. Self-preservation is part of the process nurses employ to shield themselves from what can deeply hurt them. Research studies found distancing and disconnecting from patients facing a troubling situation is common with nurse self-preservation and self protection (IWGDDB, 2006; Lipp, 2011).

Sorrow

The nurses described "sorrow" when explaining how it would concern them if a fellow pediatric nurse did not cry after caring for a dying child or possibly at any moment "burst out into tears." Abby discussed her thoughts and experiences in dealing with the sorrow of the dying pediatric patient. This sorrow was so vivid in her memory that she was able to describe the first pediatric death she was involved in: "My first time a patient of mine, my first death, I remember my husband picking me up and just not knowing what to say because I was inconsolable."

Betty stated:

So I think that when we have kids that come in healthy and quote/unquote "normal," and then they deteriorate and pass very quickly, that's tougher for everyone to deal with...But it definitely moves you. You have to pull for these kids; you pull for their families.

Sorrow can interfere with help in enhancing parental interactions with the dying pediatric patient and can hinder the last moments between the dying child and family. Gabby described sorrow as becoming a deterrent to providing quality care for the dying pediatric patients:

Some people lose it more, and I think that that's actually detrimental because we're the ones that have to keep it together, and keep things moving, and say, "Okay, it's time. Come hold his hand." You know, that sort of stuff.

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The author(s), editor, editorial board, content reviewers, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

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Sorrow is distinctly conceptualized as a normal response to a situation involving a loss (Eakes, Burke, & Hainsworth, 1998). This normal response is labeled as sadness or some other grief response associated with a gap between what the nurse expects and what actually is. Nurses experience sorrow when patients die, and this is especially significant when nurses care for dying pediatric patients (Lee & Dupree, 2008). Sorrowful reactions are a predominant theme nurses disclose in qualitative studies about nurses' experiences of caring for dying pediatric patients (Lee & Dupree, 2008; Morgan, 2009).

Discussion

The Roy Adaptation Model (RAM) (Roy, 2009; Roy & Andrews, 1991) served as a nursing model that guided the process to understand the nurse as an adaptive system functioning for a purposeful cause. This phenomenological study concluded that through the lived experiences of nurses caring for dying pediatric patients, an overall descriptive meaning of adaptation becomes apparent when stimuli affect behavior. By an exploration and understanding of theme descriptions derived from the nurses' conversations, the process of adaptation through the use of censoring can be understood. Using

the assumptions of the RAM (Roy, 2009), it is implied that censoring, as a mode of adaptation, is a mediator response to stimuli (the dying child), creating an integration of human and environmental stimuli, resulting in optimal well-being. Essential themes of empathy, feelings of ambivalence, inevitability, inspiration, relationship, self-preservation, and sorrow become the behaviors that mediate the nurses' compensatory adaptation of censoring.

Censoring, through empathy, filters the stimuli of death, allowing nurses to perform to the best of their ability. Censoring, with respect to feelings of ambivalence, allows nurses the ability to let go of their own judgments and adhere to the ethical role of nursing, focusing on the needs of the dying pediatric patient and not their own personal needs. Censoring becomes the mediator to compensatory adaptation when nurses experience inevitability. Nurse participants used censoring as they reasoned why dying pediatric patients were subjected to sufferable procedures, knowing what the outcome would ultimately be. Censoring, in the presence of inspiration, provides nurses with the thoughtfulness and courage to endure the dilemmas they face themselves (Maeve, 1998). Relationships allow nurses to cope with the event of pediatric death through

censoring. Censoring, mediated through the actions of self-preservation, provides strength and endurance, so the nurse can give optimal patient care. The use of censoring to mediate emotions until it is appropriate gives the nurse the opportunity to carry on with patient care without distraction. While nurses use censoring to mediate the stimuli of sorrow that accompanies a dying pediatric patient, they also adapt to the moment and give themselves the ability to experience the sorrow at a more appropriate time.

Study findings need to be understood in relation to the social and cultural context of dying pediatric patients. Data that emerged from this study may or may not be applicable to other populations, specifically to nurses caring for dying adult patients. Further, as in any qualitative study, findings are not generalizable because they are limited to the experiences of the participants within the context of this study.

Implications of the findings allow for the opportunity to hear stories about nurses and their patients and families. Personal and emotional stories of lived experiences provide the ability to create strategies to improve quality of life for the patient and for nurses, as well as adding to the identity of the practice of nursing

(Graham, Andrewes, & Clark, 2005). These events, as told by nurses, provide a better understanding of what it is like to be a pediatric nurse caring for dying children. In listening to and exploring the description to which the nurses told their story, it is believed that lessons can be learned and translated to nursing students and novice nurses. By using personal knowledge narrated by nurse participants of this study, specific behavior, self-discipline, and theoretical knowledge may enable information transference to nursing curriculum (Chinn & Kramer, 2008).

Knowledge gained from this study will provide reasoning and substantiate practices in nursing, increasing knowledge and experience sharing within the domain of pediatric death and dying. In learning about the lived experiences of nurses in this study, many similar themes emerged, deepening the understanding of events surrounding pediatric death. These themes incorporated actions, feelings, relationships, and spirituality, as well as "meaning making" of life. Caring for dying pediatric patients involves not only the dying child, but the family and other healthcare providers. Preservation of the mental well-being of nurses concluded that when nurses are put in demanding experiences during the dying process, they use censoring to carry on.

Additional studies are needed to add censoring as a central construct in the theory of the human life process of adaptation (Roy, 2009). Theoretical clarification on the construct of censoring as a compensatory adaptive process will enable the questioning and understanding of how nurses use adaptation through censoring. Additional research articles will focus on how nurses interacted with families and other staff members. ■■■

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